

**CONSTRAINTS ON HEALTH AND HEALTH
SERVICES ACCESS OF RURAL-TO-URBAN
MIGRANTS IN CHINA: A CASE OF DENG CUN
VILLAGE OF BEIJING**

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Abstract

China is experiencing a dramatically increasing process of rural-urban migration, which is almost parallel with the phenomenal economic growth and development in China in the last decades. Given the massive scale of rural-urban migration in China, the health services access and health constraints not only matter to rural-urban migrants but also have important implications for broad public health concerns. However, this issue has not been paid enough attention in academic research.

This study focuses on the multifaceted reality of health constraints and health services access among migrants by originally exploring the social strata, social networks, and the understanding of health and health services among migrants. The research questions are stated as follows: What constraints and difficulties do migrants face with respect to their health and health services access? Is there a hierarchical structure in health services access and medical treatment access among migrants? When there is a shortage of financial resources, do they resort to informal social support (such as informal social networks/ *guanxi*.) to obtain help and why? What are their understanding and experience of health and why?

Furthermore, this study investigates the health constraints and health services access of rural-urban migrants in the absence of equal social protection by the government. By conducting 36 qualitative interviews in Dengcun Village, a migrant community in Beijing, China, this paper: (1) Investigates issues concerning environmental health risks of migrants, their health seeking behaviours, and the constraints they

encountered in accessing health services with respect to the social strata among migrants. It argues that the main obstacles to access health services are not only the shortage of financial resources among rural-urban migrants, but also lie in the institutional blindness regarding health security provision, rural-urban dualism and the household registration system in China. (2) Highlights the key function that social networks play in health and health services access among migrants in China, which has rarely been discussed in previous studies. Examines the range of social networks among migrants, from which they can acquire support, including financial and spiritual, when they are dealing with health problems. The study argues that social networks resemble a double-edged sword to rural-urban migrants in terms of health care access. The fact that migrants lack savings may not be the sole and essential reason for their extreme vulnerability in times of illness. Some migrants, who are in financial difficulties though, may have some assistance, including financial support and emotional support from their social networks. However, on the other hand, the assistance from social networks on their health and health care access is limited, not only because their social networks is limited, but because the social networks should not bear the responsibility to support health services access of migrants, similar to or more than the state and migrants' employers. (3) Discusses the understanding of health among migrants, and further analyses that although many migrants have not formed proper understanding of the connotation of health and have limited knowledge of health, prime responsibility should not be put on the migrants because their poor understanding of health mainly results from their rural perspective while health and health services access depend on the social-economic environment in which they live and work.

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Chapter One

Introduction

1.1 Contexts and Issues

China has experienced the largest human migration historically and across the world. By the end of 2008, 140 million people are migrating (NBS, 2009). Although crude, some estimates suggest that one in ten Chinese people can be identified as migrant (Cai, Du, and Wang, 2009). These migrants are not permanently registered in their current places of residence, and most of them were rural residents moving from rural villages to cities in coastal regions.¹

In China, Rural-urban migration was tightly controlled for over 3 decades since the establishment of the residential registration system (*Hukou*) in 1958 (Knight and Song, 1999). In the early 1990s, after 10 years of economic reform, the policy over the movement of labour from poorer rural regions to more prosperous parts of the country has loosened. The typical type of migration during the decade was seasonal, temporary, individuals bringing no family with them (Song, 1998; Zhao, 2001). Since the current government came to power in 2002, central policies have been made more favourable towards the rural sector, and rural-urban migrants. Chinese government in

¹ This number is from the National Bureau of Statistics of China (2009). Available at: http://www.stats.gov.cn/tjfx/fxbg/t20090325_402547406.htm. Accessed on 01/04/2009. As He (2003) stated, the number of internal migrants in China in 1997 was around 80-100 million and was 120 million in 2002.

the late 1950s set up its strict household registration² (*Hukou*) system in order to control the movement of labour during the planning period. The system identifies a person's residential status between rural and urban by the residing place, including the divide between rural and urban. This system still has impacts on current rural-urban migration as rural residential identification is permanent, even though rural residents may have left their rural origins for an urban life. In the last two decades, attracted by better job opportunities and higher incomes in city areas, rural-urban migration has been increasing each year, despite the unfavourable working and living conditions (Xiang, 2005).

Health as a key component of human capital (UNDP, 2000) has attracted much attention by scholars and policy makers over recent decades. Migration is a process of complexity – it helps migrants raises monetary capital, enhances human capital by skills-developing, but it can also be detrimental to those who migrated (Xiang, 2005). Some research findings prove that initially health people tend to migrate (Wang, 2006). However the poor living and working conditions to which migrants tend to be exposed are potential health risks. Others argue that migrant labourers often suffer from exploitation at work, yet are hardly ever covered by any labour protection or social security measures. Rural-urban migrants unavoidably face more health problems and risks (Xiang, 2005).

Given the massive scale of internal migration in China, health issues matter not only to rural-urban migrants but they also have important implications for a wider range of communities. While the literature focuses on describing the demographic trends and

² This is a formal household registration system for population administration in China, by which every Chinese citizen should be registered. For those living in cities and in towns with public security, each household was issued with a household registration booklet, whereas in rural areas, only a collective registration booklet was issued to each cooperative (Dai, 2003).

economic effects of rural-urban migration (Xiang, 2005), very little in-depth research has been done on migrant health and the constrained access to health services among migrants in urban China.

1.1.1 Rural-urban Migration in China

The segregation of China's rural and urban economies was in place for almost 40 years. During the period of strictly centralised planning (1955-78), the Chinese government controlled all types of migration (rural-urban, rural-rural and urban-urban), and central government was the planner for almost every aspect of society (Song, 1998). It was not until the late 1980s that the restrictions on rural-urban migration were gradually eased. China launched economic reform since 1978 and has been transforming from a command economy to a socialist market economy, economic reforms have released millions of rural labourers from agricultural production, who were originally absorbed by the 'township, village, private enterprise'(TVP) sector since migration was tightly controlled until the mid-1980s (Meng and Zhang, 2001). Similar to other developing countries transforming to modern societies, in China many of the 'surplus' labourers of rural areas, namely 'actual migrants', moved to urban areas (Cai, 1990; Wei, 2000; Huang, 1998). The movement has changed from 'moving away from the farming practice but not the countryside' to 'leaving the farming sector and also the countryside' in pursuit of economic betterment (Fei, 1985; Fei, 1986; Yeh and Li, 1997; Yeh and Li, 1999; Wong and Zhao, 1999a, Wong and Zhao, 1999b; Kirkby and Zhao, 1999; Cai, 2000; Zhu, 2002;Liang, 2006; Chan, 2008; Li, 2008; Cai and Wang, 2008).

In last two decades, the Chinese government pursued a more positive policy towards rural-urban labour migrants, and adopted a number of approaches in support of labour migrants in urban areas. Most of the migrants go to cities in the eastern coastal areas and are from the western and central inlands (Cai and Wang, 2003). While Sichuan, Henan, Anhui, Hunan and Jiangxi Provinces have the largest number of emigrants, Beijing, Shanghai, Guangdong, Zhejiang and Fujian provinces have the highest number of immigrants (Wong, Li, and Song, 2007).

1.1.2 Socio-economic Status of Rural-urban Migrants

Socio-economic status can be measured by a series of indicators. In this section, employment and social welfare are employed to reflect the socio-economic status of rural-urban migrants.

Rural-urban migration has made an enormous contribution to the formation of the labour market in recent decades in China. The government has reacted passively to this movement, but the controls on migration have gradually been loosened. Rural-urban migration in China has two unusual features. The first is the labour market segregation between rural-urban migrants and urban residents. As a result of the lengthy separation of the rural and urban sectors, urban residency entitled city dwellers to generous subsidies and benefits that were not available to rural residents. Although rural residents are now allowed to work in the cities, they are excluded from the welfare benefits of urban jobs. The jobs that rural-urban migrants take pay less and have no job tenure or other benefits. Moreover, rural-urban migrants are not

entitled to formal jobs in the formal sector. The second feature lies in the existing institutional constraints on rural-urban migration, including the household registration (*Hukou*) system. Analysis indicates that rural-urban migrants are almost exclusively employed as trade, service and manual workers, while more than 30 percent of urban employees are professional, managerial and office workers. The government has implemented its policies of severely restricting the permanent urban settlement of rural people and ensuring preferential access to urban jobs for urban residents (Meng and Zhang, 2001).

Employment

Xiang (2005) states that migrants typically fill those job positions what are unwanted by urban residents and have high health risks, these are sometimes referred to as “3-D” (Dirty, Dangerous, and Demanding) jobs.

Some researchers' surveys indicate that rural-urban migrants are mainly concentrated in those jobs considered to be inferior by urban residents, such as construction, services and self-employed businesses in the non-economic zones (Meng, 1996; Tan, 2002). A survey conducted by the Institute of Population Studies at the Chinese Academy of Social Science on 1,504 migrant workers in Jinan City, Shandong province, suggests that about 42 % of migrants surveyed worked as construction workers, 15% were employed in the service sector and another 13% were self-employed (Meng, 1996). Another survey conducted by the Rural Development Research Institute finds that about 33% of migrants surveyed worked on construction sites and about 31% in the service sector (Zhao, 2001). In China, especially in major

cities, such as Beijing and Shanghai, rural-urban migrants cannot work as formal sector employees because of their rural residential registration (*rural Hukou*). Xie (2000) mentioned the concept of 'self-isolated career': "considering their different *Hukou* status from ordinary citizens, many rural-urban migrants are engaged in low-class jobs with low incomes and thus form a concentration in such kinds of jobs" (Xie, 2000: 97).

Social Welfare

Social welfare supported by government offers necessary living materials to those who suffer unemployment, disease, and lack of labour capability and income source (Dai, 2003).

However, the subsidies from government in urban China are mainly for permanent urban residents. Temporary rural-urban migrants, as long as they keep the status of rural *Hukou*, have no chance to enjoy the same social welfare as permanent urban citizens, no matter how long they service the city or how long they stay there. At present a view prevails that government today cannot build an overall welfare-system for the society, and rural-urban migrants will not achieve equal social welfare for a long time (Xiang, 2005).

Increasingly, the Chinese government has taken action to promote migration as a development strategy and recognized the contribution of migrants to the economy. Steps have been adopted and targeted at ending the discriminatory practices to migrants and integrate them into urban social welfare systems. In 2006, the State

Council issued a Number 1 document³ concentrating on improving the circumstances, working conditions, and rights of rural-urban migrants (Wang and Cai, 2006). This was followed in 2008 by a ‘Notice on Major Issues for Promoting Rural Reform and Development’, which was also issued by the State Council and required local governments to make greater efforts, such as providing more services, better working conditions for migrants, and schools for their children. Importantly, training in management and financing for migrants, education for their children, and social security were made part of the budget of the national and local-level governments (Holdaway, 2008).

With the changes in government’s approach to migrants, a series of policies specifically targeted at improving the circumstances of rural-urban migrants have been put forward. These include efforts to reduce migrants’ exposure to health risks and to improve their access to health care, although they are remained policy plans at the current stage and are difficult to achieve in short time (Holdaway, 2008).

1.1.3 Migrants within Health Service Scheme

The health service systems in China are directly established within the context of the rural-urban dualist structure. Very different health-care services are provided in rural and urban China. The rural-urban divide has moulded the health-care institutions and the organisation and administration of health services (Song, 1998: 94; Liang, 2006).

³ These documents indicate the government’s priorities for work during the given year.

In the countryside, from the 1980s the individual family-based Household Responsibility System was adopted, but currently there are scarcely enough collective resources left to support the medical funds. The management of these funds has also become a problem (Li, 2002). According to the 1998 National Health Service Survey, the Cooperative Medical System covered only 1.83% of all the farmers (Li, 2002). Furthermore, the inputs from the government in rural health care have also been declining. Li (2003) stresses that during the period 1991-2000, government input dropped from 12.5% to 6.6% of all the investments in rural health care, while input from society (such as donations) went down from 6.7 to 3.3%. Meanwhile the share shouldered by peasants themselves increased from 80.7% to 90.2%. Migrants are supposed to claim for medical care benefits in their home towns/villages since they are still registered there, but it is evident that because of the very poor medical care system in rural areas, migrants cannot benefit from it at all. Moreover, although the new Rural Cooperative Medical Scheme (RCMS) was launched in limited rural areas from 2003, there are some performance problems in this scheme, such as poor effectiveness (Gao and Meng, 2008). It is unrealistic to require migrants to return to their home towns/villages for treatment or to expect the rural authorities to reimburse medical costs incurred in urban areas where the cost is much higher.

In urban areas, migrants are not entitled to the state benefits equally compared to urban residents. As Dong (2002) states, rural-urban migrants actually benefit very little or cannot enjoy health benefits in rural places at all; they also experience difficulties in accessing health care in urban areas.

The Chinese government has taken more action to develop policies aimed at addressing the health problems that migrants face. The 2006 State Council document (e.g. *Several Opinions on Resolving the Problem of Rural-urban Migrants*), called for further efforts to ensure equal rights and access to public services for migrants (State Council, 2006a). The State Council further held a Joint Conference of relevant agencies, which is supposed to be replicated at each level of government to coordinate work on migrant issues (State Council, 2006b). In response to the State Council's initiation, the Ministry of Labour and Social Security issued a document indicating its plans for implementing this directive (MOLSS, 2006a), which was followed up by another plan to expand migrants' participation in health insurance (MOLSS, 2006b). Meanwhile, some local urban governments, such as Chengdu, Dalian, and Shanghai, have begun developing programmes to include migrants into insurance schemes (He and Hua, 2006).

Despite greater awareness embodied in the official documents, many realistic difficulties remain in addressing the health needs of migrants. Although the new insurance schemes will expand the coverage, a big proportion of migrants are defined out of the eligible population. For example, Beijing has released two documents in 2004, namely, 'The Provisional Measures for Rural-urban Migrants to Participate in the Basic Medical Insurance in Beijing' and 'The Provisional Measures for Rural-urban Migrants to Participate in Industrial Injury Insurance'. In terms of these documents, migrants who have formal contracts with their employers may have access to medical insurance, however, self-employed migrants, who represent a large group, are not covered by the new policies. These will be further discussed in Chapter Four.

1.1.4 The Definition of “Rural-urban Migrants”

According to whether *Hukou* (household registration) is transferred or not, migration is divided into two categories: permanent migration and temporary migration (Dai, 2003). Permanent migration refers to the migration across the boundaries of certain administrative districts undertaken by the residents after they go through the necessary procedures of transferring household registration. Temporary migration refers to migrants who enter the urban areas to work without transferring household registration. In modern China, rural people flowing into cities are typically temporary migrants, who are different from permanent migrants under the government’s plan. As a temporary migrant, one should go to a local police station to get a temporary residence permission card.

As most rural-urban migrants are temporary migrants, in this study, rural-urban migrants are specified as temporary rural-urban migrants with or without a residence permission card. Permanent rural-urban migrants with urban residence registration (urban *Hukous*), according to census statistics, have been listed as urban permanent residents and normally are treated the same as original urban citizens.

This research concentrates on migrants who have kept their rural residential registration but work and live in the urban sector, either wage-employed or self-employed. Migrants I interviewed in this study are long-term migrants, more than three years⁴ as mentioned in Chapter Three.

⁴ The reason why I conducted interviews with long-term migrants is because that, this research will analyse the constraints and health experience and social networks, including some discussion relating with savings of migrants,

1.1.5 Why Rural-urban Migrants in This Study?

Rural-urban migrants, after they enter the urban areas, typically fill job positions that are unwanted by urban residents. Migrants have health risks, due to their rural identity. These migrants are doing the dirtiest, most heavy physical and dangerous jobs in the city. The high workload, bad working environment plus the dirty, chaotic and bad accommodation are things to which migrants become accustomed. Meanwhile, there are also some migrants who are bosses (employers) and migration changed their economic status. Although some become better-off or even wealthy, they may still suffer from their lack of social status in comparison with urban residents. This leads to the discussion in Chapter Four on the possible social strata among migrants and the constraints on health and health services access in terms of their social strata.

Shao and Chen (2005) comment that among migrants, many will not go to see a doctor if they are ill, they will not stay in the hospitals when they need, they leave earlier than expected if they do stay in hospital. Also the proportion choosing inexpensive self-medication is quite high. Most do not enjoy any form of social security in the city. At the same time, their income is low and unstable. When they incur a critical illness, they will resort to measures like 'take meal or take medicine'. Hu and Zhang (2006) claim that migrants have made a great contribution to the development of Chinese urban life and play a vital role in the growing strength of the state's economy; furthermore, they were actually "hardest workers in the world factory".

for short-time migrants, for example, one or two year migrants, they have not been settled down long time in the city and they can not provide more relevant information, such as their health experience and their social networks, let alone some migrants used their first year in the city for job-hunting as indicated by Mr. Shi-one interviewee of this study. Moreover, this length of migration has been used originally in a project (on Epidemic Risk Control in China) I have completed successfully with Prof. Lina Song.

As discussed above, the health of rural-urban migrants has become an extremely serious issue in China. Most migrants have almost completely assumed responsibility in the cities to do all the dirtiest, heaviest and most physically dangerous work. They are the group that most need medical protection. However, in reality they encounter many difficulties and constraints in access to proper medical treatment. They are marginalised⁵ people in city areas, unable to integrate into city life (Wong, Li, and Song, 2007). When they fall ill, many of them do not receive proper treatment in time and their illness may be prolonged.

There is as yet little empirical research on constraints and difficulties of health and health services access among rural-urban migrants in China. The relationship between the urban and rural sectors in China is complex, which makes a study of rural-urban migration and health in China complicated as well (Song, 1998). This study asks what are constraints on health and health services access in urban areas? Whether social strata exist among migrants? If so, whether their social strata have impacts on their access to health services and medical treatment? If not, why not? Whether there are institutional constraints in migrants' access to health service system in China? If so, whether any informal channels such as social networks may help them? What are the understanding and experience of health related issues from the migrants' point of

⁵ There are at least three ways of defining the concept of marginalization in the literature on migration. First, marginalization can be defined as an involuntary exclusion from participation in one or more spheres of life. This definition focuses on the involuntary exclusion of an individual from participating in a society. Second, Kuitenbrouwer (1973) states that marginalization can be referred to as a state of relative deprivation characterized by poor housing conditions, lack of opportunity for education, poor health conditions and limited chances to improve income and employment opportunities. This definition points to the nature and consequences of marginalization on the lives of individual migrants. Third, marginalization can be conceptualized as a process of excluding an individual migrant from participation in some areas of social life that are viewed as essential in a given society. This definition highlights the importance of examining the underlying processes leading to marginalization of a particular migrant population (Wong, Li, and Song, 2007)

view? And why? To answer the questions like these, carefully designed research is required. That is the rationale for this thesis.

1.2 Current State of Knowledge on Health Related Issues among Migrants

Some researchers have examined the impacts of health on labour productivity, as well as the effects of income on health and education in developing countries (Strauss, 1986; Behrman and Deolalikar, 1988; Thomas and Strauss, 1997, for urban Brazil; Haddad and Bouis, 1991, and Foster and Rosenzweig, 1992 and 1994, for Philippines; and Glewwe, 1999, for Ghana; Shaikh and Hatcher, 2004, for Pakistan; Le and Le, 2005, for Vietnam). Other researchers have explored the subjects of migration and its links to poverty; health, wealth, and economic development (Skeldon, 2002; Bloom, Canning, and Sevilla, 2003; Resosudarmo, Suryahadi, Purnagunawan, Yumna, and Yusrina, 2009).

Discussion about urbanward migration, health and health care can be found in some previous studies (Wessen, Hooper, Prior, Huntsman, and Salmond, 1992; Le and Le, 2005). A number of studies highlight the benefits of access to health services, information, education, safe drinking water, and cash incomes afforded by urban living. Other studies have found that poverty, housing and living environments, inadequate water services and waste disposal limit the benefits of urban environments and exacerbate health problems (McDade and Adair, 2001; Ngyamongo, 2002). Two general findings are: firstly, migrants and non-migrants tend to have different health status; secondly, socio-economic factors, such as age, sex, income, education,

ethnicity, housing, population density, and labour force status determine the health status of both migrants and non-migrants, but at different levels.

Detailed studies on migration and health in urban China are rare. Surveys sponsored by the Ministry of Health have facilitated the monitoring of the nutritional and health status of the population (e.g. China Centre for Preventative Medicine and State Statistical Bureau, 1998). The well-known China Health and Nutrition Survey, a panel survey of households in eight provinces conducted in 1989, 1991, 1993, 1997, and 2000, has documented health outcomes and some of their socio-economic correlates (Popkin, 1994; Popkin et al., 1993, Zhang, 1999). However, these datasets contained little information on the health and living status of migrants. The datasets did not reveal the human dimension of individuals' efforts to balance the health risks associated with a migrant lifestyle and discrimination in the provision of health services on the one hand and the pursuit of a better standard of living for themselves and their families on the other.

Some scholars (such as Cai, 2003) point out that migrants experience financial difficulties in urban areas, and rural-urban migrants' income and benefits lag behind those of local urban residents by a wide margin. Some mention that financial difficulty determines the health-care seeking behaviours of migrants (Wang and Zou, 1997; Guan and Jiang, 2002; Cai, 2003; Huang and Zhan, 2005; Xiang, 2005). For instance, Shao et al. (2003) explore the financial obstacles to maternal health-care access for rural-urban migrants in Shanghai, seeking to understand why women migrants do not use the antenatal care provided and its relation to financial difficulty.

However, after I completed a project⁶ and interviews with rural-urban migrants in the Dahongmen area of Beijing in summer 2006, I found that although financial difficulty is an obstacle for migrants in seeking health care, some urban residents who are unemployed also have this problem. So are there any other reasons affecting the health and health services access of migrants? Do they have other constraints and difficulties and why? These will be explored in this study.

Although much research has been carried out on Chinese migration (this will be discussed in Chapter Two), very few studies have concentrated on migrant health, especially by social strata, the impacts of social networks on the health and health services access of migrants, and the understanding and experience of health and health services access. The main focus of this study is upon the situations surrounding the rural-urban migrants in urban China. And the aim of this study is to apply qualitative methods to explore health constraints and health services access among rural-urban migrants in respect of social strata, social networks, and the migrants' understanding of health and health services access. This study also explores the potential reasons and institutional factors that constrain health activities and health service choices of migrants.

⁶ In summer 2006, I joined a project of my supervisor, Professor Lina Song. Individual interviews and focus groups were conducted in Fengtai District of Beijing. I conducted some interviews with rural-urban migrants in that area. These interviews have covered many occupations that migrants are currently undertaking in Beijing, such as construction workers, cook and waitress in restaurant, workers in garment factory, employer and employee in barber shop, street vendor, cleaner, etc. Each interview contains information about the interviewee's current employment status, employment history, current job, about their health, about their family, current living conditions, working conditions, and their experience of the 2003 SARS outbreak. I also took voice records for these interviews and have made transcripts for them, at the end of every transcribed record, I have written down the simple impression obtained from the interviewee.

My experience for this project not only enhanced my ability in interviews and fieldwork but also provided me a good opportunity to contact and get acquaintance with some migrants, employers and organizations, such as neighbourhood committee, via these contacts, accessing relevant respondents for my own work can be achieved.

1.3 Research Questions

The aim of this research is to investigate the nature and the level of constraints that rural-urban migrants in China have confronted when they need to access health services. The issues investigated concern health constraints and health services access among rural-urban migrants in the absence of equal social protection compared with local residents by the government. Thus the study intends to establish the constraints to migrants' health services access within the framework of socio-economic costs and benefits including economic motivation and consumption of health treatment; their differential ability to access public health services by classifying their socio-economic status; and the roles social networks play when there is a lack of social assistance. Finally, this research examines their understanding and experience of health and health services access.

The research questions are:

- (1) What constraints do migrants face with respect to their health services access? Is there a hierarchical structure in health services access among migrants?
- (2) When there is a shortage of financial resources, do they utilise informal social support (such as informal social networks/ guanxi,) to obtain help?
- (3) What are their understanding and experience of health and health services and why?

One important issue in this study is to establish the diversified types of health services choice, and to investigate the different constraints they have when they want to access health services.

In urban areas, migrants encounter many difficulties and constraints in access to the public services. As a channel for supporting or protecting their health, in which access is the key providing them with the ability to use formal or informal support, migrants usually make medical care choices not only by going for cheap services but also developing their own strategies to limit the impacts of ill health and medical shocks. But this is dependent on the different migrant classes and different social networks they have, and their health services choice and constraints will also be different. This is why I address the first research question and it will be explored in detail in this research.

1.3.1 Some Clarifications of the Research Questions:

The aim of this research is to explore the issues of health constraints of rural-urban migrants and their access to health services. Health services comprise health care and medical treatment. Health care embraces all the products and services designed to promote health, including “preventive, curative and palliative interventions, whether directed to individuals or to populations.”⁷ Medical treatment includes treatment of illnesses and injuries by utilising professional (such as physicians or doctors) and nonprofessional (such as lay persons or medicine bought by themselves) ways.

⁷ World Health Organization Report (2000). ‘Why do health systems matter?’, WHO.

In this section I will explain each research aim in turn, and will state the research questions which can help me to fulfil these.

The first aim is to analyse the health constraints and access to health services with respect to the social strata of migrants.

Social Strata

As an expanding social group, rural-urban migrants pursue different jobs and have incomes at different levels. They would be expected to have different social classification according to their different economic and employment status. Zheng (2003), for example, mentions that after the division of migrants into various occupational groups, each group may be separated into several sub-groups, in terms of their income, wealth, and possession of the means of production or of the prestige associated with the job.

I understood more about the differences from the fieldwork in Dahongmen area of Beijing in 2006. I found from the interviews that there are quite different levels of living conditions and income among migrants, and in the migrant community. For instance, according to the types of occupation, migrants might be divided into different sub-groups, namely: the owners, who hold the relative productive capital and employ other people, the self-employed migrants, who hold little capital and run their own private businesses, and migrants who are totally dependent on others for work. There is a complete lack of information in current studies on social strata among rural-urban migrants and a number of previous studies treat this grouping as a

hotchpotch, and say nothing about how the health and health care of rural-urban migrants relate to these social strata. This study will try to make some contribution to this important issue and cover some gaps in this area.

In this study, social strata of rural-urban migrant will be identified by occupations, based on the characteristics of the migrant community, and it involves an analysis of their access to health services.

Throughout the process of data collection and data analysis, it is important to be mindful of different constraints and the perspectives of different migrant strata.

- What obstacles are they faced with when seeking health services? What do they share as migrants with common citizenship? And what separates them?
- Does the chance of access to professional health services differ according to different social groups of migrants?

The second aim is to analyse the social networks of migrants and the role of social networks on migrants' health and health services access when they encounter a shortage of social assistance.

Social Networks

The term 'social capital' is defined by Ostrom (1994) as 'relations between persons that facilitate action', and is used to describe the constellation of social networks and

social relations that can sustain those who draw upon them (Ostrom, 1994). The notion of social capital has been adopted to provide an explanation of social structures and institutions and has also risen to prominence in development policy (for example, Harriss and de Renzio, 1997: 920; World Bank, 1997). Much of the writing on social capital shows the way in which social relationships can be mobilized, and in so doing helps to build an understanding of the interaction between access, behaviours and institutions (Bebbington, 1999: 2037).

A social network that is largely determined by the relationship that people have with others is regarded as the key asset in modern society. The relationship may be among family members, friends, workers, neighbours, communities and wider institutions of society, and can be defined by their purposes and qualities such as trust, closeness, strength and flexibility (Ashong and Smith, 2001). Social networks are important not only for their intrinsic value but also because of the accessibility of additional resources through the development of relationships that allow people to meet their needs. In this sense, social networks are expanded when people use them whereas they get smaller by underuse (Jack and Jordan, 1999). The common aphorism, 'it is not what you possess, it is who you have', can be said to sum up much of the common understanding in relation to the importance of social networks. It is the understanding born of our experience that it is our family, relatives and friends who provide us with a variety of support when we fall upon hard times. However, a distinction should be made between the presence of a social network and the attainment of social support. This is because the presence of a social network does not necessarily assure the acquisition of social support (Wellman and Wortley, 1989). This argument suggests that accessibility is highly dependent on the intensity of social relationships. Here, the

question as to how we measure the intensity of social relationships can be raised. This brings us to identify horizontally who are their contacts, the range of social networks; and to do a vertical search of how close they are, namely, the strength of social ties.

As the ‘Villagers in the city’ (Xiang, 1994), rural-urban migrants can not enjoy social protection equally with local residents in urban society; but social networks might be a channel and resource for them to access health services and assistance. But what roles do social networks play? How do migrants utilize their networks to limit the impacts of ill health and medical shocks? No previous studies have analysed these issues and these questions will be explored in this study.

Some researchers suggest that one reason for the migrants’ lack of capacity to use the existing health services is their financial difficulty (Xiang, 2005). Due to financial obstacles, access to big hospitals is a problem for most migrants. In the meantime, their remittances to their home villages also result in financial constraints (Huang and Zhan, 2005). In 2007, the average monthly wage of a migrant reached 1,200 RMB Yuan⁸ (around 110 British pounds), up 200 RMB Yuan over the previous year, but 22.2 percent of migrants said they were unable to save any money as their incomes covered only living expenses.⁹ Without savings, access to the health services in public hospitals is very difficult for many migrants.

This study will examine the migrants’ social networks. Firstly, the questions to be asked are as follows:

⁸ RMB is the Chinese unit of currency.

⁹ AFP (Beijing), 14th January 2008, *Very few Chinese migrant workers are happy: report*.

● What are their social circles in the urban sector?

It will go further to explore the impacts that social networks have on the health and health services access of migrants and try to answer the following question:

● What is the role of social networks in the health and health services access among migrants?

The third aim is to examine the understanding and experience of health and health services access of migrants.

Understanding of Health and Health Services Access

To investigate health and health services access among migrants, the analysis identifies not only a detailed discussion about migrants' social strata and social networks, but also concerns their own understanding and experience of health and health care.

The understanding of health can be said to centre on 'the ideas and knowledge on health experience', it is based upon the individual's experience of health and the personal consciousness or perceptions that influence health activities. It may comprise, first, how people decide whether or not they are healthy and what they need to do to maintain their health. Second, the impact that family life can have on health by looking at, for example, different eating behaviours. Third, how and where they live can affect their health, for example, the influence of housing conditions. Finally, the

influence of the social environment on health by examining the people's understanding and perspective of health related issues.

To rural-urban migrants, although policy measures by the government are important to their health and health services access, the understanding and experience among migrants, as the internal factors, affect significantly the migrants' health. If we explore the issue of migrants' health, the discussion from migrants' point of view cannot be neglected. Questions to be asked are:

- What is their understanding on health related issues? In this study, it will discuss the understanding and experience of health and health maintenance among the migrants.
- What are the characteristics of their understanding? And why?
- How do they access health services when they are ill?

1.4 Structure of the Thesis

Chapter 2: Literature Review

Chapter 2 reviews the literature related to the research issues and questions. There are three major parts in this chapter. The first part is a review of rural-urban migration, including the socio-economic status of migrants, classic rural/urban sociology, and

migration studies in China. This section provides some background for the research. The second part reviews the health relevant issues among rural-urban migrants, including choice of medical treatment, and living and working environments, and the impact of migration on health status. The third part reviews the health services system and its impact on health services access among migrants. Government health provision is reviewed in this section to highlight how the institutional changes that have occurred at national level establish the status of rural-urban migrants within the health services system.

Chapter 3: The Methodology and Methods of the Research

Chapter 3 provides a detailed summary of the rationale and links between the aims of research and the research methods used. It discusses the way in which I set about analysing the health constraints and health services access by introducing the qualitative approach as the research method. Dengcun Village in Dahongmen area of Beijing has been chosen to conduct the fieldwork, and multiple sources of data have been collected. In this chapter, the research process in relation to methodological issues is extensively discussed. It begins with sample selection, goes on to a discussion of the recruitment of participants, and ends with ethical considerations. The multifaceted reality of migrants' health constraints and their living and working details is a sensitive research issue in this process, and the importance of confidentiality is respected.

Chapter 4: Constraints on Health and Health Services Access: One Class of Migrants?

Chapter 4 is the first empirical analysis chapter. Drawing on the data gathered from the fieldwork, this chapter gives an original account of constraints on health and health services access in respect of the social strata of rural-urban migrants. After the discussion of three strata among migrants, the chapter analyses the financial reasons for the hierarchical medical access, and pays particular attention to the specific constraints on health and health services access for the majority of migrants. A detailed examination of illegal private clinics which reflects the constraints for accessing public health facilities reveals another side of the health choice among migrants. The chapter also assesses the institutional factors which make all rural-urban migrants unequal in the health service system in China.

Chapter 5: Social Networks: Channels or Constraints?

Chapter 5 reports the results of exploratory research into the social networks and their impacts on the health and health services access of rural-urban migrants. This chapter analyses the nature and composition of social networks among rural-urban migrants, explains the reasons leading to the social networks of migrants, discusses the barriers/facilitators to the establishment of the social networks in migration and the subsequent impact on health and health care access, assesses the types of support and constraints resulting from the social networks on health services access, and also develops ideas for further research on urban social policy and health for the rural-urban migrants in China.

Chapter 6: Understanding of Health Related Issues: Health Constraints among Migrants?

Chapter 6 moves on to study the migrants' understanding and experience of health and health services access. The discussion mainly focuses on their different level of understanding on health and health maintenance, and attention has also been paid to the factors that affect the health understanding of migrants, including the conception of traditional culture, weak capability of accepting information, exclusion from some specific systems of society, the possibility of health and health care participation, exclusion from some social networks and obstructed channels of health maintenance, and exclusion of crowd psychology.

Chapter 7: Conclusion

In this chapter I provide an overview of the study and summarize the policy implications which are based on the empirical analysis of this research. Implications for policy reform and institutional improvement are particularly discussed in this chapter. The importance of this research and the extra care needed to support the migrants are re-emphasized.

Chapter Two

Literature Review

This chapter is organised into three main sections. The first section is a review of studies on migration, rural-urban migration in China, Household registration (*Hukou*) system and migration, social strata and social networks. This section mainly provides some background and institutional arrangements on the rural-urban distinction and migration in China. The second section discusses the health related issues among rural-urban migrants, including the impacts of migration on health status, and choice of medical treatment. The third part reviews the health services system and its impact on health services access among migrants. Government health provision is reviewed in this section to highlight how the institutional changes that have occurred at national level establish the status of rural-urban migrants within the health services system.

2.1 Studies on Migration

The literature on migration in developing countries has been regularly surveyed and reviewed over the past four decades (including Nelson, 1969; Brigg, 1973, Connell et al, 1976; Yap, 1977; Pryor, 1979; Banerjee, 1986; Stark, 1991; Sly, 1992; Bhattacharya, 1993; Baker and Aina, 1995, Leveine and Price, 1996; Song, 1998, Ma

and Xiang, 1998; Huang, 2003; Resosudarmo, Suryahadi, Purnagunawan, Yumna, and Yusrina, 2009). Numerous empirical studies have been conducted focusing on different aspects, and this has improved our understanding. There are both sociological and economic aspects to the literature discussed in this section. Economic theories provide a means by which migration can be analysed as a movement, but they are based on the assumption that migrants are rational beings with mainly economic concerns.

Non-economic theories relating to migration are concerned with environmental settings (e.g., geographic types and urban infrastructure), social organisations, and the personal behaviour and psychological adjustment of migrants. For instance, urban planners are concerned with congestion and inadequacy of basic urban services. Sociologists pay attention to the problems of social and personal disorganisation, political instability, crime and delinquency, and the effects of city life on the family (Song, 1998).

Migration is generally defined from two perspectives: geographic and social-economic. Eisenstadt (1953) defined migration as “the physical transition of an individual or a group from one society to another. This transition usually involves abandoning one social setting and entering another different one” (Eisenstadt, 1953: 1). This comment clearly takes the change of the social surrounding and setting as the most important “signal” of migration. Another definition, focusing on spatial transition, for migrants was put forward and claimed that any act of migration consists of an origin, a destination and an intervening of obstacles without concerning the distance and the difficult degree of migration. Thus, according this definition, a move

across the hall from one apartment to another is counted just as much as an act of migration as a move from Bombay, India, to Cedar Rapids, Iowa, though, of course, the initiation and consequence of such moves are vastly different (Lee, 1966; Dai, 2003).

Rural-urban migration has its own unique features in China, besides the spatial and social transfer. At first for most migrants, this migration is temporary, which can also be observed from their alternative name: 'floating people'. This temporary situation reflects their social status and the tight connection between their present residential place and the original residential location (Dai, 2003).

2.1.1 Rural-urban Migration in China

Some studies discussed how rural-urban migrants make decisions. Roberts's research (2001) on migrant workers in 1993 dismissed the notion of 'blind' migration and pointed out that the family, education and regional backgrounds of migrants and their social networks helped to channel migrants into particular occupations and destinations. Wang (2002) also had similar findings based on a study of migrant labourers in the catering industry.

Other studies examined how long migrants stay in cities. Zhao (1999a) discovered, with a data set from Sichuan province in 1995, that rural households treated the income earned in cities as transient income and did not intend to rely on this income in the long run. Therefore, migration was usually temporary. In this sense, the majority of migrants did not really migrate. However, some other scholars, such as

Seeborg, Jin, and Zhu (2000), point out that although many rural–urban migrants initially planned to earn some money and return, once they settled in the city, many were attracted to urban life and decided to stay permanently. Yang (1993) related the length of stay to the reasons for coming to cities: 'Permanent migrants with agricultural registration predominantly move for non-economic reasons, but those with non-agricultural registration are more likely motivated by economic reasons. The pattern is reversed in temporary migration.' However, the data were collected in 1986 and the urban social and economic environment for migration has changed dramatically since then. Li (1999) found that the younger generation did not enjoy farming and wished to earn money quickly and settle down in cities.

Some studies explored the determinants of migration: Why do peasants come to cities and why might they return? Some scholars have examined the driving forces of rural-urban migration in China, Huang (2003) claimed that the migration can be motivated by several reasons: economic, social and institutional. Although urban people have many prejudices about rural labour migrants, rural migrants still keep on coming to the cities to earn money. By and large, the previous studies on the reasons for migration include the following: the first is surplus labour in agriculture (Robert, 2000). The driving forces of rural to urban migration are commonly characterized by *push* and *pull* factors. The surplus rural labour is often viewed as the main push factor (Zhao, 2003: 9). The second is the rural-urban income disparity (Zhang and Song, 2003). Despite China's overall impressive record of economic growth since the economic reform in the beginning of 1980s, income disparities between urban and rural areas, as well as regional imbalances, remain large (Fan, 1997 and Wei, 2000; Wu, 2005). Todaro (1969) and Harris and Todaro (1970) admitted the chronic unemployment problem in urban areas and instead suggest that the expected wage gap

between rural and urban area is the pull factor (Zhao, 2003). In China, migration is not only driven by the huge rural-urban income gap, but also driven by a regional income gap. Zhu (2002) modelled the impact of the income gap on migration and thinks it is the most important positive factor; the introduction of the household responsibility system in agricultural reform, has led to the development of 'township, village, private enterprise' (TVP) in the countryside (Iredale, Bilik, Su, Guo, and Hoy, 2001), and Song (1998) concluded that migration is more remunerative than TVP employment, although the development of TVP may reduce the incentive for migration. Shen (1995) and Huang (1999) argued that migrants left rural areas because of changes in the agricultural sector, and the slower income growth and lack of work opportunities in rural areas in comparison with cities. Zhang and Song (2003) argued that rural-urban migrants were attracted by urban economic growth and income gaps. The third factor is the disintegration of state-owned enterprises (SOEs) and the emergence of private enterprises and a modernised market economy (Iredale et al., 2001). The fourth is the policies in some poorer provinces that favour out-migration (Iredale et al., 2001). Yang and Goldstein (1990) and McErlean and Wu (2003) found that government policies on urbanization contributed greatly to migrants' decisions to move to urban areas to work. Hare (1999, 2002) and Zhao (1999a, 2002) studied migrants and returning migrants respectively and concluded that a range of push and pull forces contributed to migration and returning migration in China. Zhao particularly pointed out that the government's slowness in granting rural migrants urban residency increased the rate of returning migrant workers. Murphy (1999) highlighted the impact of local government policies in attracting migrants back to their home villages. Solinger (1999) found that the reason that these

people came and left seasonally was because the migrants were not granted permanent, official household registration in the place they lived.

Some research found that the home towns of rural–urban migrants benefited from migration. The main findings concerned remittances (Rozelle, Taylor, and Debrauw. 1999; Murphy 2002) and the impact of out-migration on rural productivity (Zhao 2002). As Zhao (2002) and Murphy (2002) demonstrated, returnees were crucial to the modernization of their rural home town. Ma (2001) studied some returnees in 1997 and found a significant correlation between the duration of urban employment and non-farming activities upon their return.

The differential treatment of migrants in urban labour markets and employment was studied by Meng and Zhang (2001), Knight, Song, and Jia (1999), Nielsen, Nyland, Smyth, Zhang, and Zhu (2005) and Fan (2004). Meng and Zhang (2001) claimed that most of the occupational segregation and wage differentials between rural migrants and urban residents could not be explained by productivity-related differences between the two groups and concluded that urban residents were more favourably treated by enterprises.

Differential treatment in social provision was examined by Chan and Zhang (1999), who reviewed the changes in the *Hukou* system and how it restricted rural–urban migration. Solinger (1999) examined from a citizenship point of view how the rights of rural–urban migrants differed from the rights to which urban citizens were entitled. Ma and Xiang (1998) studied the migrant enclaves in Beijing, focusing on migrant networks and the successful migrant economy. In the late 1990s a growing number of research studies explored the 'rights' of rural–urban migrants in cities. Nielsen, Nyland, Smyth, Zhang, and Zhu (2005) focused on social insurance and discussed the reasons

why some rural–urban migrants in Jiangsu Provinces did not participate in the social insurance schemes. Another intensively studied field has been the urban spatial distribution of rural–urban migrants. Ma and Xiang (1998), Zhang (2001), Shen (2002), and Gu and Shen (2003) all examined the concentration of rural–urban migrants in cities and their interaction with urban society and local governments.

Most of the researchers mentioned here focused on rural workers who came to cities to look for jobs and did not intend to stay long. Following this logic, better access to urban labour markets seems to be the single most important factor in improving rural–urban migrants' lives in cities. The presumption of temporary settlement justifies the state's practice of taking no hasty steps to transform the 'temporary' migrants into permanent urban citizens, because most would be moving back to their rural areas sooner or later. However, it is possible instead that observed rates of return are the result of the barriers to long-term settlement established by urban policies and urban society. It can thus be argued that cities need to be prepared for accommodating long-term rural–urban settlers.

2.1.2 Household Registration (*Hukou*) System and Migration

One of the most important institutions in China is the household registration (*Hukou*) system. As a matter of fact, it plays a crucial role in the social life of migrants. After the rural-urban migrants have entered the cities, the direct link between them and the state welfare programmes is disjointed. Their rural household registration (rural *Hukou*) hinders them from enjoying equally with local residents the benefit from urban public services, including health care services.

The various national policies and regulations that affect people's lives are fundamentally defined, constrained and enabled by their *Hukou* status. Contrary to some common perceptions, in which *Hukou* is regarded as an invention of the post-1949 Communist party's regime, the household registration system has actually existed in China for almost two thousand years and has evolved through the imperial era in various forms (Wang, 2005). However, only under the Communist party's rule did the *Hukou* system become a powerful mechanism, which decisively shaped China's collectivist socialism by creating a spatial hierarchy of urban places and prioritising the city over the countryside.

In the first constitution of People's Republic of China (PRC) of 1954, before the completion of the national *Hukou* system in 1958, people were constitutionally guaranteed the right of free migration. Before the implementation of the 1958 household registration (*Hukou*) rule, there was a short period of rapidly increasing rural-urban migration in the early 1950s (Solinger, 1999; Davin, 2000). Although the state was not entirely absent in monitoring this migration, official regulation was largely erratic, fragmented, and ineffective. As a result, many peasants had moved into the urban industrial sectors by 1954. In those days, migrants were not treated as a distinct group of subjects who needed to be put under special control and legal regulation. Neutral terms, such as *yimin* (migrants) or *ximin* (migrating or relocating people), were used to refer to relocated peasants. Other slightly different, nonjudgemental terms regarding migration, such as *qianxi* (relocate), *renkou yidong* (population movement), and *renkou liudong* (population mobility), were also used.

By the mid-1950s, voluntary labour migration to the cities came to be seen as an urgent national problem. According to Seldon (1988), about twenty million peasants rushed into the cities from 1949 to 1957, and these rural migrants could not be fully absorbed by urban industry, thus exacerbating the problem of urban unemployment (Walder, 1996). Further, some officials believed that industrialization required the rural population to remain on farmlands so that they could continue to produce food for those working in industry (Zhang, 1988). As a result, the state passed new regulations to block the 'blind flow' (*mangliu*) of peasants into cities to avoid the pathological growth of oversized metropolises experienced by other developing countries. Restricting people's spatial mobility was also regarded by bureaucrats as a reliable way to maintain socialist stability.

It was through the reinforcement of the 1958 household registration (*Hukou*) stipulations that Chinese peasants were turned into what Potter (1983) calls 'birth-ascribed' rural *Hukou* (household registration) holders. By requiring every Chinese citizen to register at birth with local authorities as either an urban or a rural *Hukou* holder of a particular fixed place, this system divides the entire Chinese population into two different kinds of subjects with asymmetric power. Under the household registration system, every Chinese household is issued one *Hukou* booklet containing the names of every family member, and each individual must be registered at birth with the local *Hukou* authorities. Each citizen can have only one permanent *Hukou*, at only one *Hukou* zone. Each town and city issues its own *Hukou*, which entitles only its registered residents to complete access to the social benefits associated with that particular *Hukou*. A person's *Hukou* registration record usually includes residential address, religion and employment information, as well as birth, death and migration

details. Until the 1978 reforms, the system strictly prohibited population movement, and people could not change residence unless the changes were part of the state's socioeconomic plan. In the following two decades, nonstate-directed population movements were largely eliminated from China's social landscape.

Rural and urban residents were subsequently placed under different forms of state control and social surveillance. In the countryside, state control was made possible through a far-reaching grassroots cadre network (Oi, 1999). In the cities, pervasive state control over urban citizens was made possible through work units and neighbourhood committees (whyte, 1995; Lu and Perry, 1997).

During the 1960s and 1970s, however, a very different kind of state-directed, politically motivated population movement took place. To promote economic and technological development in the frontier areas, many skilled urban workers and professionals were relocated by the state to underdeveloped border provinces or minority autonomous regions like Xinjiang, Inner Mongolia, Yunnan, and Heilongjiang (Shen and Tong, 1992). Millions of urban youth and intellectuals were also sent down to the countryside to be 'reeducated' by poor and lower-middle-class peasants (Bernstein, 1977). During the heyday of the Cultural Revolution, millions of floating Red Guards, mostly urban youth, travelled from place to place and eventually gathered in Tiananmen Square to be personally received by Chairman Mao (Meisner, 1977; Yan, 1993). But such large-scale displacements of urban people and spatial mobility were not seen as population movements, instead, they were conceived of as political events, described in highly politicized terms such as *zhibian* (supporting the border areas by professionals), *shangshan xiexiang* (the sending of urban youth up to

the mountains and down to the countryside), and *dachuanlian* (establishing revolutionary ties among Red guards). Those who were involved in these movements were not regarded as distinct social groups to be subjugated to special regulations as the floating population is today.

After the late 1970s, the situation changed dramatically, as mass labour migration rose on a scale unprecedented in modern China. A number of factors motivated millions of peasants to leave the countryside. First, agricultural reforms greatly improved the efficiency of farming, generating nearly 200 million surplus rural farm labourers¹⁰ (Taylor, 1988; Davin, 1999). Second, a rapidly growing urban economy and the penetration of foreign and overseas Chinese capital demanded large numbers of cheap labourers. Third, the collapse of the state-monopolized ‘urban public goods regime’ (Solinger, 1995) made it possible for migrants to obtain basic resources and services through market exchange in the cities. Fourth, the gradual relaxation of migration policy allowed rural-urban migrants to live and work in the cities on a temporary basis.

Huang and Pieke (2003) divide migration policy evolution into four periods after the year of 1979. The first period is from 1979 to 1983, and in this period, the government still prohibited migration. The second period is from 1984 to 1988, and the government started to allow peasants to enter the urban areas on the condition that they provided food by themselves. The third period is from 1989 to 1991, rural-urban migration was not a significant social phenomenon yet, and had not attracted much attention from the government. The term ‘rural migrant wave’ was coined in 1989 to describe the enormous number of rural-urban migrants during the Chinese New year

¹⁰ Surplus rural labourers existed in Maoist China, but they remained invisible because of the collective farming system and tight rural-urban migration. Post-Mao agricultural reforms intensified the problem of surplus labourers and made them more visible.

period in 1989. After the ‘migrants wave’ in 1989, the government felt the need to interfere and restrict rural-urban migration. The fourth period is from 1992 to 2000: during this period, the government in some degree encouraged rural-urban migration, but since 1994, a lot of major cities tightened their control on migration because of the layoff and unemployment problem in the cities. Since 2000, the government is reforming the *Hukou* system and allows people more mobility. Moreover, the factor of rapid growth of foreign direct investment (FDI) sector since the late 1990s provides another big demand for rural-urban migration alongside urbanisation in China.

The *Hukou* system is one of the major tools of social control employed by the state. Its function goes far beyond simply controlling population mobility (Chan and Zhang, 2003); it was part of a larger economic and political system set up to serve multiple state interests. The system alone is less effective in controlling rural-urban migration. Since the *Hukou* system links people’s accessibility to state-offered benefits and opportunities, it significantly affects personal life in many aspects. Its power in controlling people’s lives has declined during the reform era in the wake of enormous social and economic changes and increases in rural-urban mobility, despite the central government’s continuing efforts to adjust the system to fit the new situation (Chan and Zhang, 2003). The significant changes in the last three decades after the reform of social and economic system have put a lot of pressure on the pre-existing *Hukou* system, leading to some important changes and the emergence of a number of new categories.

With the development of a market-oriented economy, more people tend to be found outside their place of formal *Hukou* registration. It is widely noted that in the country

there is a ‘floating population’ of some 140 million people who stay outside their own *Hukou* registration place, compared to only a few million in the late 1970s (Chan, 1994; Yang, 2008). Many of these people are *de facto* urban residents for years but do not have proper urban or non-agricultural *Hukou* registrations. More in-depth analysis on the impacts of the *Hukou* system on the health and health services access among migrants will be unfolded in the data chapters.

2.1.3 Social Strata and Social Networks

One aim of this study is to explore originally the constraints on health and health services access in terms of social strata and social networks of migrants. Therefore, it is necessary to base my analysis on proper understanding of relevant concepts and theoretical framework.

Social Strata

The term ‘Stratum’ has been borrowed from the science of geology. There it refers to the successive layers or strata of rock and other materials which have been laid down over the millennia to form the earth’s crust. Translated into the very different science of sociology, the concept of stratum or classes has been adapted to refer to the different ‘layers’ or strata of social groups which are thought to be arranged, one on top of the other, in various human societies (Saunders, 1992). Usually we find that different groups or strata are related unequally. One group may own and enjoy more economic resources than another, or it may be held in higher esteem, or it may be in a position to order the other groups around. In our own society there are poor and

wealthy people, there are families of high birth and families of commoners, and there are politically powerful elites and relatively powerless groups of people who are expected only to follow commands and obey orders (Saunders, 1992:2).

Within sociology, there is a long-standing debate on the nature and measurement of social class (Bartley, 2004: 24). Measures of social class are based on theories of social structure: people choose their measure according to the theory they prefer. The two most prominent theories of social structure used in studies that work with a concept of class are those of Marx and Weber. They divide occupations into groups according to typical employment conditions and relationships. These groups are the social classes. Both schools of thought agree on the importance of two things. The first is the ownership of assets, such as property, factories or firms. That is what determines whether a person needs to work at all or whether she or he is the owner of a business, land or other assets sufficient to make work for pay unnecessary. The second feature of social class which is of generally agreed significance is the relationship of all those who do have to work for a living to those who own and manage the establishments in which they work, and also to any others whose work they in turn may manage or supervise (Crompton, 1998; Bartley, 2004).

As an expanding social grouping, rural-urban migrants would also be expected to have different social strata according to their different economic and employment status (Zheng, 2003). However, there is a complete lack of information in current studies on the social classes within rural-urban migrants and a number of studies treat this group as a hotchpotch.

In the existing studies, Li (2004) proposes that, the term rural-urban migrant is too general and the classification should be expanded. Otherwise it is impossible to implant effectively any kind of medical protection. Rationally migrants should be classified more precisely in order to build up multiple types of the health protection, so that they can always find a suitable type for their needs. Zheng (2003) argues that migrants should be divided into three groups. One is the already urbanized migrant people. This group comprises approximately 15% to 20% of the urban workforce, they have been working for many years in the city, have had stable jobs, sources of income and relatively fixed residence, and they have already become a part of the industrial work force. The second group are seasonal migrant workers; they only work during the slack farming season. The third type is the mass of mobile rural people who do not have a fixed residence or stable post. These kinds of workers comprise over 60% of total migrants. They may in future transfer to city, or continue to work as farmers (Zheng, 2003). Another scholar, Lu (2002) provides us with a measure to classify migrants from another angle. Lu points out that the criteria for dividing the social classes depend on two factors: the first is occupation, and the second is the possession of organizational resources, cultural resources, and economic resources. Apart from the measures mentioned above, through the analysis of survey data in regard to three cities of Wenzhou, Hangzhou and Shenzhen in China, Wang (2001) claims that migrants can be divided into two generations, e.g. the first generation of migrants was those who entered cities between the beginning of economic reform and the beginning of the 1990s; the objective of this generation was job search. The second generation of migrants was those who moved to cities after the beginning of the 1990s, and their purpose was to seek more income. These classifications of migrants proposed by scholars above reflect the characteristics of the group of rural-

urban migrants in contemporary Chinese society, but in this research, the approach to understanding social strata among migrants is associated with the study area, especially with the occupations that the migrants are pursuing there.

Social Networks

A 'social network' is a component of social capital and refers to the structural properties that characterize a set of relationships (Levy, 2002: 271). For instance, the relationships we have with our neighbours may vary from simple recognition by sight, perhaps with an occasional greeting exchanged as we pass by, to deep friendship involving frequent visits to each other's homes and the exchange of both emotional and material support. Such relationships are not always experienced as positive and can be characterized by rivalry and dislike. In some cases the community, and the network that partly comprises it, may be defined geographically or formally, such as a small rural village. In other cases, its boundaries may be ill defined. The network can further be characterized by its density (the proportion of people who know each other) and closure (the preponderance of intra-versus inter-community links) (Halpern, 2005: 11).

Kinship ties and native-place networks have played a significant role in sustaining migratory flows. These traditional social networks were not opposed to the development of a modern market economy; instead, they provided the organizational framework for the social lives and private businesses of Chinese rural-urban migrants (Zhang, 2001: 47). It should be emphasized that given the centrality of the place bond and the blood bond in Chinese society, it would be problematic to oppose them when

developing a modern market. Social network is a set of nodes (people, organizations or other social entities) connected by a set of relationships, such as friendship, affiliation or information exchange (Mitchell and Clyde, 1969). Theoretically speaking, after migration, rural-urban migrants must rebuild their social networks while trying to adapt to the changes in their occupation and habitation. Numerous studies have demonstrated that migrants commonly use kin and native-place ties to develop their businesses within and outside China (Crissman, 1967; Goodman, 1995; Honig, 1992; Oxfeld, 1996; Rowe, 1984; Sangren, 1984; Skinner, 1976; Wang, 1987). For example, Goodman (1995) illustrates the powerful role of pre-existing native-place ties in the formation of sojourning communities in Shanghai and in nationalist movements at the turn of the century. This ethnography also attests that traditional social networks do not hamper a modern market economy; rather, they provide the very social basis on which rural-urban migrants organize their social and economic lives (Zhang, 2001: 55).

As Wang (2006) analysed, after migration, the community of migrants not only refers to their family members and villagers, but also includes all rural-urban migrants who are in the same situation as them. Their contact circle is founded on the logic of: family members (defined by blood relationship or marriage affinity) friends (friendship reason) –villagers (location and career reason) - from identical towns (location and career reason) – from identical county (location and career reason)-from identical area (location and career reason) – identical province (location and career reason) – rural-urban migrants (status and career reason). The biggest grouping is rural-urban migrants. For them the key determinants of communication or contact are: blood relationship, location and career considerations, and social status. These factors

have brought about a social support system to enable them to survive in the city (Wang, 2006).

Social networks are regarded as one source of social capital and the relations between them have been discussed by scholars such as Lin, who stated that social capital is defined as the resources embedded in one's social networks, resources that can be accessed or mobilized through ties in the networks (Lin, 2001). Through such social relations or through social networks in general, one may borrow or capture others' resources. The general premise that social capital is network-based is acknowledged by researchers who have contributed to the discussion (Bourdieu, 1980; Bourdieu, 1983, 1986; Lin, 1982, 2005; Coleman, 1988; Coleman, 1990; Flap, 1991; Flap, 1994; Burt, 1992; Putnam, 1993; Putnam, 1995; Putnam, 2000; Erickson, 1995). Since the 1990s, social capital, which is usually defined as a list of components including social network, has been widely considered to have an influence on health (Abbott and Freeth, 2008; Almedon, 2005; de Silva, McKenzie, Harpham, and Huttley, 2005; Macinko and Starfield, 2001; Hawe and Shiell, 2000). The data supporting this point consists primarily of survey data: indicators of high levels of social capital are positively associated with indicators of good health (Abbott and Freeth, 2008; Coulthard, Walker, and Morgan, 2002; Veenstra, 2000; Kawachi and Kennedy, 1999). Some literature includes social networks and social support (Cooper, Arber, Fee, and Ginn, 1999; Coulthard et al., 2002). Some research discusses trust's influence on health, for example, trust may promote social networks, which themselves improve health (Berkman, 1995; Cohen, 1988; House, Landis and Umberson, 1988). Although some researchers, such as Meng and Zhang (2001), (see also Xiang, 2005; Li 2008; Nielsen and Smyth 2008; Wong and Zheng 2008; Sun, Rehnberg, and Meng, 2009),

have looked at migration and social protection in China, very few studies have analysed social networks and their impact on the health and health care access of rural-urban migrants in urban China.

How do these social networks play roles in health and health services access of migrants and which roles? How do migrants utilise their networks to limit the impacts of ill health and medical shocks? No previous studies focus on these issues. To answer questions like these, carefully designed positive research is required. That is the rationale for this research.

From above discussion of this section, first, there is large number of literature on rural-urban migration in China, however, the literature abounds in describing the determinants and economic impacts of migration. Second, although some studies mentioned the social strata and social networks among rural-urban migrants, the analysis has not been brought further, and most studies treat all migrants in the same group. Third, as far as the best of my knowledge, research on the health and health service access to migrants is scarce in China, especially with respect to social strata and social networks, this study has a potential to seed a lively and constructive debate.

2.2 Health Related Issues among Rural-urban Migrants

This study adopts health as a crucial notion. A commonly adopted definition of health is in the World Health Organisation's Constitution as 'a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity'.

Thus health 'is a positive concept emphasising social and personal resources as well as physical capabilities' (WHO, 1946). In this work, I have not covered all aspects of WHO concept of health, as this research does not aim to analyse the health itself and health status of migrants, but originally concentrates on the multifaceted reality of health constraints and health services access among migrants.

A healthy person needs to maintain healthy habits such as taking regular exercises and adequate rest, adopting a high level of personal hygiene, eating a nutritionally balanced diet, abstaining from the abuse of drugs and alcohol, taking care of one's mental well-being and developing social skills to interact in a positive manner within society. To be healthy is to be in a state of homeostasis (balance) with one's surrounding. To avail oneself to the advances of medical treatments and preventive measures such as immunizations may further booster one's health. Many factors affect health, including inherent factors and outside factors. Inherent factors comprise age, ethnic origin, genetic makeup/inherited and sex; outside factors include social class, occupation, education, nutrition, habits, habitat and environment. Among them, socio-economic factors play an important role in affecting people's health status in contemporary society (Milio, 1986; Chiu, 2002; Graham, 2004; Walters and Suhrcke, 2005; Chen, Martin, and Matthews, 2006; Propper and Rigg, Witoelar, Strauss, and Sikoki, 2009; Hatton and Emerson, 2009).

This study explores the constraints on health and health services access among rural-urban migrants. It should be noted that health and health services access are different, and one distinction is that access to health services will not on its own bring health. Some scholars argue that nutrition, housing conditions, socio-economic conditions

and equality, for instance, are more important for health than health services (Wilkinson and Pickett, 2009). The word 'health' cannot stand for 'access to health services' or vice versa.

For migrant people, some scholars claim that they tend to have better health status than non-migrants. Klaassen and Drewe (1973) state that physical capability is a motive to migrate, 'to regard good health as a precondition of movement, or ill health as a migration barrier, is common sense, and as can be seen from United States data relating past mobility to perceived health, accords with the facts' (Klaassen and Drewe, 1973: 30).

On the health issues of rural-urban migrants in China, there are a few studies. Firstly, there are descriptions of the health condition of rural-urban migrants: Liu (1996), based on survey on the health knowledge and behaviour of 103 rural-urban migrants in Liaoning province, finds that the rate of acquiring health knowledge and the rate of developing health behaviour of the migrants who are better-off are higher than those of the migrants who are worse-off. Chen's (2001) results of evaluation on a 90-symptom checklist for 81 migrants show that the mental health of the migrants is in general worse than the average. Secondly, there are comparative studies on the health of migrants before and after intervention: Zhang and Tan (2006), study psychological intervention as occupational therapy for migrants and find that, during treatment, the migrants show intense mental pressure, helplessness and inadequate ways of protecting their rights, exerting negative effects on society as well as on the prevention and treatment of occupational diseases. Lin (2007) examines health education for the migrants with pneumoconiosis and finds that the migrants'

knowledge about pneumoconiosis is of significance for the prevention of controllable occupational diseases. Thirdly, there are studies of the application of health theories in practice: Fang (2006) holds that protection motivation plays an obvious role in the prediction of risky behaviour of migrants. Fourthly, studies on the measures for improving the health condition of migrants: Shi (2004) sets forth five measures: improving social security system, reflecting fairness, increasing the coverage rate of insurance, strengthening legislation and expanding education. Chen and Yang (2007) believe that the government should emphasize investment in the public health service for migrants, and, relying on public institutions and cooperating with communities, bring the migrants into the system of the public health service of communities.

However, there is as yet little empirical research on China that can illuminate the constraints on health and health services access of rural-urban migrants.

2.2.1 The Impact of Migration on Health Status

Rural-urban migrants are the biggest non-regular employment group in urban China. Compared to other non-regular employment groups, migrants are characterised as those who cannot obtain legal and other municipal safeguards and are often checked and deported by the local government administration. Their rewards are low and they are the “working poor” in city society. Their work environment is very bad and they work long hours compared to standard physical jobs. They cannot obtain guaranteed and normal rest periods, not to mention not having a right to enjoy the legal holidays. Employment for them is unstable and with little prospect of promotion (Wang, 2006).

Vulnerability

Vulnerability is a dynamic concept, which captures the sense of a threat posed by adverse events. These events can take several forms, which include long-term trends (demographic trends or changes in the natural resources base), recurring seasonal changes (prices, employment chances), and short-term shock (illness, infectious and parasitic diseases, chemical and physical hazards) (Carney, 1998; Rakodi, 2002).

In some existing literature rural-urban migrant workers are regarded as vulnerable groups in urban China due to discrimination and their subordinate social status. Although there are only a few papers focusing on migrants' health, these papers describe and analyze migrants' health problem mainly in terms of their dangerous working conditions. In China, most migrant workers work under dirty, difficult and dangerous conditions. As one example in Tan's paper (2000), in Shenzhen, a city in Guangdong province with more than two million migrant workers, a high rate of occupational injuries is recorded.

According to an official record, 12,189 labour migrants were 'certified' as occupational accident victims at Shenzhen in 1998. More than 90% of them were injured by machines. More than 80 migrants died. On average, thirty-one are disabled everyday as a result of injuries, while one worker dies every four and a half days. According to research conducted by HKCIC, most migrant workers in the Pearl River Delta suffer long working hours, illegal overtime, and wages below the legal minimum (Tan, 2000).

All these factors make migrant workers highly vulnerable. Occupational accident victims say that accidents occur when they work overtime performing risky duties without clear instructions, proper training or sufficient technical protection. When they are injured, employers simply give them lump-sum compensation which is always lower than the legally required amount, and ask them to leave the factory immediately. Xiang (2005) stated that there are some reasons that may lead the migrants to be vulnerable to health risks, such as high levels of mobility, supposedly active premarital and extramarital sexual activities, low income, lack of awareness, and lack of social contact with the local community. Other authors, Tang (2001) and Dong (2002) explained this problem through a policy approach. But some other important facets, for example, migrants' living and working conditions have not yet been paid sufficient attention.

Living Conditions

Housing conditions to a large degree reflect individual and family social position (Wang, 2006). In many Chinese cities, the household register is being opened up to enable the non-native population to acquire a property. However, at present, migrants are mostly stuck in one of three forms of accommodation, namely a simple rented house, a self-built 'shed house', or accommodation provided by their employers.

The demand for housing from rural-urban migrants inevitably leads to the emergence of rental markets in urban fringe areas. With an increasing demand for housing and the lack of private rental housing in cities, the areas on the urban fringe naturally

become the ideal destination for migrants as the rent there is normally cheap. In some suburban countries and towns, migrants outnumber local residents and the localities have become known for outsiders, using their native hometowns' names: for instance, in Beijing, there are areas called Zhejiang Village, Henan Village, Xinjiang Village. Within the Villages, many migrants build shacks next to their rented houses or along roads, these so-called illegal buildings encroach on public space and weaken the general living conditions in the villages.

In terms of region, they mostly live in the 'village of the city', an area midway between the city and the countryside. Their housing conditions are extremely 'peripheral' because, first, they mainly rent low cost, unofficial housing in the letting property market. Second, the houses they occupy are the crudest, with a vile environment and usually in the worst location. Living in such far-flung urban conditions like 'isolated islands' has given rise to a migrant lifestyle with aspects of unnormalization, compartmentalization and village (Wang, 2006).

Unnormalization denotes that their life is unstable and incomplete. In the other words, many are single and live in same-sex groups; they cannot find ways to establish contact with friends of the opposite sex. At the same time, married migrants cannot pursue family life as many of them have been separated from their spouses or children for a long time (Xiang, 2005).

Compartmentalization means that migrants only live among their own social circle with limited horizons (Wang, 2006). In terms of social life, they have no contact with local city residents and city society: they are separated from city society and only live

in their own community in a 'countrified' manner similar to when they lived in their villages. Their circle of contacts is limited to their own community and they rely on communication among themselves in order to dispel feelings of alienation from city society. Meanwhile, they have to accept each other. For them, the most important thing is contact with their fellow villagers. Lacking communication with outside communities, they live together forming the migrant workers' settlements.

The living environment of migrants in city has been mentioned by some scholars. Xiang (2005) claimed that, in many migrant communities in cities, due to the financial difficulties of migrants and their desire to reduce expenses, their living conditions are usually quite poor and they are faced with some environmental problems, such as pollution, including garbage, air, water and noise; these are not problems for non-migrants. Dai (2003) stated that in the migrants' accommodation area and on the street, solid household waste can easily be found everywhere; when effective cleansing facilities and staff are not provided, waste is left to pile up on the roadside, in corners and in any small spare space.

Working Conditions

It has long been customary (and widely seen) that migrant workers suffer from work overload. Moreover, there is high level of work-related injury. This is because migrants tend to undertake work categorised by the '3-Ds' – 'dirty, dangerous and difficult'. For instance, in 2004, of the 136,000 people that died from work-related injuries in China, over 80% were migrant workers, especially in three industries, mining, construction, and dangerous chemicals (Zheng and Lian, 2005). Migrants also

incur a high level of occupational disease, which is reflected in short working lives. The most common occupational disease is dust-related pulmonary tuberculosis; the next is poisoning (Tan, 2002).

Far more serious than injuries are chronic diseases caused by work. Besides the high treatment costs, the symptoms of the victims of chronic disease become worse only after leaving the workplace; sometimes it is even quite difficult to determine which workplace should be held responsible for their diseases. For instance, pneumoconiosis, which has been found among many construction workers, is such a disease. Benzene poisoning is probably the most common serious chronic disease found among female migrant workers. Large numbers of benzene poisoning cases have been found, particularly in garment, shoe or suitcase factories, which often use cheap glue with a high content of benzene.

After they become ill or injured, migrant workers have to spend their own money to get treatment and are unable to obtain any compensation from their employers (Tan, 2002).

2.2.2 Choices of Medical Treatment – Some Theories

The Choices of Medical Treatment for Ordinary People

Engel (1993) states that the model of how consumers buy can be divided into five stages: confirmation of the problem, the information search, the project evaluation, the purchasing decision and after buying behaviour. This model means that when a

consumer purchases products, they usually experience these five stages. In other words, the purchasing process is already underway before buying and it will take some time to conclude after purchasing.

People do not wish to buy most medical services in terms of being a patient. For them, the purpose of medical service is recovering, or keeping healthy.

Some scholars have suggested some medical models be used. Anderson, R. M. (1968, 1974) introduced a medical model which provides a complete framework and contains three elements of usage of medical service:

- 1) Tendency: Demographic characteristics, social structure characteristics and attitudes towards healthy living.
- 2) Capabilities: Individual, family and the social resources.
- 3) Need: A person's own appraisal of their health and the medical officer's objective appraisal.

According to empirical studies, researchers, such as Shaikh and Hatcher (2004), found that the choice of medical services is governed mainly by the following factors: the treatment skills, medical ethics, medical service instrumentation and equipment, service attitude of the doctors and the distance to obtain the medical service.

2.2.3 The Choice of Medical Treatment for Rural-urban Migrants in China – Empirical Realities

Is there any difference between ordinary people and migrants? What are the main elements that make them decide where to go for treatment? Some scholars have pointed out, that the utility ratio which migrants use when choosing a hospital service is lower than the local resident (Zheng, 2003).

For instance, an investigation of rural-urban migrants who fell ill conducted in Shanghai in 2005 demonstrated that 11% migrants did not take any treatment, 65% of migrants chose self-medication, because of the low cost and although 24% migrants went to hospital after becoming ill, 48% of these people chose town or private clinics. This investigation also demonstrated how the migrants used the medical services after illness. If they have a normal disease, for instance, a cold or headache, generally they buy medicine from a pharmacy or take self-treatment. If they are unable to treat the illness themselves, the first choice for them is the county or city level hospital, next is the provincial level hospital. The basic level of medical service accounts for 20.4%, private clinics accounts for 5.9%; the community health service achieves 14.5%; the self-medical service accounts for 18.3%. There are some reasons for them to choose the medical service. 48.5% of migrants trust the quality of the service, 63.1% thought it was convenient with a cheap price; 18.0% and 7.2%.of migrants respectively chose the services with a good attitude and environment (Peng, 2007).

Medical Insurance

The majority of migrants simply do not have any insurance (Shao and Chen, 2005); investigations have shown that the reason for this is their low income compared to the excessively high insurance premium charges. This causes migrants to think that medical insurance is only for city residents and thus to avoid it. At the same time, insurance companies have not take action on behalf of the migrants. In fact, in terms of occupational disease, migrants are classified as a 'high-risk group'. The insurance companies, of course, clearly know about the high-risk working conditions that are frequently detrimental to the health of the migrants. To maximise their profit, the insurance companies are not willing to accept migrants' requests for medical insurance.

In addition, the underwriting system currently in use in China also acts as a barrier to migrant people taking out insurance. At present, insurance companies in China generally offer annual policies based on place of residence (Hu and Zhang, 2006). However, the itinerant life of migrants means their domicile is certainly not fixed and they are frequently mobile. They do not want to buy insurance in one place because they may not be there long enough to justify the expense. Another reason for migrants having to give up their legitimate rights and interests is that the number of unemployed in the labour market exceeds the number of work places, so the relationship between labourers and employers is always unequal. Many labourers, in order to secure a job, have to sign a contract with employers that is similar to a 'contract between life and death' or an 'overlord contract' (Shao and Chen, 2005).

Illegal Clinics

There is a ranking system for Chinese hospitals; and the costs of treatment differ according to the rankings.

Areas with many migrants living together have many private small clinics. Compared with the expensive medical services in the hospitals, most of the migrants think the private clinics are their best option. The high cost of hospital services makes them prohibitive. The reasons¹¹ for their choice of medical service are usually:

1) First and foremost, the cheap price.

2) If they are ill, they will leave themselves to recover on their own rather than going to see a doctor or going to a small hospital to obtain medicine only. Regarding the question of which situations could make them stay in a hospital, most agreed that they would do so only if they had a serious disease, and then they 'must return to the hospital in their hometown'.

3) Regarding why they choose private clinics, they think that private clinics have cheap medicine and offer long business hours near the places where they are living.

Last year I went to 'Dengcun village' to interview a leader who is in charge of a public hospital. He said that although the medicine is cheaper in these illegal clinics than in the big hospitals, because of their low prices the drugs probably are obtained through illegal channels. If taken by patients, these illegal medicines might damage their health, even causing poisoning and endangering life. Moreover, most of the

¹¹ These reasons are summarized from the interviews conducted by me in Dengcun Village last year.

doctors practising in these clinics do not have approved medical practice and business licenses.

The main reason for illegal clinics spreading without restriction is because of the demand for them. It is difficult for rural-urban migrants to obtain regular health services (Xiang, 2005). A further cause is that there is no well-established medical or social security system. I will investigate this further in chapter four.

Social Status-Income Effects

Migrants' income and benefits lag behind those of local urban residents by a wide margin. Excluding various in-kind incomes enjoyed by urban residents, such as heavily subsidized housing, food provided at the workplace, childcare, transportation, and entertainment, urban employees' cash incomes still far exceed those of rural migrants (in Shanghai the mean difference is about 40%). This is the case even though rural migrants work on average 25% longer per week (54 versus 43 hours) (Wang and Zou, 1997).

Migrants also get poor benefits in urban areas. For instance, in addition to the hidden and indirect subsidies through urban infrastructure mostly enjoyed by urban residents, urban residents also receive welfare benefits associated with their employment, whereas only about 10% of rural migrants report having any kind of medical insurance coverage and less than 5% have retirement pension benefits, two-thirds of urban employees have medical insurance, and 80% have retirement pensions (Wang and Zuo, 1999).

Rural-urban migrants, obtain more job and earning opportunities after their migration, but in urban areas, they cannot benefit from healthcare. Their health status is not improved by migration. Due to 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 100RMB Yuan for medical treatment a month. According to a survey carried out in 2000 and 2002, 46% of respondents had been ill during their stay in Beijing, 17% more than three times. Despite of this, a full 93% had not received any payment for their medical expenses from their employers (Xiang, 2005).

Due to the financial constraints, access to big hospitals is very difficult for most rural migrants. One consultation for a minor problem in a big hospital may cost 500 RMB Yuan, almost one month's income for many migrants. Giving 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% gave birth at home rather than in hospitals, and surprisingly, 22% of those who delivered babies at home did so in Beijing (the rest delivered in their home places) (Ketizu, 2000; Xiang, 2005). The financial difficulty also forces some migrants to stop their treatment even after they are sent to hospitals in emergency (Xiang, 2005).

One reason for financial difficulties of migrants is their low income, but the remittance to their sending areas also results in financial difficulty for them.

Some researchers think that the remittances by migrant workers have played a very significant role in reducing poverty and promoting local development in the sending areas (Huang and Zhan, 2005). A poor family could basically escape poverty with the help of remittances. Comparative research showed that relative to those in other developing countries, migrant labours in China saved more out of their wages to remit to their families (Li, 2001; Huang and Zhan, 2005). These remittances are mainly used for daily living expenditure (including healthcare), children's education, house building and/or improvement, and even for agricultural production.

A survey in Jinan city, Shandong province indicated that 82% of migrants interviewed had brought or sent money home to the countryside, accounting for an average of 1776 RMB Yuan and more than 30% of their earnings in the city. Other surveys show even greater amounts of remittance (Cai, 2003).

From above discussion of this section, first, direct and systematic studies on migrant health and health service access are still too few, and the data on migrant health are still too spotty. Second, most studies are based on journalistic and official report, and lack first-hand data. This research is seeking to fill up this gap, and will make following contributions: first, this research originally explores the constraints imposed on the rural-urban migrants' access to health services in China, and examines the effects of migrants' social strata, social networks and their understanding of healthcare on their ability to gain access to healthcare services. Second, this study is based on the first-hand qualitative data collected from a migrant community. And

third, investigating the constraints on health and health service access of migrants also help us to have a better understanding of Chinese healthcare system.

2.3 Governmental Provision on the Health-care System in China

2.3.1 The Institutional Divide

Health care has been provided very differently in rural and urban China. The rural-urban divide has moulded the institutions, organisation and administration of health services.

Until 1949, rural China lacked an effective health care system. The health services were mainly curative and traditional. The new government gave priority to preventive over curative care and organized campaigns against particular diseases, including immunisation against half-a-dozen of the most common diseases. With the formation the peoples' communes, the number of commune (township) health centres increased rapidly.

The rural health service had three tiers, corresponding to the county, the commune and the brigade; the same three tiers (county, township, and village) exist today. As a consequence of Mao's effort, and as a result of the Cultural revolution, by 1970, 1.2 million 'barefoot doctors' had been trained, and 3.6 million brigade health aides. Barefoot doctors were part-time farmers who received a share of collective income like other brigade members. The brigade functioned as a health service provider: it

collected funds from its production teams, and used them for its barefoot doctors and for the purchase of medicines. Such a service could not satisfy any serious medical needs. The upper tier medical service to backup the barefoot doctors was the commune health centre (*wei shen yuan*), above which was the county hospital (Song, 1998).

The dissolution of the peoples' communes had serious implications for rural health care. Townships and villages no longer had the resources or the political directives to fund health care on a cooperative basis. Except where revenue was available from township and village enterprises, cooperative health schemes collapsed: the proportion of villages covered fell from 82 percent in 1978 to 5 percent in 1986 (Shanghai-IDS, 1993: 32). The barefoot doctors had to rely more heavily on user charges and sales of medicines. The number of village health workers declined although their quality improved through a programme of training and certification. In 1988 there were 732,000 certified 'village doctors' in China's 734,000 villages, and 1,714,000 village health workers altogether (Shanghai-IDS, 1993:34). At the township level, health centres, and at the county level, hospitals, became more dependent on user charges; and preventive programmes were commonly no longer fully subsidised. The decentralisation of rural health care funding in the period of economic reform increased inequalities in health services between rich and poor rural areas. Almost three-quarters of the funds for rural health services came from user charges, but these were less important in relatively prosperous areas with revenues from township and village industry.

In 2003, China launched a new health insurance program, aimed at covering the

whole rural population. This new program is called new Rural Cooperative Medical System" (RCMS), which is a matching fund comprising central government subsidy, county government contributions and individual contributions. Some research claims that despite many efforts made to revive the RCMS, as it is still at an experimental stage, there are some problems in practice, such as poor effectiveness, low social satisfaction, low level of protection, publicity is not in place, and process is cumbersome (there are some cases about the RCMS in Chapter Four). The RCMS should be substantially improved by extending its benefits package and strengthening insurance fund management (Jiang, Braun, and Asfaw, 2004; Gao and Meng, 2008).

In urban China, the emphasis from the start was on state-supported health care. Two major employment-related health schemes were established in 1951. In urban areas they functioned as a publicly funded and centrally managed health service through two major schemes: the government insurance scheme (GIS) and the labour insurance scheme (LIS) (Gu and Tang 1995; Liu and Hsiao, 1995). The GIS covered mainly employees working in the public sector and government agencies as well as college and university students. The LIS fully covered workers in state-owned and collective-owned enterprises and partially covered their direct dependents. Thus almost all urban workers, excepting only workers in the small private and self-employment sectors, were covered by health insurance schemes, many of them free of charge.

Since the 1980s, there have been changes in these two schemes. Some changes are associated with the introduction of cost containment (e.g., co-payment), which aimed to control a rapid rise in health-care costs. Gao and Tang (2001) consider the actual changes to have been varied. For instance, some enterprises provide their employees

with a fixed monthly sum of money for health care and the employees have to take full responsibility for the health services they use. Other changes have also reduced the ability of the two schemes to ensure the access of employees to basic health services. The number of people in urban areas who have to pay for their health care is growing as more people work for small private or collectively owned firms and more rural residents migrate to cities for temporary work (Gao and Tang, 2001: 303). In the meantime, the unit cost of expenditure on urban health services has risen rapidly as a result of changes in government financing of the health sector and the increasing adoption of high-level medical technologies and expensive drugs. Therefore, access to health care is becoming increasingly unequal in urban China (Yuen, 1996; Liu et al., 1999).

2.3.2 Provision and Access

As I have discussed in the previous section, the provision of health care is very unequally distributed between urban and rural China. Adequate indicators of provision are hard to come by as it is a matter of quality as well as quantity. The quality of medical services varies with the concentration of population. High quality and specialised hospitals are generally located in cities. Low-quality county-level hospitals are located in county towns, township health centres in township headquarters, and village clinics in the villages. These disparities might represent either political rank and power or economies of scale in the face of transport costs and difficulties; both are likely to be relevant.

Two measures of access to high-quality health care are the number of hospital beds and the number of qualified medical doctors, both expressed per 1,000 people. Information is available for cities and for counties (including county towns). As Song (1998) claims, during the period 1949-1986, there was a sharp urban-rural contrast in the provision of hospital beds throughout. Urban provision was almost three times as high as rural in 1986. Qualified doctors were very scarce in both urban and rural China in 1949. Thereafter, their availability improved greatly in urban areas but there was almost no progress in rural areas. In 1986, urban availability was nearly four times greater than rural.

Urban and rural China differed not only in the quality of services, the greatest disparity being in senior health staff, but also in the quantity. In 1986 the urban areas had on average 6.73 salaried health workers per 1,000 people whereas the rural areas averaged 2.14 (Song, 1998).

The location of provision could give a misleading picture of access. For instance, the higher quality and more plentiful hospitals and other medical facilities that are found in cities could be made available to country as well as city people. Three factors diminish the access of rural people to urban hospitals: transport problems associated with distance, administrative exclusion, and user charges.

First, transport costs and difficulties hinder rural people, especially when they are ill or when they live in remote areas. Unless they have relatives in the city, peasants who are referred to an urban hospital have to find and pay for accommodation if they have to wait for admission.

Secondly, particularly in the pre-reform period, medical treatment in the cities has been rationed and urban-dwellers given priority. Whereas urban residents were registered with a hospital, rural people had no such entitlement. Even if they were referred to an urban hospital, they were likely to receive lower priority than urban-dwellers.

Thirdly, the economic reforms have made urban health services more market-oriented: hospitals are required to meet many of their costs from user charges. However, this has had the effect of rationing the rural sick by price instead of by rule. Whereas most urban people are covered by public service, state labour or collective labour insurance schemes, only a small minority of rural people are insured against the heavy costs involved in hospital services; most rural population are not covered by medical insurance at all (Hu, 2000).

2.3.3 Reforms and the Impacts on Migrants

The most recent health-care system reform started with the issuing of the Decision on Health-Care Reform and Development by the Chinese Central Committee and the State Council in 1997. Through August 2000, the State Council issued a set of documents to elaborate detailed policies on urban health-care reform. The main aims of the health-care system reform are: 1) to establish a cost-sharing system in order to control the growth of health-care expenditure and ensure basic health care for urban workers; 2) to prompt competition in the health-care sectors, allowing patients to choose hospitals and doctors, and to improve service quality and efficiency; and 3) to

break a regional and industrial monopoly in pharmacy research, production, selling and consumption, and promote better management in order to assure drug quality and reduce costs (Hu, 2000, Dong, 2002).

Strength of the New Health Policy

The major achievement of this recent change in health care is that medical insurance is separated from one's place of employment, which helps employees and retirees of firms that are not profitable to get medical care cover without any delay. It is particularly beneficial to retirees. For instance, in Shanghai, there are more than 1.8 million retirees (Hu, 2000). Although almost all of these retirees previously had medical insurance (with GIS or LIS), some of them faced difficulties in receiving reimbursement of their medical expenses from their previous employers. The newly issued medical insurance card for the purpose of health service access relieves them from the concern of their previous employer's ability to pay their medical fees claims (Dong, 2002: 15-16).

Meanwhile, the ongoing restructuring of health resources is benefiting the whole society (Dong, 2002). Efficiency is brought to medical services by more rationalized allocation of health resources. This has led in particular to almost all the enterprise-based health resources now being encouraged to open to the public, providing more opportunities for neighbourhood residents to access their services. At the same time, patients have more freedom to choose hospitals and doctors, which promotes competition among medical service providers; thus, the quality of health services is improving in most health institutions.

Limitations of the New Health Policy

The new system has been put in place nationwide to replace the Public Fund Medical Care and the Labour Security Medical Care Systems. However, some researchers, such as Dong (2002), point out that there are still some limitations within the new health-care policy. Dong (2002) thinks that there are three main limitations of the new health scheme. Firstly, this scheme does not reduce inequality in health-care access among urban residents; secondly, this policy does not cover socio-economically vulnerable groups; and thirdly, this scheme places the financial burden for health care on most urban Chinese people, since most people have to pay their share of medical costs and the burden is not evenly distributed.

Exclusion of Migrants from Medical Coverage

According to recent studies, about 140 million migrants have accommodated by urban sectors before 2010 (Cai, Du, and Wang, 2009). These migrants may register their presence in the community but they are not entitled to the equal state benefits that permanent residents enjoy, such as health care (Chen, 1991; Tang and Jenkins, 1990; Yang and Goldstein, 1990; Goldstein et al., 1991; Gorgan, 1995; Hsiao, 1995; Bloom and Fang, 2003; Duckett, 2007). These migrants experience many disadvantages in urban areas. They usually work as manual labourers with no job security and without work-related benefits. As discussed in Chapter One, although some positive policies adopted from 2004 (e.g., ‘The Provisional Measures for Rural-urban Migrants to Participate in the Basic Medical Insurance in Beijing’ and ‘The Provisional Measures

for Rural-urban Migrants to Participate in Industrial Injury Insurance’), there is still a large proportion of migrants are not covered by urban health services.

2.4 Conclusion

Existing literature on migrants’ health in China, in both English and Chinese, focuses mainly on HIV/AIDS, STD and reproductive health (Hansen and Li, 2002; Yang, 2002, 2004; Xiang, 2005; Yang, 2008; Li, Chen, Song, Zhang, Ping, and Liu, 2008). Some authors just analysed the migrant group’s risk for the spread of epidemic disease, such as SARS and HIV (Hong, Stanton, 2006; Kaufman and Jing, 2002; Sutherland, 2005).

In previous studies, most papers are descriptive and take a biomedical approach (Xiang, 2005). Yang’s papers (2004) 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 fall short in providing policy and 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 policy analysis, but most studies concentrated on income distribution and inequality between rural and urban areas. 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 health system), but it is still not clearly designated which department should be the focal point for rural health care (Xiang, 2005).

Most of the points and conclusions of existing literature are drawn from journalistic sources or studies based on documents or official reports. There have been no systematic academic works based on primary data collection and fieldwork that explore and evaluate rural-urban migrants' health constraints and health services access, or consider their relevance to wider policy issues.

Chapter Three

The Methodology and Methods of the Research

3.1 Introduction

This study adopts a qualitative approach as the research method to understand the health constraints and health services access among rural-urban migrants. In this chapter, the rationale of application of qualitative methods will be discussed in relation to the main concern of the study. Following this, discussion turns to more detailed methodological issues such as research design, sampling and gaining access to interviewees, concrete process of interviewing, challenges in doing interviews, ethical considerations and data analysis.

3.2 Rationale of Qualitative Approach

Qualitative methods have been chosen for this study because of the nature of the research topic and the main concern of the study aiming at identifying the health constraints among rural-urban migrants.

This study will concentrate on context and depth and aim to “make a lot out of a little” (Silverman, 2000: 102). This study tends to be more appropriate for applying

qualitative methods for the following reasons. Firstly, the qualitative method can be employed to meet my aim of accessing migrants' experience of their daily lives around attitude, thought process, and their own accounts of attitudes, values, motivations and behaviour (Hakim, 1987). It offers richly descriptive reports of individuals' perceptions, beliefs, views and feelings, the meanings and interpretations given to events as well as their behaviour" (1987: 34), which are difficult to learn through quantitative methods (Strauss and Corbin, 1998: 11). Secondly, qualitative research can be a useful tool for the significant understanding of complexity, detail, and context in the field of culture, organisation or setting (Bryman, 1998, 2001; Strauss and Corbin, 1998: 11; Miller and Dingwall, 1997; Marshall and Rossman, 1999; Denzin and Lincoln, 2000; Mason, 2002). So the qualitative approach emphasising the importance of attitude, process and context is seen as particularly relevant to my study, as these are directly associated with the nature of the research topic; and the main concerns of the study are the experience about health constraints and the health services access among rural-urban migrants.

Very few studies have put forward a strong case for using qualitative methods for the sociological investigation of health constraints and health services access among rural-urban migrants. As far as research method is concerned, a number of existing studies have been dominated by quantitative methods, statistical data, or large-scale survey methods in relation to the issue of economic impacts of rural-urban migration in China, such as its contribution to industrial development, to the inflow of foreign direct investment, and to agricultural efficiency as a means of reducing surplus rural labour (Xiang, 2005).

Moreover, health research is commonly conducted through large scale surveys with quantitative analytical approaches. This could be useful if the investigations were to examine the patterns, determinants and consequences of health-related issues for a population. However, health *per se* could be idiosyncratic. This is to say studying health in-depth on an individual base would be advantageous. This would allow the researchers to have ‘an opportunity to see what others have not yet seen, to reflect the uniqueness of our own lives, to engage the best of our interpretive powers, and to make, even by its integrity alone, an advocacy for those things we cherish’ (Stake, 1995: 136). Yet, in-depth understanding of migrants’ health through qualitative methods has not been thoroughly studied to elicit deeper understanding and intentions of people. Insofar as people tend to contain the complexity of belief systems in a given context, understanding people’s intentions and reasons for health services choice should be examined on the basis of the sets of understanding, rules and meanings, which govern their daily lives (Armstrong et al., 1990). For that reason, qualitative methods can provide us with a better understanding of the health constraints and health services access, which operate to affect migrants’ lives in a given situation.

To sum up, I have identified qualitative methods as the most appropriate method to meet my aim of accessing migrants’ health experience in the context of the Chinese urban areas. It is noted that qualitative research is centred on explanation and argument involving understanding of complexity, detail and context (Mason, 2002). This study is concerned with the whole picture of the health constraints of rural-urban migrants: while the primary concern is based upon the detailed account of health

constraints in respect to social strata of migrants, a further another concern is associated with the function that social networks play in health and health services access among migrants, before discussing migrants' understanding of health. Given these concerns, qualitative methods that put an emphasis on the importance of understanding the phenomenon in the context of culture, and setting will help capture people's intentions and activities. Thus, the emphasis on process and context within qualitative research is particularly valuable to view health constraints and health services access of migrants.

3.3 Research Area

The massive rural-urban migration has transformed the spatial and social landscapes of Chinese cities. One of the most prominent imprints of rural-urban migrants is literally 'villages in the city' (*Chengzhongcun*)¹², also called as 'migrant communities' and 'urban villages' (Zhang and Song, 2003; Wu, 2007; Tian, 2009). These migrant communities are generally located in the (former) outskirts of the city, e.g., the urban-rural fringe.

The emergence of 'migrant communities' with large concentrations of migrant populations is an outcome not only of migration but also of the persistent divides between rural and urban citizenships and between rural and urban administrations in China (Zhang and Song, 2003; Song, Yves, and Ding, 2008). First, occupational segregation in contemporary Chinese society is legitimized by government regulations. Regardless of their active economic activities in urban society, rural migrants have always been outsiders in terms of social life in the city. Individual

¹² It should be noted that these 'villages in the city' or 'migrant communities' are migrant enclaves and compact communities of rural-urban migrants in the cities. But not all rural-urban migrant workers live in such villages.

migrants and migrants as a group do not have equal access to urban labor markets in formal sectors (Guo, 2004). Moreover, millions of rural-urban migrants working in cities have generated enormous demand for inexpensive housing. Most migrants are excluded from the formal housing market because: (1) without urban household registration (*urban Hukou*) they are not eligible for low-cost affordable housing subsidized by city governments; and (2) they cannot afford “commodity housing” in the private housing market.

Migrants’ lack of status through these institutional arrangements leads them to second-class citizenship compared to urban residents and hence, to forming their own ‘community’ isolated from outside the ‘world’. This study chooses Dengcun village, a rural-urban migrant community in Beijing as its research site, to carry out the research.

This study is to investigate the above issues through a case study of Dengcun Village—a migrant community in Beijing of China. Dengcun village is a typical migrant enclave in Beijing, as other migrant communities in major cities in China, it has two common features: first, its emergence is the result of large concentrations of migrant populations in major cities, especially since the launching of reform in early 1990s; second, it is located in the suburban district of the city, that is to say, the urban-rural fringe.

Beijing is situated at the northern tip of the roughly triangular North China Plain, which opens to the south and east of the city (see Figure 3.1). As the capital of China, Beijing is a centre for national and international exchanges, including tourism and businesses, and also a city with a high density of migrants¹³ in China. In Beijing,

¹³ Official statistics show that non-official registered citizens in Beijing numbered 2.29 million in 1997, 3.08 million in 2000, and 3.28 million in 2001. Seventy to eighty percent of these non-official registered citizens were

Dengcun Village in Fengtai District was taken as the research site. Fengtai District, one of Beijing’s suburban districts (see Figure 3.2),¹⁴ has been a concentrated migrant community (see Table 3.1) for low-skilled manual workers and their families for nearly two decades. It experienced the changes in national policies over migration and the changes in patterns of migrant settlement, yet it remains one of the least developed districts in Beijing.

Figure 3.1 The Location of Beijing in China



Source: <http://www.chinahighlights.com/beijing/map/location-map2.htm>

Figure 3.2 Beijing City Map

migrant labourers and entrepreneurs (He, 2003: 127).
¹⁴ Beijing, as the capital city of China, has its 14 downtown and suburban areas under the municipal administration. The suburban area is composed of inner suburban areas (Fengtai, Shijingshan, Chaoyang and Haidian), and outer suburban areas that comprise 4 counties. The inner suburban areas like Fengtai are traditionally known as ‘the urban-rural interaction belt’ where state intervention is relatively less robust. That is one of the reasons why Zhejiang migrants chose to settle down there. See Xiang Biao, *Kuayue Bianjie De Shequ (A Community beyond Boundaries)* (2000); see also Li Zhang, *Strangers in the City: Space, Power, and Identity in China’s Floating Population* (2001).



Source: http://www.urbanhabitats.org/v01n01/beijing_full.html

Table 3.1 The Number of Rural-urban Migrants in the Districts in Beijing

District	Permanent Population	Rural-urban Migrants
	(10,000 persons)	(10,000 persons)
Total	1538	357.3
Urban Central Districts	205.2	36.4
Dongcheng	54.9	10.2
Xicheng	66	11.8
Chongwen	31.1	5.1
Xuanwu	53.2	9.3
Inner suburban Districts	748	209.2
Chaoyang	280.2	84
Fengtai	156.8	36.6
Shijingshan	52.4	14.9
Haidian	258.6	73.7
Outer Suburban Districts (New Districts of Urban Development)	411.6	94.4
Fangshan	87	11.9
Tongzhou	86.7	19.7
Shunyi	71.1	15.6
Changping	78.2	21.9
Daxing	88.6	25.3

Outer Suburban Districts (Ecological Preservation Development Districts)	173.2	17.3
Mentougou	27.7	4.1
Huairou	32.2	5.3
Pinggu	41.4	2.4
Miyun	43.9	3.5
Yanqing	28	2

Source: Beijing Municipal Bureau of Statistics (2006), available at :
http://www.bjstats.gov.cn/sjfb/pcsj/rkpc/200607/t20060704_45124.htm

The history of Dengcun Village can be traced back to the Wenzhou petty traders from the rural areas to do apparel business in Dahongmen area in the middle of 1980s. In 1989-1990, Beijing municipal government made repeated attempts to drive out the migrants, in anticipation of the Asian Games. At that time, Dengcun Village was almost empty. Beginning from 1991, the Beijing municipal government has adopted a more accommodative attitude, much more migration from Zhejiang entered Dengcun area through the relations of relatives, friends, and fellow villagers. In the meantime, migrants from some other provinces, such as Henan, Hebei, and Shandong came to Dengcun for business opportunities. From then on, the development of Dengcun Village has become much steadier.

Dengcun Village currently has a total population around twenty thousand, the overwhelming majority is rural-urban migrants¹⁵. The migrants there are mainly from Zhejiang Province, some from Henan, Hebei, and Shandong. Many are usually living and doing business in privately rented room (s) rented from Beijing natives, and some are residing in dormitories of the work sites, such as construction sites. Many Beijing

¹⁵ This information was got from an interview with Mr. Hu, a Section Chief of Fengtai Health Inspection of Beijing Fengtai Health Bureau.

natives no longer lived at Dengcun, they rented their housing to migrants to earn some income.

In Dahongmen area of Beijing, Dengcun Village is an important distributing centre for garment and shoe businesses, and some migrants are the business proprietors of shoes and garment industries based in that area. In Dengcun Village, all the services necessary to the life of a community have been created by migrants, such as restaurants, open-air food stalls, shops, hairdressing salons, repair workshops for bike carts, nurseries, clinics, small printing shops, and small embroidery shops.

As to the public and private medical provisions, there are nine private clinics in that community, including three private dental clinics, two private clinics for general illness, two private clinics for diverse illnesses (such as gynaecological diseases, skin disease, sexually transmitted disease, Chinese medicine, etc), one private clinics for gynaecological diseases (such as abortion and the sale of contraceptives), and one private paediatric clinic. There is also one public hospital with the name of 'Dahongmen health service station'. This station was the out-patient Department of Beijing 5th Rubber Factory previously, which was on attachment on Beijing Chemical Industry Group previously, and was out of business in 1996. From then on, the out-patient Department was transferred to health service station, and the role was changed to provide health services to Dahongmen and Dengcun areas.

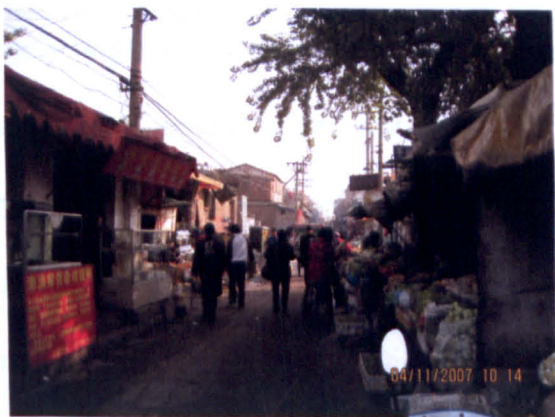
Dengcun Village is not an officially defined village in administration. It is a migrant community that transcends the geographical, social, administrative and ideological boundaries essential to the established system. It shows that spontaneous migration

challenging the system is not only because migrant issues cross boundaries, but also because migrants may establish their own ‘rooted’ and ‘territorialised’ space in the new destination areas. To these trans-regional flows of people, two facts –money and information on the one hand, and the creation of tangible communities on the other – are inter-related. The migrants are living or running diverse business there, but have few direct contacts with local urban residents.

Photo3. A One street of Dengcun Village



Photo3. B Retail Business in Dengcun Village



The majority of migrants I interviewed were originally from the rural areas of South China. Specially, many were from rural Zhejiang province with Zhejiang dialect speaking. They were not new migrants; none had been resident in Dengcun Village for less than three years.

3.4 Sample and Recruitment

For this study, a combination of the ‘snowball approach to sampling’ and ‘contingency method’ were utilised in gaining access. The ‘snowball approach to sampling’ is a recognised method of getting at ‘hard-to-reach populations’ (Silverman,

2000). Most of the participants were obtained through contacts with migrants that had taken part in another study¹⁶ in 2006 in which individual interviews were conducted in the same research site, 30 interviews were completed successfully with rural-urban migrants in that area. Through the interviews, I made some migrant friends, and some of them left their contact details with me. In this research, I started from those acquainted migrants who have direct experience of illness or health problems themselves or among their family members; I then tried to build up a snowball sample. I also contacted those acquaintances and ask them to introduce me to interviewees with full interpersonal trust. For example, a migrant acquaintance I met in 2006 runs a private clinic. She has experience of treating many migrants with health problems and has a steady flow of migrant customers. My migrant acquaintances who mediated between me and potential interviewees directly or indirectly introduced me to relevant respondents willing to take part in the interviews in diverse settings. Access was then achieved through the human networks to gain a range of potential interviewees who met my sampling criteria. Under the circumstances that my friends/acquaintances did not provide as many as contacts as I needed for this research, a contingency plan was used. I have utilised this method successfully in the project in 2006. In this research, a few participants were obtained by visiting and revisiting in the research area to negotiate access. The participants were found in Dengcnu Village, or identified at their outdoor or indoor workplace. Some participants were interviewed on the spot. Some participants at work agreed to book an interview for a later time. I either came back to the same place or visited the interviewee's place of residence to carry out the interview.

¹⁶ The project title was: Epidemic Risk Control: A Case Study of the 2003 SARS Outbreak in Beijing, and was led by Professor Lina Song.

3.4.1 Criteria

Bearing the principles of sampling in mind, the following groups were recruited as participants. First, the migrants with illness experience were recruited as the participants for this study. As noted earlier, the primary concern of this research is to examine the health constraints and health services access in the absence of social protection by the government. In this regards, the participant should have illness experience or the experience of using health services.

In this study, a theoretical sampling strategy was adopted. Theoretical sampling refers to an approach to selecting people which involves a search for validity for the findings rather than an attempt to be representative of the study population (Finch and Mason, 1999).

In the fieldwork, 36 rural-urban migrants¹⁷ have been included in the following categories:

Firstly, the participants had direct experience of illness in the past or currently, or they had experience of illness in an immediate family member;

Secondly, a sample with varied employment status was selected, that is, both employers and employees were included;

Thirdly, the sample was also selected by length of migration, which was at least 36 months;

¹⁷ As to the number of 36 samples, it is because the sample was structured with the categories, as the number of 36 can cover the sample of this study well, including the categories of migrants and illnesses.

Fourthly, the participants comprised male and female migrants¹⁸;

Finally, the interviewees included those with different marital statuses.

Categorising illness (health) conditions for sample selection¹⁹:

- (1), chronic illness that can be treated and a recovery made;
- (2), chronic illness that can be treated temporarily but may reoccur;
- (3), acute illness that can be treated and a full recovery made;
- (4), acute illness that can be treated but the subject remains weaker;
- (5), often weak without any diagnosed illnesses.

3.4.2 Interview Methods

Interviews are an extremely popular research tool within the field of sociology and social policy. They provide a flexible strategy for sociological enquiry, ranging from the tightly structured question format to a more conversational line of questioning.

¹⁸ As to the gender dimension of this research, because there are some jobs pursuing by female migrants in that migrant community, such as shoe shine, garment and shoe industries, and the illness categories contain the gynaecological diseases, so it is necessary to cover female and male migrants.

¹⁹ This research also explores the health-seeking behaviors, the health constraints and the understanding of the importance of health with respect to the illness categories, so the illness categories were applied to the fieldwork.

Interviews are thought to be beneficial to social science research as they enable the researcher to tap into the views of the respondent in order to gain an insight into their personal views and experiences, including descriptions, narratives and accounts of a particular social phenomenon. Interviews constitute the most important element of the data collection in my research.

In this study, the interviews were conducted on the basis of a semi-structured interview. It was preferred because it gives the interviewees the opportunity to speak freely with their own words (May, 1998). The interview generally tends to contain a list of questions or fairly specific topic to be covered. However, it does not necessarily mean that the interviewees do not have a great deal of leeway in how to reply. So, I was reminded that the interviews also allowed space to pursue a topic of particular interest to the interviewees as long as the interviewees understand issues and events (Leidner, 1993). Despite the fact that it can be distracting, the semi-structured interview helped me to capture a more detailed description of their health constraints and experience.

3.5 Doing the Interviews

3.5.1 Practical Arrangements

The fieldwork took place from April to May of 2008, using the methods of 'snowball approach to sampling' and 'contingency method' to gain access. Each interview was arranged at the convenience of the interviewees.

The interviews, usually took place at the outdoor or indoor workplace of participants. For the interviewees found by 'contingency method', some of migrants were interviewed on the spot. In few cases, the interviews were conducted at the interviewees' places of residence by appointment. The interviews occurred during the day time, between 9 o'clock in the morning and 6 o'clock in the afternoon, except one interview with Mr Wang, which took place at 8 o'clock in the evening as he required. Wherever possible I tried to limit the number of interviews conducted in a day. During my interviews experience of previous project, I realised that the process of interviewing is hard work for both the interviewees and the interviewers. So I decided that no more than two interviews would take place in a day to ensure the interviews' quality, and arranged that the interviews did not happen successively.

3.5.2 Interview Setting

The interviews were based around a semi-structured approach using a check list that assured the main points of the research concerns I wanted to cover. At the same time, I wanted to assure flexibility allowing participants to express their views freely during the interviews. The check list was particularly useful in the first few interviews as I could turn to it whenever necessary to make sure the interviews were flowing through the areas of research interest.

I carried out a total 36 interviews through the fieldwork. And the interviews with each participant included completion of the questionnaire in order to know his/her background and the basic indication of income/expenditure level. Ages of interviewees ranged from 18 to 50, and the mean was 28.5. Sixteen interviewees were women, and twenty interviewees were men. Twenty-two interviewees were single,

and fourteen were married, of whom thirteen had one or more children. Each of the interviews lasted between one and two hours, although most were completed in one and a half hours. When the interviewees were answering questions they were not interrupted and were allowed to elaborate on issues they found important. All interviews were audio-taped and later transcribed.

3.5.3 Recording and Transcribing

Given the agreement from participants, all interviews were tape recorded. Two tape recorders were prepared for the interviews. In case the digital recorder failed to work correctly, another mini tape recorder was put on standby. Following the brief introduction of informed consent, I then introduced them briefly to the aims and objectives of my study. After that, I explained to participants that I wanted to use the recording equipment to certify that an accurate record could be kept of what was said during the interview. I also stressed that confidentiality would be maintained and tape recordings and written records on the interviews would be kept in a safe and locked drawer. Following the collection of those data, all recordings were then transcribed and translated in full. A pseudonym was used to protect their identities and, notes were taken to enable precision recall.

3.6 Ethical Issues, Confidentiality and Consent

When it comes to ethical consideration, the first thing that comes to my mind was interpersonal relationships with the people I contacted. The qualitative research

method that is clearly based on an interactive process and participation demanded my ethical consciousness as a researcher. Frankfort-Nachmias and Nachmias (1992) assert that social scientists face a conflict between two rights, 'the right to research and to acquire knowledge and the right of individual research participants to self-determination, privacy, and dignity' (ibid. 78). While I would agree that the latter is indeed a right, the former, I believe, is overstated and should be seen more as a privilege as opposed to the *right* to intrude into ethically sensitive areas. Nevertheless the ethical dilemmas of whether or not to undertake research if it interferes with participants' lives is relevant. There is no absolute right or wrong solution to this problem, but the researcher has an obligation to balance any costs to the participants against any potential benefits of the research. For my study, when finding participants, I bore in mind that the migrants, as autonomous individuals or members of their families, had the right to decide whether to permit an invasion of their personal privacy for research purposes (Fetterman, 1989; Lipson, 1994). As my interviews related to sensitive topics from the cultural point of view (questions associated with personal issues like health, insecurity and economic deprivation needed to be asked discreetly), some people would feel very protective about their personal affairs, especially in an Asian culture. Therefore, my position as a researcher required special ethical consideration. Given that the interview data was likely to touch on sensitive or private topics, I needed to consider the confidentiality of participants' identity. From the beginning of the interview to the very end of the data analysis, I was well aware that it is my responsibility to protect the identity of those participating in the interviews. It was essential that not only must I obtain informed consent from the participants, but also I should pay enough attention to the right to privacy, prevention from harm and power relationship that could be reflected within the interviews.

3.6.1 Informed Consent

As is the case in general in research, despite all efforts on the part of the researcher to inform clear information and offer explanations, the consent issue is one of the challenging ethical responsibilities (Mason, 2002). The ethical challenge ranges from obtaining initial consent to taking part in research to imparting information concerning the use of tape recordings and written records of the interview. This required informing participants about the overall aim of the research and its main features, as well as of the risks and benefits of participation. To this end, it was important to aim at gaining informed consent from participants, providing them with information about the purpose of the study, how the data would be used and why participation would be required of them. Consent may be given in a written format, verbally and audio-taped, or videotaped. An individualised consent form, which is either literal or verbal, should be used to ask for consent both to take part in the study and to the archiving of tapes and transcripts at the end of the interview. It is important that the individualised consent from participants could maintain a crucial balance between indicating that the participant is free to leave the research at any time, and encouraging her or him to stay and continue the work. In all ways, informed consent should be based on understanding that participation is voluntary. It may require particular emphasis that consent is not absolute and needs to be assessed and sometimes renegotiated (Lewis, 2003). Overall, it is of paramount importance for the researcher to make clear to the participants at the beginning what questions a participant might be asked or what potential risks might be involved in the future.

Then what do participants consent to? I was clear about the point of gaining consent by telling them that they were free at any time not to respond any questions and could withdraw their involvement at any stage. This included information given when I spoke to participants to arrange the interviews. While I fully understand the detailed principles of the above informed consent, I tried to apply the principles in as detailed a way as possible. I represented them in the form by detailing the purpose of the research by emphasising both confidentiality and the voluntary nature of participation.

3.6.2 Anonymity and Confidentiality

The consideration of mechanisms that protect the identity of participants appears to have become central to the design and practice of ethical research. The most crucial ethical issue in protecting the identity of participants can be focused on the matter of anonymity and confidentiality as the primary protection against disclosed revelation (Bulmer, 2001). It is suggested that researchers should consider the issues of anonymity and confidentiality of study participants, whose concern may be most likely to focus on how they can be maintained, particularly regarding the topics or subjects of research involving obtaining knowledge in relation to the misbehaviour or criminality of interviewees and examples of mistreatment, child abuse, the use of drugs and so on (Kvale, 1996). As noted, mechanisms for the protection of individuals have a central place in the design and conduct of ethical research and there are many instances in which the guarantee of anonymity and confidentiality to research participants is of the essence.

In my research, it was important to me to be aware that there are degrees of anonymity which are particularly relevant for research into people's health issues. It would be admitted that my research included investigation of personal information which was then discussed on tape and referenced in the text. It is likely that during interviews, particularly those which relate the life story or specific health experiences of the participants, details, and names of friends, associates or others might be revealed. In ensuring confidentiality, I did not report private data that identifies participants. One of the safest ways to ensure anonymity was that I did not record the names of the participants at all and provided an information sheet that asks for verbal rather than signed consent. However, it is much more usual to use pseudonyms so as to protect the privacy of participants. As confidentiality is still a very sensitive issue, in particular for the migrants with health constraints and financial difficulties, it is important that any information about others which has been included in the interview data should be anonymous, even if there is permission from those named.

3.6.3 Protecting from Harm

The risk of harm to participants should not be neglected. Although it is hard to predict where harm might arise, it is clear that the best approach is to be alert to all potential harm to participants both during the process of data collection and data publication (Bulmer, 2001). In particular, my research interest on sensitive topics such as health, vulnerability and exclusion that uncovers painful experiences of the migrants is likely to provoke powerful emotional responses from participants. So it was expected and confirmed that the participants in my study would experience high levels of stress, anxiety, and damage to self-esteem as a consequence of being asked about private

issues. Some participants asked me what I intended to do with information about their income and health. For example, one participant reflected a common line of questioning when he asked: 'How must I possibly say about my financial affairs?' In addition to this, some participants appeared comfortable and revealed information exclusively during the interview, but later regretted going too far (Lewis, 2003). There were cases when I asked about self-esteem where some female participants felt miserable about their own situations and showed the drain on their emotional self-esteem by crying during the interviews.

My experience as an interviewer throughout the interviews gave me considerable understanding that participants tended to be easily swayed away from the main points with too big questions. And they found themselves in a situation that exposed them too much. If that was the case, it would be sensible to make clear judgements about what is and is not relevant and to avoid unnecessary detail about their personal profile. What seems to be significant is that the interviewer should readdress the topic through clear and direct questions so that participants could avoid an explosion of their personal details that it is not necessary to reveal in the interests of participants' self-esteem.

3.7 Data Collection

Collecting data in all the disciplines of the social sciences and in educational research may involve the process of collecting (sifting, organising and summarising) masses of data. The process of collecting data by and large takes two forms: gathering data that had already been collected by someone else, and creating new data. Every piece of

data can potentially be important. However, it should be decided what type of data to collect. Most researchers are aware that data are only useful in the right context and data out of context are simply unhelpful, even at worst misleading. Good researchers thus need a sense for knowing which data are useful and relevant, and which are not. It is important for the researchers to find the best way to make use of the data, what various forms of data can be used and why data may be collected for a specific purpose.

There are various sources of data that I obtained for the study: books, newspapers, journals, reports, documents found on the internet, government reports and other relevant sources. Those data includes quantitative or qualitative. First of all, I found that documents are of conventional use in that they are a major feature of contemporary society (Murphy and Dingwall, 2003). They might include newspapers, legislation, materials on the web, journals and reports from agencies. Of course, qualitative interviews that I imply as the main source of data have also been extensively used for the data collection across all the disciplines of social science research. There has been a considerable growth in using interviewing as a method for social science research and now it is generally agreed that interviewing is a key method of data collection (Hall and Hall, 1996; Kvale, 1996; Bryman, 2004; Mason, 2002). This interview approach is particularly helpful for me to explore something that can not be obtained via observation and number-oriented documents.

I was convinced that semi-structured interviewing would be used as the research method to collect data for the study. The central concern of interviewing methods is to understand human experiences at a holistic level. And its concern is exactly consistent

with my concern in attempting to draw out the whole picture of constraints on health and health services access of rural-urban migrants. The advantage of semi-structured interviews enabled me to capture what the migrants say, think and do about their health and health services access. In addition, allowing further access to the various documents such as journal and newspaper articles, internet material, reports and publications provides me with an important source of data and a unique version of reality. Therefore, although both quantitative and qualitative research methods have their own strengths and weaknesses, the qualitative methods can provide me with a better understanding of the research topics and improve the depth of my study.

3.8 Data Analysis and Writing up

Data analysis techniques are best chosen in relation to the types of data collected. The approach to data analysis may be on a particular model basis such as grounded theory, statistical analysis or narrative case study based on a combination of quantitative and qualitative methods. On the one hand, quantitative data tend to largely rely on correlation and regression methods, analysis of variance and chi square as statistical outputs in which software application for statistical analysis may be useful. On the other hand, qualitative data may include transcripts from questionnaires, interviews or focus group. Qualitative software can be employed to manipulate words, whilst statistical software works with numbers. Qualitative data on a small scale can be reviewed manually, extracting key emerging themes and providing anecdotal examples and quotes to emphasise and personalise points.

For my study, the data collected from semi-structured interviews, based on the grounded theory emphasising discovery and theory development, was tape-recorded under interviewees' agreement. In addition, interview notes, focusing on fundamental moods, describing the atmosphere, and my reflections upon the interactions, were made as soon as each interview was finished. This was because during the data collection, I needed to pay attention to many contextual factors, which did not get onto the tape recorders. These included the crucial non-verbal data of postures, gestures, voice intonation, facial expressions or eye contact (Jones, 1985) and emotional content such as laughing, crying or sighing. These paralinguistic and linguistic features helped not only to build rapport between the researcher and those being researched but also to obtain good quality data. All recorded interviews were fully transcribed by the researcher because the production and use of transcripts was very important (Atkinson and Heritage, 1984). Following transcription of the recorded interviews, a two-phase qualitative data analysis procedure was applied to explore the key facts of health constraints and health services access in terms of coding data and developing themes. First, the content of transcripts was carefully examined and annotated. The statements made by the participants were classified and grouped according to the similarity of the content. This process invariably involved me doing a number of iterations. Second, the main themes on health constraints and health services access were identified. This involved me coding participants' statements about their experiences, grouping them according to similarities and finally developing distinct themes. Then the transcripts with these themes in mind were re-read to ascertain whether all information from the participants was adequately covered by the themes. There followed the process of framing a set of identified themes in order to confirm the findings.

3.9 Protecting from Risks

Risk and danger to the personal security of the researcher is an issue gaining greater recognition within the social sciences (Renzetti and Lee, 1993; Lawrinson and Harris, 1994; Lee, 1995). Safeguards and precautions can be built into any research strategy but more attention needs to be given to how this is done and how ad hoc risk is dealt with in the field.

For my research, I interviewed some unfamiliar migrant participants at the research site. Thus, some safety strategies and precautions were developed to minimize the threat to me. I tried to arrange that, interviews would be undertaken, as far as is possible, within office hours; a mobile phone was always carried, my family members were informed of my whereabouts and were alerted when I was particularly concerned about a specific interview. The aim of these precautions was to provide backup or support in potentially vulnerable situations and to facilitate exit from the research site if necessary. My anxiety and sense of threat in conducting the fieldwork also varied depending on who else was in the respondent's home or workplace, such as construction work sites when interviews were being undertaken. Also, whilst visiting participants' home or work place I was alert to the possible threat of attack or theft on the street. So the necessary preparation for undertaking my fieldwork to minimize the risks included: planning research thoroughly, working in a safety-conscious way, remaining constantly alert to potential risks, and being prepared to take action to respond to threat, even if this meant leaving the field. During the

fieldwork, I paid attention to the protection from risks, and the interviews were conducted successfully and smoothly.

Chapter Four

Constraints on Health and Health Services Access: One Class of Migrants?

4.1 Introduction

Chapter Three offers a detailed discussion of the rationale and links between the aims of research and the research methods used. It states the way in which I set about analysing the health constraints and health services access by introducing the qualitative approach as the research method. Chapter Four, Five, and Six will focus on the empirical analysis of the fieldwork at Dengcun Village conducted for studying health and health services access of migrants. In this chapter, based on the exploration whether there exists social classification among migrants, it examines the constraints on health and health services access with respect to the social strata among migrants.

4.1.1 Context and Issues

The huge influx of rural migrants into the city, and the way in which they have flocked into the hybrid areas (these refer to the combination areas of city and country), amount already to a structural phenomenon of social life in contemporary China. A

new socio-geographic group has thus been formed (Li, 2005). Migrants who live and work within the city with peasant origin have ways of life, standards of action, networks of acquaintance (social networks of migrants will be discussed in the following chapter), and ways of thinking that are different not only from those of urban residents but also from those of peasants who stay on in their home villages. Moreover, the settlements and communities of rural-urban migrants in those hybrid areas have, in large measure, transformed the demographic structure there. Thus, in Dahongmen area of Beijing, where the Dengcun village locates, as early as ten years ago, the ratio of the migrant population to the local population was of the order of seven to one (Wang, 1998).

These special groups and communities, which have evolved in the formation of a socio-geographic space, developed further and became more and more significant. In the context of a dual social system within which rural and urban are divided structurally, this phenomenon makes up one type of urbanization in China: a migratory practice that is not institutionalized, but spontaneous, whereby peasants take part in urbanization (Li, 2004). With this in view, it becomes very important to analyze the internal mechanisms upon which the continuing existence of this space and its uninterrupted development are based. Social strata among rural-urban migrants, who are also known to the urban people as 'floating rural people' (*liudong nongmin*), in this study, refer to the phenomena of differentiation that have arisen within the relatively unified groups of migrants, once the migrants have, as a result of the evolution and life in the receiving area, been classified according to their occupations.

So far, not much study has been carried out in regard to the social strata among rural-urban migrants in China, especially of the medical services access and health constraints with respect to the social strata. Few researchers have raised this question in related studies having some connection with it. Zheng (2003), for example, argues that migrants should be divided into different social classes, in terms of their wealth, income, possession of the means of production or of the prestige associated with the job. And, with respect to the social security of migrants, including their health, it should be reformed according to the respective needs of each group among migrants. Zheng is certainly the scholar who notices this issue and argues for 'social strata' among rural-urban migrants, but he has not brought his analysis further. Therefore some intensive study needs to be pursued here.

4.1.2 Organisation of the Chapter

This chapter focuses on the constraints on health and health services access in terms of social strata among migrants. In this chapter, based on observation of Dengcun Village, it first supplies readers with a preliminary sketch of social strata among migrants, related to that, the first and foremost questions are: whether social strata exist among migrants? If so, what are the social strata among migrants in the community? Following that, it analyses what they do share as migrants with common citizenship and what separates them in terms of health and health services access? The study identifies the institutional constraints which make inequality to all migrants in the health service system in China. Then the discussion moves to the hierarchical structure of health services access among migrants, which is followed with the analysis on health constraints for the majority of migrants. In the end, it analyses the

illegal private clinics, which are a popular health service choice to migrants who are in the second and third strata within migrant community.

4.2 Identifying the Social Strata of Migrants

As an expanding social group, rural-urban migrants in China may be expected to have different social strata according to their different economic and employment status (Zheng, 2003). However, there is a complete lack of information in current studies on the social classes within rural-urban migrants and a number of studies treat this group as a hotchpotch.

Hitherto, no intensive study has been done on medical treatment and health issues with respect to social strata among migrants in China. Few studies (such as Yuan, 1996) have pointed out the internal differences that make of migrants a ‘heterogeneous group’, which indicates it has not received the attention it deserves. For many people, there is no clear image of this multi-layered group, and the general feeling is that the migrant population sounds very homogeneous and that its movements seems to be above all horizontal (Xie, 2005). This is what I am going to argue against in this chapter.

In this study, based on the case of Dengcun Village, one of those areas in Beijing where migrants are relatively concentrated, I argue that, although the migrants still constitute a unified statutory group within the current system of social stratification, more explicitly, a group at the bottom of the scale, for around two decades, this group

has been undergoing a profound evolution of its internal structure, which has helped greatly in widening its living space. These migrants, who share the same rural origins and the same peasant identity, have already split up into a number of extremely different groups. On the one hand, considered from a horizontal perspective, the types of their occupations appear diversified, such as, migrants who pursue business as proprietors of the garment and shoe industries; migrants who are self-employed in small businesses; and migrants who are employed and self-employed as manual workers. On the other hand, from a vertical perspective, the significant distinction lies in factors such as the possession of capital, economic income, social prestige, interest relationships and values. Such distinctions give evidence of the emergence of a new social stratification.

4.2.1 Causes of Classification

The causes and the basic context of social strata among migrants in Dengcun Village can be boiled down to three main factors:

First, Contextual and Policy Factors: Along with the progress of urbanization, more positive policies on rural-urban migration were put forth, which weakened the institutional obstacles to mobility and enabled peasants to float about. Once migrants had entered the city, they found themselves to be subject to the standards of urban economic life, and assumed their position on the ladder of an established division of labour (Li, 2004) Thus, the original homogeneity of rural-urban migrant group was broken up.

Second, Personal Motivation Factor: The intensity of desire to improve one's position determines whether or not an individual will carry out his upward mobility, or whether he will stagnate in the position where he originally stays (Xie, 2005). Because vacancies are limited, many migrants are content to remain 'little workers' (*xiao gong*) in Beijing. Therefore, to sustain an absolute will to become a 'boss' (*lao ban*), at least partially, means to take the risk of dangerous indebtedness.

On this point it is illuminating to compare the situations of two interviewees in this study, Mr Zhang and Mr Liu, who both started off from similar situations. Zhang is from Zhejiang province and is a little younger than Liu who is from Henan province, but Zhang's level of education is slightly lower: he did not complete his studies in junior high school, whereas Liu stayed on until graduation. Liu came to Beijing in 1993, when business was booming following Deng's visit to the South in 1992. As Liu was content with his overall circumstances in life he had no other ambition than earning some money and returning to his village to build a house. After being a construction worker for two years, he remained as a peddler. By contrast, Zhang was driven by the desire to upgrade his socio-economic status and was completely filled with this desire. Thus, no sooner had he started the garment business than he began seeking the best ways of making as much profit as possible. When he had a certain amount of funds put by, he did not choose, as many other migrants do, to go back to his village and build a good house, which is a normal way to bring honour to family and ancestors in China. Instead, he made the decision to re-invest and, as a result, he gave up his renting clothes stall and bought a clothing shop to extend his business. As a matter of fact, earning money is no longer his only target. He seeks to change his status and social position. He wants his two children to go to university in the future,

have good education and become urban dwellers. So what principally explains the success of Mr Zhang is his powerful entrepreneurial motivation which started with the purpose to work hard for food and survival, and was later transformed to earn money to escape from poverty, and then the determination to bring children out from the identification as peasantry forever.

Third, Geographical Factor: It should be pointed out that, the appearance of social strata in this migrant community is also related to some birth place factors. Dengcun Village is mainly inhabited by migrants from Zhejiang province and Henan province, and among these people, especially some migrants from Wenzhou of Zhejiang province have already become specialists in the shoe industry and been called ‘migrant bosses’ (*lao ban*). They had some economic and business bases in their home villages before migration. For some other migrants from Henan province, such as Mr. Liu, their only capital is the capacity for labour, before coming to Beijing, most of them were destitute. And for some other migrants who have little financial basis, their businesses were often limited to the service industry, which are basic and necessary services to this migrant community, such as restaurants and barber shops.

In the area of Dengcun Village, which is located within the business centre of the shoe and garment industries in Beijing, the division of labour there has gone through a constant process of evolution, to the point where a specialised treatment has been developed gradually for each type of job. Not only has this enabled migrants to improve their job prospects, mainly including the shoes and garment business in the first place, it has also induced migrants occupying different jobs in this migrant

community to form new occupational and social relationships, and therefore to divide those migrants into different groups according to a clearly stratified structure.

Social stratum is the most commonly used indicator of the socio-economic circumstances of individuals and families. In numerous health surveys, classification of occupations is used as the basis of social strata. Occupation is believed to provide a general guide to a person's social position; it not only indicates the type of work undertaken but is also considered to imply differences in income and life style (Clarke, 2001). In view of the occupational structure, migrants in this study are divided into the following three strata in terms of their occupations:

- 1, the migrants who work as employers with the possession of productive capital;
- 2, self-employed migrants with little capital;
- 3, migrants do totally depend on others for work.

The measure that I have chosen to group the social strata of migrants can show not only their working situation, but also reflects the different economic and social status among them in the sample: migrants in the first stratum have the highest income; and then the second stratum of migrants is lower; and the income of the third stratum migrants is at the bottom. To a specific extent, these also reflect the overall social classes of rural-urban migrants in China more widely.

First Stratum

This stratum includes the owners who hold the relative productive capital and employ other people. Dengcun Village in Dahongmen area is an important distributing centre for garment and shoe businesses in Beijing, and the representative migrants in this stratum are the business proprietors of shoes and garment industries based in that area. They (n=3 among participants) are actually urbanised and have the following characteristics. Firstly, their average family income per year reaches hundreds of thousand of RMB Yuan or several million RMB Yuan. Secondly, they have already bought a flat or high-grade flat in Beijing. Housing investment in Beijing is expensive and it costs understatedly hundreds of thousand of RBM Yuan for a flat in this City. Therefore, housing in Beijing is another criterion to measure the economic capabilities of migrants. Thirdly, as for the migrants in this stratum, their children are enrolled at urban primary school or middle school with good education. Fourthly, they have some social prestige and possess some social capital. And finally, these migrants are usually living with their family in Beijing. They are also described as ‘stall bosses’ (*dian laoban*), ‘shop owners’ (*dian zhu*), or ‘traders’ (*shengyi ren*).

The migrants of this stratum blend into urban life and the local communities well although their identity is still peasant. The only major difference they have from urban residents is their rural household registration status (*Hukou*).

Second Stratum

This stratum includes self-employed migrants, who possess little capital and run their own private businesses. They (n=10) are individual practitioners in tertiary industry. In this study area of Dengcun village, almost all the services necessary to the life of a

community are involved, such as restaurants, open-air food stalls, shops, hairdressing salons, repair workshops for bike carts, nurseries, clinics, small printing shops, and small embroidery shops. In general, these services, provided by rural-urban migrants, remain at a basic level, for instance, the meals offered by the restaurants are usually steamed stuffed buns, noodles, large flat breads, braised meat of mediocre quality, and they are usually very cheap; some products sold in the shops are copies or fakes; even the doctors in private clinics do not have licenses and medical certificates. These migrants have a small amount of productive capital and this group mainly has three characteristics. Firstly, they earn a bare living by their business; secondly, they can not afford housing investment in Beijing; and thirdly, their children are not enrolled at urban schools, they attend schools run by non-natives or migrants with cheaper fees.

Third Stratum

This stratum includes those migrants who are totally dependent on others for work. Apart from that, some self-employed migrants who do not have capital but body strength are also included.

This group of migrants are undertaking work in secondary industry and low-end tertiary industry. The characteristics of this stratum of migrants are: firstly, they have heavy intensity of labour with long working hours, and their working conditions and living conditions are poor, or even without necessary protection; secondly, they are struggling to feed a family or themselves with very low incomes; thirdly, their education level is low and they are unskilled or low skilled; and fourthly, their sense of belonging to the city is very weak, and they do not regard themselves as urban

residents but still peasants, no matter how many years they have been working and living in Beijing. This stratum of migrants is the most vulnerable group among the three strata but account for a majority of all migrants (Zheng, 2003). The data in the sample indicate that the majority of the peasants who came to work in Dengcun Village were poor, or 'medium-poor' before they arrived in Beijing and started their work. But within less than twenty years, a differentiation has taken place, and utterly broken up such initial homogeneity. The amount and structure of their capital and wealth vary according to the division of their occupations.

There is always a gradation in the division of investment in labour and in capital; at the bottom are the migrants who depend solely on their working capacity, such as peddlers, scavengers, construction workers, and shoe shiners; further up are the migrants who run small business, and their income includes a proportion of return on capital; and, at the top, are the business proprietors in the shoe and garment industries. Profitability is also very different according to the position occupied among all the migrants. The result is that today, Dengcun Village is demonstrably stratified.

4.3 Institutional Health Constraints to All Migrants

Because of their *Hukou* status of rural origin, migrants, no matter which stratum of the three they belong to, they are not covered by the urban health services system, as their identities are still rural household registration. As a whole, the status of migrants, no matter poor or rich, in the medical insurance system is the same, and this is an institutional problem in contemporary China.

4.3.1 Medical Insurance

Rural-urban migrants are a vulnerable group in the city with respect to health issues (Hu, He, and Wen; 2008). On the one hand, they have a great need for medical services, including disease control and prevention, and birth control. On the other hand, compared with the medical services and social welfare the urban residents enjoy, the situation of migrants at this point is usually poor and much worse, although they also work and live in the city as do local urban residents.

Medical insurance for migrants in Beijing at the present time can be described by the following characteristics. Firstly, population coverage is limited, as only employees of enterprises can qualify. Secondly, benefits are limited, as only catastrophic inpatient illnesses are covered. Thirdly, the insurance scheme is ambiguous, as although from the year of 2004 insurance is a mandatory requirement by the government, the lack of support from policy and tax subsidy leads to high insurance premiums. As a result, medical insurance officially only covers a very small range of migrants, because migrants employed in enterprises account for the minority of total rural-urban migrants (Wong, Li, and Song; 2007).

Very few migrants in this study have access to financial assistance for medical treatment. In the survey, almost all migrants do not have any insurance, and only one out of the total interviewees has urban medical insurance in Beijing:

I am working as a maintainer in a state-owned network corporation; I got this job through one relative in Beijing. My work-unit buys insurance for me every year, and according to the contract, the cost is deducted from my salary. I think medical insurance is useful for us, for example, I fell ill of pleuritis last year, and got some reimbursement for treatment as I had medical insurance (Mr. Shi).

As to the rest of migrants interviewed, the high charge for insurance premiums made more than half migrants feel it was difficult to afford with their relatively low income; some thought that medical insurance was only for city residents and they thus neglected it; a few thought that insurance was not important at all so they had no intention of buying it, in some cases from the first stratum migrants, they think that medical insurance is not important, they do not care about how much money for health services, so they do not buy it.

I think the medical insurance is not important, we only target at making money, if I have illness, I will definitely go to the first-class hospital. Besides, the designated hospitals of medical insurance are not first-class hospitals. (Mr. Zhang, a boss of garment business, a first stratum migrant)

There are three reasons for the low purchasing rates of medical insurance among rural-urban migrants. Firstly, a majority of migrants have low income and lack awareness about social security. They may be unwilling to join the medical insurance programme because a big part of the expense for it will be deducted from their low wage. Secondly, employers are not willing to pay extra money for the migrants they

hire. Even when they have to comply with governmental regulations regarding medical insurance for their migrant employees, they often only buy it for a small portion of them, or they deduct the insurance premium from wages of migrants, such as the case of Mr. Shi. Moreover, in other studies, the employers sometimes deliberately avoid informing their migrant employees (even the individual employees for whom they have bought the insurance) of the relevant policies. Thirdly, as Hu and He (2008) indicated, during the planning of the basic medical insurance programme, employers were not involved in the discussion. As a result, the plan is not welcomed by the employers of migrants (for its coverage, benefit items, and management).

According to the stipulation of 'Interim Procedure of Basic Medical Insurance for Rural-urban Migrants in Beijing' which was implemented from the year 2004, migrants who have a stable labour relation with the employing units, which include enterprises, public institutions, and nongovernmental organizations, can be involved in basic medical insurance in Beijing.²⁰ One principal defect of this Interim Procedure is that those self-employed migrants are not yet covered by basic medical insurance, and remain as the "untended group" in the city.

4.3.2 Migrants within Medical Services System

In China, social welfare is firmly tied in with one's residence status within the *Hukou* system. Such status does not change when the peasants float into the city and settle there. Therefore, rural-urban migrants are largely excluded from the social security system and medical subsidies in urban areas because they are not "institutionally

²⁰ 'Interim Procedure of Basic Medical Insurance for Rural-urban Migrants in Beijing' is available from the website of Beijing Bureau of Labour and Social Security, available at: <http://www.bjld.gov.cn/LDJAPP/search/fgdetail.jsp?no=10221>. Accessed on 20/03/2009.

acknowledged” residents in the city. Although it is compulsory for employers in urban China to contribute to the unemployment funds set up by the government, these funds are usually applied only to the local residents. Rural-urban migrants who work in the same units are not entitled to such allowances for unemployment (Zheng, 2003).

Although, in China, rural residents started to have access to the Rural Cooperative Medical Scheme (RCMS), the RCMS is newly established and immature, it started experimentally in some selected regions in China from 2003, and for the time being, it is probatively implemented in limited districts in rural China. At the current stage, it is not yet explicit enough to tell whether it can provide substantial welfare in health services to rural people, let alone those peasants who have left their home village and floated into the urban areas.

From the interviews with participants, one fact obtained is that there are some barriers in the implementation of the RCMS among rural-urban migrants, and the migrants do not enjoy actually the RCMS. Mr. Zhu’s experience reflects this point:

I paid some money in my home village and registered with the Rural Cooperative Medical Scheme. But if I spend money for medical treatment in urban areas, I can not get reimbursement from my rural place. There are also many obstacles to get reimbursement from the local village, for example, my youngest son got encephalitis last year and I spend around sixty thousand RMB Yuan for the treatment in a public hospital of home village but only with difficulty got ten thousand RMB Yuan reimbursement from the Schemes. At the beginning, the staff did not give me any reimbursement. After I offered some

gifts to them, then eventually I got some reimbursement, otherwise, I would have got nothing. It is very difficult for us to get medical services in urban society, but in my home village, I feel that the help from the Rural Cooperative Medical Scheme is really very limited. That is a dilemma for us (Mr. Zhu).

Since rural-urban migrants are not covered by the urban health scheme, even if they are linked to the RCMS at fixed rural places, when they get health problems in urban areas, especially urgent and serious diseases, it is difficult for them to go back to their faraway home villages to get opportune treatments. In that case, RCMS is too minor a factor to be taken into account on the issue of migrants.

4.4 Financial Status: Realistic Reason for Hierarchical Health Services Access

The importance of financial resources for migrants is highly related to the life in cities, illustrating a strong dependence on a cash economy (Farrington et al, 2002). According to the data from nearly all of the interviews, their financial resource consists of the funds available to them such as wage income, business income, and savings. On the one hand, the financial resource is often the most lacking resource for most migrants because many of them are engaged in manual jobs with very low payment, or worse if they experience wage arrears (Xie, 2000). Yet on the other hand, financial resource is of the first and foremost importance since it can be used directly or can be used to acquire other services, including medical service.

To the participants in the sample, business income and wage income are major sources for health services. Based on the data about the monthly income of the participants, migrants who are in the first stratum were the richest group in this study. Their income range is from the hundreds of thousands of RMB Yuan to millions of RMB Yuan per year. In the example of Mr. Xia (who is a boss of shoes business and in the first social stratum), he said that his family expenditure was more than two hundred thousands RMB Yuan per year. For the migrants in the second social stratum, the income range is thirty thousands RMB Yuan to one hundred thousands RMB Yuan per year, the participants (n=8) stated that some savings remained each year after family expenditure, although it was not much. For the migrants in the third stratum, wage income and earnings from their self-employed manual work are a major source of income of the migrants in the sample. Among the migrants in third stratum interviewed, wage income and earning from the sale of their labour is the only financial resource and it might be the only resource that their family depends on.

There are two factors which may disadvantage migrants bringing negative financial status: low income and insecurity. Especially for those self-employed manual workers, apart from low and unstable income, sometimes they are severely fined by the municipal administration staff due to their tax evasion behaviours. As such, financial resources available to migrants in the third stratum are scarce. Most of the migrants (n=14) in the third stratum stated that they used up all of their disposable income every month and nothing is left for savings. The used-up monthly income does not mean that all their needs in life are substantially met, on the contrary, they had always been under the pressure to squeeze the monthly expenditure to the level of their monthly income. And monthly income is basically used to meet the basic necessities

of living: eating, clothing and housing rent. The popular saying ‘live day by day’ used by migrants undoubtedly reflects that life is a struggle with financial constraints.

One finding in this study is that financial status is a crucial factor for medical services access among migrants. The medical treatment access among these three strata migrants appears with a hierarchical structure— their financial status influence directly their capability of consuming the existing medical services, particularly in a situation not being covered by the urban medical scheme. Eighteen among all participants responded that due to the financial constraints, they chose to avoid medical treatments, especially they think the illness is not very serious and can endure it. As Mr. Liu stated:

If I suffer general illness and feel I can endure it, I usually leave it until it has gone, such as cold or fever, I do not go to pharmacy for medicine...the reason is only no money. (Mr. Liu, a pedicab driver, a third stratum migrant)

In China, legal hospitals are divided into three levels according to their medical technology and equipment. For example, the level three hospitals are general or comprehensive hospital at a national, provincial or city level; the level two hospitals are at the level of medium size cities, counties or districts; and the level one are township hospitals. According to the functions, tasks and scopes of services, hospitals in China can also be classified into three types, namely, comprehensive hospitals, specialized hospitals (such as dental hospital, tumour hospital, mental hospital, and so on), and hospitals of Chinese medicine. Moreover, in the light of ownership, hospitals

in China can also be divided into public hospital and private hospital. Apart from the legal hospitals, there are also some illegal private clinics without formal licenses playing an important role among migrant communities.

In this study, there exists a diversity of health services choices among migrants. Among the three strata, migrants in the first stratum have the best financial status. When they take medical treatment, all three of them are inclined to go to the level three hospitals which have the most advanced equipment and the best quality of services. For migrants in the second stratum, in order to save money, most (n=6) utilise the level two hospitals and level one hospitals, and a few of them (n=2) go to illegal private clinics. For the migrants in the third stratum, financial difficulties have kept them away from good quality medical treatment. Some of them (n=4) utilize the level one hospitals, and many of them (n=8) more often seek medical services from illegal private clinics although they know that doctors in those clinics do not have formal licenses. The illegal private clinic will be discussed in the latter of this chapter. Some migrants (n=5) return to their home villages to seek medical services. The following three childbirth cases illustrate the hierarchical structure in medical services access among migrants.

My son was born in Beijing Maternity Hospital (this is a level three hospital and the best maternity hospital in Beijing)...In the event of illness, we usually go to the Concord Hospital (level three hospital), money is not a problem, we trust first-class hospital and first-class equipments (Mr. Xia, a boss of shoe business, a first stratum migrant).

I gave birth to our second baby in Dongtieying Hospital (a district hospital in Beijing), it was very expensive and cost us around seven thousand RMB Yuan (Mrs. Guo, a barber shop owner, a second stratum migrant).

It is very expensive to get medical services in Beijing...my son was born in my home village, when I was about to deliver, I returned to my home village for childbirth as I can not afford the costly expense of delivery in Beijing (Mrs. Yang, a shoe shiner, a third stratum migrant).

While eighteen participants in the study said that they had always attempted to avoid medical services, among them, seven participants made the opposite point in relation to children's medical services. They expressed their perception that parents inherently favour their children over themselves, not only in taking medical services, but also in keeping good health status. Children are protected with better conditions. Thus, there are two extremes when they dealt with their own diseases (or injuries) and with those of their children (further discussion on this is made in Chapter Six).

Mrs. Lin, who is a cleaner in a small commodity market, and in the third social stratum, is a typical case in the sample. She tries to avoid medical services when dealing with her own disease (or injuries), but goes to the opposite extreme for her children's disease (or injuries). The following narration from Mrs. Lin, who was a cleaner in a small commodity market, is very illustrative of this point.

Mrs. Lin: "it is very expensive to get medical treatment in Beijing's public hospitals. I can endure the ordinary illnesses and injuries (by myself)... I

usually feel low back pain and soreness of waist, but I did not seek treatment as the cost for treatment is very expensive here and I can still endure that pain."

Interviewer: "What if your son needs to see the doctor?"

Mrs. Lin: "He must definitely be well taken care of in the hospital, even if I have to borrow money from others."

4.5 Specific Health Constraints: Consequences of Social Strata?

One aim of my fieldwork is to understand health constraints of rural-urban migrants. As discussed in the previous section of this chapter, because of different social classes among migrants, each stratum has constraints of health and health services access at various levels. The second and third strata constitute the majority of rural-urban migrants, and meanwhile, owing to their lower occupational and economic status, they face more health constraints than those in the first stratum. These constraints include living conditions, and working conditions. The discussion in this section will focus on the constraints experienced by the migrants of the second and third strata.

4.5.1 Working Conditions

As Tan (2002) and Xiang (2005) observed, migrants typically fill job positions with high health risks that are not favoured by local urban workers, which are sometimes referred to as '3-Ds'-'Dirty, Difficult and Dangerous' jobs.

Work-related Health Risks

According to the data from this study, there are typical examples coincident with their observation, for instance, benzene poisoning cases can be found among female migrants particularly in garment, shoe or suitcase factories, where cheap glue with a high content of benzene is often used without any protective measure for female migrants. In this study, some construction workers (n=3) were forced to work 12-15 hours a day, seven days a week, with no guarantee of one day of rest per week. As Mrs. Fan (a worker of a garment) described, some factories in Dengcun Village do not provide maternity leave for female workers.

Work-related Illness

Since the majority of migrants are poorly educated and do not have special skills, they normally take up less technical or non-technical jobs (Yu and Hu, 1998). Many migrants, especially from the third stratum pursue outdoor jobs as manual labourers and service workers. Some participants reported that it is the unhealthy and harmful working condition that resulted in their health problems:

I make my living by shining shoes in Dahongmen area...during working, I was suffered from the gynecological illness because of shoes cleaning. My

hands touched a lot of dirty shoes everyday... the underwear was transmitted by germs... (Mrs. Yang)

My problem of lumbar muscle strain is caused by my job as a tricycle driver... (Mr. Fan)

Lack of Assistance

When they get ill or injured, migrant workers have to spend their own money to get treatment and in most of the cases, many of them can not acquire any compensation from their employers. Some employers were not willing to do anything to protect the health of migrant workers, putting these people in hazardous environment with dust , toxic substances, noise and poor ventilation. Pneumoconiosis also occurs among construction workers, and below is how Mr. Zheng recalls his experience:

I got pulmonary disease because I worked as a construction worker for many years. This disease resulted from the heavy dust at the worksite because there was not enough safeguard in the workplace. I have never got any financial support from the employer for treatment and have to use my own money. If I go to the public hospital, the cost is very expensive, and I can not get any reimbursement from my employer or the urban government. I do not have medical insurance because I want to save money, so I did not buy it. My illness is getting worse as I do not have enough money for medical treatment, let alone I need to remit some money regularly to my home village. (Mr. Zheng, a construction worker, a third stratum migrant)

4.5.2 Living Conditions

Housing conditions to a large degree reflect individual and family social position (Wang, 2006). Migrants are mostly stuck in three forms of accommodation: simple rented rooms, self-built 'shed houses', and the accommodation provided by their employers (Wang, 2006). In many cities in China, policies allow the non-native population to acquire a property there. According to the 'Report on Rural Migrant Workers in China' in 2006, in most of the cities, most of migrants live in rented houses and the dwellings offered by the employment enterprises (State Council Study Group, 2006).

Different Levels of Living Conditions

The findings of this study show that , due to the financial difficulties and the desire to reduce expenses, the living conditions of migrants are usually poor, although a very few of migrants who are in the first stratum have bought their own housing.

In this study, distinctions between different levels of social contact and among the identities of social strata are apparent. As to the location of migrants' houses, different strata live in different places. The three bosses of the first stratum live in their own housing settling in good residential community, and in general, each of them has a fully furnished or high-grade flat with several rooms including living room, bedrooms and bathroom. For migrants of the second stratum who manage small businesses, although some live in privately rented room(s), one main type of accommodation is

the dwellings in shops or factories, which are usually owned by landlords who are Beijing natives. Living in such accommodation, private bathrooms and toilets are not available. Migrants who live in such accommodation have to use the poor public toilets (see Photo 4.A) and to boil water for bathing. Those migrant labourers (except for the ‘nomads’) in the third stratum, some (n=3), such as construction workers, live in lodgings provided by their employers. However, these lodgings are kept away from the houses of their employers. Some others (n= 15) live in privately rented room (s) similar to those of some second stratum migrants. According to the data of this study which is based in Dengcun Village in Beijing, each room described is about ten square metres with a cheap rent between 150 and 300 RMB Yuan, and air-conditioner and heater are not available. The accommodation of types of migrants in this study is shown in Table 4.1 below:

Table 4.1: Accommodation types of migrants in this study

Accommodation	Owner/landlord	Type	Social stratum
Flat/high-grade flat	Migrants	Own	First
Privately rented room(s)	Beijing Natives	Renting	Second and Third
Shop/factory room (s): Dwellings in shop/factory	Beijing Natives	Renting	Second
Dormitory	Employers or Beijing natives	Renting	Third
Self-built shed/hut (illegal building)	Migrants (illegal ownership)	Self-built	Third

Closed Environment

A majority of migrants interviewed live in the ‘village of the city’— an area between the Beijing city and the countryside. Their housing conditions are extremely ‘peripheral’ because, firstly, they mainly rent low cost housing in the letting property market. Secondly, the houses they rent are crude in condition, with a vile environment and are usually in bad locations. Living thriftily in such conditions within this city is like living in an ‘isolated island’, which gives rise to a particular lifestyle of migrants that is relatively marginalized and abnormalized.

Being marginalized here means that migrants live only within their own social circle with limited horizons. There is not much social life the rural-urban migrants can share with local city residents in city society: migrants are separated from local urban society and only live in their own community in a ‘countrified’ manner similar to that in their original villages. Their circle of social contacts and scope of social life are limited within their own community and they rely on communication among migrants themselves so as to dispel the feelings of alienation from the city society. Because of lacking communication with outside communities, migrants live together and thus form their own settlements. For them, it is important to keep in touch with their family members, relatives, migrant friends, and fellow villagers (*laoxiang*) within their own circles (further discussion on social networks of migrants will be unfolded in Chapter Five).

Being abnormalized here denotes that their life is unstable and incomplete. In other words, many are single and live in same-sex groups; they cannot find ways to establish contact with friends from the opposite sex. At the same time, married migrants cannot enjoy family life because many of them have been separated from their spouses or children for a long time.

Sanitary Conditions

Moreover, migrants face serious environmental problems, such as pollution, including garbage, air, water and noise. In the accommodation area of rural-urban migrants, solid household waste can be easily found everywhere. Effective cleansing facilities and staff are not provided, and wastes are left to pile up on the roadside, in corners, and in any small spare space (see Photos 4.B, 4.C and 4.D). When it rains, ponded dirty water normally remains some days due to shortage of drainage system.

The one-bed accommodation we rent from a local landlord was built in the beginning of the 1980s. The rent is very cheap, this room is around 15 square metres. I am living here with the other two migrant friends, we do not have private kitchen, bathroom and private toilet, we normally cook outside using honeycomb briquette and use shared tap-water outside. There is serious environmental pollution in this area, for example, especially when it rains, the roads in this area become very muddy and dirty with much of litter. (Mr. Wang, a waiter in a restaurant, a third stratum migrant)



Photo 4.A: Public toilet with litter in Dengcun Village



Photo 4.B: Main street of Dengcun Village (1)



Photo 4.C: Main street of Dengcun Village (2)



Photo 4.D: Side street of Dengcun Village

Poor living condition is a potential health threat for the migrants. It increases the probability of infection from diseases. During the SARS crisis in 2003, the Beijing government enforced some regulations that some construction companies had to meet so as to improve the living conditions (such as poor ventilation) of migrant workers, for the reason that SARS cases were discovered among migrants working on the construction sites. It was reported that 184 SARS cases were found in 104 construction sites in Beijing (Chinese Financial Magazine, 2003).

In this study, due to the unsanitary and overcrowd living environment, flu was found to occur frequently among construction workers, and rural-urban migrants take a majority of them.

I lived with dozens of young migrant workers when I worked at a construction site in 2005, we lived in one room altogether with poor ventilation...although very serious disease was not found at the time, flu was a frequent problem, if one of the fellow worker got flu, then some of the workers would be infected soon in our dorm (Mr. Feng, a construction worker, a third stratum migrant).

4.6 Illegal Private Clinic: An Ideal Option or a Health Constraint?

In Dengcun Village, there are some small private clinics which are illegal, because they do not have formal licenses. The existence of illegal private clinics not only provides a channel to migrants for medical treatment services in the city, but also reflects the difficulties and high cost of getting medical services to migrants in public hospitals. Illegal private clinics are a popular health service choice for majority migrants, e.g. migrants in the second and third strata, so it is necessary to analyse the role of private clinics on the health services access among migrants. From the findings of this fieldwork, there are nine illegal private clinics in that community, including three private dental clinics, two private clinics for general illness, two private clinics for diverse illnesses (such as gynaecological diseases, skin disease, sexually

transmitted disease, Chinese medicine, etc), one private clinics for gynaecological diseases (such as abortion and the sale of contraceptives), and one private paediatric clinic.

4.6.1 How do the Private Clinics Get Established?

The definition of 'private clinic' is based on its private ownership. Non-state-owned institutions can be defined as 'private' (Xiang, 2005). Hence, a doctor who runs an individually owned private clinic solely is a 'private doctor'. However, in this study, the 'private doctor' is realistically described as the self-employed 'doctor' without proper license.

In accordance with the 'Regulations Governing the Administration of Medical Institutions' in China, those opening a private clinic have to satisfy the following criteria: the utilization area of the clinic should be no less than forty square metres, and there at least should contain a consulting room and a therapeutic room; clinics of traditional Chinese and western medicine should have a Chinese pharmacy; and moreover, practitioners should hold the Certificate of Medical Practitioner, and have the experience of working in a specialized clinical medicine for no fewer than five years.²¹

The visited illegal private clinics in Dengcun Village are all located in the lane-side (see Photo 6F), and in general, such clinic has only one small private renting room,

²¹ 'Regulations Governing the Administration of Medical Institutions' is available from the website of The Central People's Government of the People's Republic of China. Available at: http://www.gov.cn/banshi/2005-08/01/content_19113.htm. Accessed on 15/04/2009.

which is around fifteen to twenty square metres. The equipment in these clinics is poor and they offer only a small range of medicines.

The emergence of these clinics has several explanations. For instance, Mrs Wang was from Leqing County of Zhejiang province, and she claimed in the interview that her dental skills were inherited from her earlier generations and ancestors. Mrs. Wang opened an illegal private clinic in Dengcun Village because there were many migrants from Zhejiang living in this area, which was good for her business. Based on the information provided by Mr. Jiao, the director of a public hospital in Dengcun Village, in Dengcun area, there are many migrants from southern Zhengjiang, and this attracted some private doctors in Zhengjiang to migrate to Beijing as well and re-settle their business in Dengcun. From the information provided by Mr. Hu, a Section Chief of Fengtai Health Inspection of Beijing Fengtai Health Bureau, the authority attitudes to illegal private clinics are cracking down on them. But in fact, the crackdown on illegal medical practice is not enough and not efficient, because there are some departments are responsible jointly for the enforcement of the law, such as Health Inspection, Public Security Organ, and industrial and commercial administrative department. The punishment on illegal private clinics is currently by means of fines and confiscation. However, after fines and confiscation, the illegal private clinics will be reopened soon by practitioners.

In this study, the staffs in the clinics are generally one or two (husband-and-wife shop) migrants. There is no nurse in the clinic, and the owner works as both doctor and nurse. Some owners (n=2) claimed that they were professional in special fields and

could treat many diseases, such as gynae, paediatrics, Chinese medicine, sexually transmitted disease (see photo 4.E and 4.F).

The prices of medicines are cheaper than in public hospitals and pharmacies, but the medicines displayed on the counter were usually not openly marked with clear prices. As to the source of medicine stocks, the interviewees in this study stated that they have their own channels, but when they were asked about the details, they refused to answer.

4.6.2 The Role of Private Clinics

In the survey, a majority of migrants acknowledged that although the private clinics in Dengcun Village were all illegal, they provided a useful alternative to the public health services in Beijing, with much cheaper prices. Some participants (n=10) responded that they could not afford the treatment in public hospitals and would rather turn to private clinics. A recurring statement from the participants was that public hospitals in Beijing charged too much, and the medical consultation very often turned out to be a huge bill for a long list of items.

Although the participants thought that big public hospitals were too expensive, five participants said they would have no choice but going there should they suffer from very serious illness. They understood the equipment in big public hospitals was more advanced and the treatment there was of much better quality. Eight would go to the public hospitals for diagnosis and return to the cheaper private clinic for continuing treatment, such as Mrs. Zhou's case shown below:

I have the illness of lumbar intervertebral disc protrusion. At the beginning, I went to Chaoyang Hospital (a public hospital) in Beijing and have spent two hundreds RMB Yuan for type-B ultrasonic, and then the doctor asked me to take the examination of nuclear magnetic resonance, which would cost me above two thousands RMB Yuan. That was very expensive and I was not willing to spend too much money. So I turned to a private clinic because it was much cheaper. I bought some analgesic drugs and took naprapathy there (Mrs. Zhou, a vegetable peddler, a third stratum migrant).

According to the data gathered from the participants, we should understand the realistic role of the illegal private clinics from two sides: on the one hand, it works as an alternative option to public hospitals and a substantial complement to the imperfect medical system in China. Because migrants are not actually covered or, covered equally to the urban residents by the social allowance system, it is too heavy a burden for them to afford the treatment in public hospitals. On the other hand, the unqualified condition²² of the illegal private clinics leads to poor quality of services, which is another constraint to the health of migrants, or even potentially dangerous to their lives..

4.6.3 Why do Migrants Choose Them?

The outcome of this study shows that illegal clinic is an important and frequent medical choice for migrants.

²² According to the fieldwork, no private clinic meets the criteria for opening a private clinic in accordance with the 'Regulations Governing the Administration of Medical Institutions' in China.

In the sample, nearly one half of the migrants, who are mostly from the third stratum and a few from the second stratum, thought that the private clinics, rather than public hospitals, are the best option. The reasons for their choice of health services in the illegal private clinics are:

Firstly, migrants are attracted by the cheap price charged by the illegal private clinics. The high cost of public hospital services makes them prohibitive.

Secondly, private clinics provide prompt service with a positive attitude towards clients, whereas in public hospitals, many migrants have the feeling of discrimination from doctors.

I can obviously feel the attitude of discrimination from doctors in public hospitals. For example, when I made an inquiry from a doctor in Dahongmen Hospital (a level one public hospital) for my son's fever last year, I felt the impatient attitude from the doctor when she knew from my accent that I was not a Beijing Native, although I just saw she had a nice manner to another patient with a Beijing accent. I do not like the feeling there so I will choose the private clinic for the treatment if my son gets ill again, because the attitude in the private clinic is much better (Mrs. Zhou).

Thirdly, private clinics offer longer and flexible business hours, and they are located in the areas where migrants live:

You can go to the private clinic at any time...what we need is just to give them a phone call at night... it saves time (Mr. Zhang).

Fourthly, uncomplicated procedures are available in private clinics, as stated by a migrant,

It is very convenient and you do not have to wait a long time for registration before treatment, unlike in public hospitals. The private clinics are convenient. Intravenous infusion can be done immediately if necessary, and the medication can be prescribed instantly (Mr. Wu).

And finally, the flexible approach in paying for the treatment also attracts the migrants to seek medical services in private clinics.

We can postpone paying for the treatment and do not have to pay on account in the private clinic here, but it is impossible (to do that) in public hospitals (Mrs. He).

In some private clinics, paying all at once is not necessary, and the cost can be paid by instalments, paid partially for the first time, or paid at other times flexibly. However, in public hospitals, prepayment is compulsory; otherwise the treatment will not be offered. The following example from Mr. Li below is illustrative of this point.

Five years ago, when I was working in a restaurant's kitchen, my hand was wounded and blooded. I went to Chongwen Hospital (a public hospital) for the

treatment first, but (the staff in) the emergency room there asked me to make prepayment before treatment. I did not have any cash with me at that time so they refused to treat me. I then ran up to a nearby private clinic and the wound was bound up by bandage soon, I told the doctor that I worked in a close-by restaurant and he agreed for me to pay on the next day. Although I knew later that clinic did not have a license, I felt it was really helpful sometimes (Mr. Li).

The demands for service lead directly to the existence of illegal private clinics, which take rural-urban migrants as their main clients. At the same time, the tendentious choice among migrants between illegal private clinics and public hospitals also reflects the problems of the current social medical system, which forms a substantial constraint to migrants and should be improved comprehensively.



Photo 4.E: One private dental clinic in Dengcun Village Photo 4.F: One private clinic in Dengcun Village

4.6.4 Problems with the Illegal Private Clinics

One problem shown from the interviews was the lack of qualified doctors, which caused the low quality of medical care. In accordance with the 'Regulations Governing the Administration of Medical Institutions', the practitioners of private clinics should hold the Certificate of Medical Practitioner, and have the experience of working in a specialized clinical medicine for no fewer than five years. From the findings of fieldwork, the visited private clinics in Dengcun Village do not have any license and the practitioners do not hold the Certificate either. Moreover, as mentioned in Section 4.6.1, the equipment in these clinics is poor with poor hygiene and a small range of medicines.

Another problem is with the medicine sold by the private clinics. Five participants mentioned fake medicine they bought from private clinics. The sources of medicine stocked in these clinics raise suspicions. Through an interview with Mr. Jiao, the director of a public hospital in Dengcun Village, one finding is that although the medicine is cheaper in these illegal clinics, the drugs are probably obtained through illegal channels and may potentially do harm to people's health.

The illegal medicines might be in bad quality and damage people's health, even causing poisoning and could be lethal. Moreover, the doctors in those clinics do not have any approved medical practice and business licenses. (Mr. Jiao)

The interviewees of private clinics in this study just stated that their medicines are cheaper and they have their own channels of stocking medicine, but when they were asked about the details, they refused to answer. Although no serious hurt or death caused by the treatment in private clinics was found in this study, some scholars, such as Zhang (2007) stated that the diseases of some migrant patients were exacerbated after using medicine from private clinics.

Last but not least, poor equipment in these private clinics is suggested as a problem. For example,

The private clinics can not treat serious problems because they do not have enough equipment, and also, the size of many private clinics is small so they can not provide a thorough examination...last year, I had a quarrel with my husband and was hurt by his violence, my fingers and ribs were aching for a long time (showing a sad expression), I went to a private clinic here, they only sold me some painkiller and antibiotic medicine without any treatment. (Mrs. Lin, a cleaner, a third stratum migrant).

In summary, for rural-urban migrants, illegal private clinics works as an alternative option to public hospitals and a complement to the defective medical system in China, given that there are limitations of public medical provisions and health needs of migrants. However, there are also some problems with the illegal private clinics lead to poor quality of services, which are another constraint to the health of migrants.

One methodological limitation regarding illegal private clinics is that because of the sensitivity of their illegal practices, the access to them for interviews was difficult although I got some participants of them, and moreover, they tended to be suspicious of interviewer, and refused to answer few questions.

4.7 Conclusion

One important point that emerges from the study is that based on the types of occupations, migrants can be divided into three social strata, namely, the owner, who holds the relative productive capital and employs other people; the self-employed workers, who hold little capital and run their own private businesses; and those who are totally dependent on others for work and self-employed manual workers. These three categories have different financial resources and their medical treatment access appears in a hierarchical structure. The latter two groups actually comprise the majority of migrants and have more constraints in medical services access. This chapter has also discussed the health major constraints for migrants, and the institutional constraints on all migrants.

Another finding shows that rural-urban migrants are particularly vulnerable to health risks due to their poor working and living conditions. Although the illegal private clinic is an important choice for health services among migrants, it also indicates the constraints for health services access among migrants, mainly including those who are in the second and third strata. The main difficulties in access to health services are not merely because of their low income, shortage of health awareness, and the lack of

social contacts with the urban society (Yang, 2002), but we argued that the institutional deficiency in term of health security and service provision is another major reason to explain their constraints in health service access.

The medical care system in China is based on the rural-urban dualist structure. The medical services provided in rural areas are very different from those in urban China. The rural-urban division has moulded the two different sets of health-care institutions and administration of health services in China.

In urban areas, rural-urban migrants are not entitled to the state benefits that urban residents enjoy and there has been no obligation on the part of collective or private enterprises to provide the migrants with allowances for medical services during the last two decades. Documents issued by the Ministry of Labour and Social Security and the State Council refer to the new medical service system as a scheme for 'urban employees' (*chengzhen zhigong*) (Yu and Hu, 1998; Zheng, 2003). Though the term 'urban employees' is not clearly defined, it is universally interpreted as those working in urban enterprises and with urban *Hukou* status. The rural-urban migrants are thus excluded.

Although migrants need to be included in the urban medical services system, it may not be realistic to achieve this in the near future. Firstly, the main aim of the central government in the medical service reform scheme is to relieve state-owned enterprises from the burden of shouldering almost unlimited medical service costs for their employees, which is considered a key element for state-owned enterprises to become profitable (Peng, 2007). Secondly, the vested interest associated with the existing

social security system has become another constraint to migrants getting involved in the urban medical service scheme. Thirdly, there are concerns that migrants would bring extra difficulties to the management of the health-care system (Xiang, 2005). And finally, some other factors, such as the *Hukou* system and the rural-urban economic disequilibrium, will remain for a long time and continue to affect migrants' access to the urban medical service.

Chapter Five

Social Networks: What Help and Limit?

5.1 Introduction

In Chapter Four, a detailed profile of health services choices and health access constraints of rural-urban migrants has been discussed; and the health and health services access constraints in terms of social strata among migrants have been compared and analyzed. From the analysis of Chapter Four, it shows that there are institutional constraints for all migrants, and financial difficulties for health services access among migrants who are in the second and third strata. In a situation of shortage of formal support from urban health system, whether there are some informal channels for migrant to get assistance for their health and health services access? In this chapter, I explore whether migrants' social networks play a role in health and health services access of migrants.

5.1.1 Context and Issues

This study sets out to understand the social networks by looking at the definition of strong and weak ties in social relationships. Several definitions of social ties have been suggested over the years, but the essential description, in my opinion, is mainly

centered on Granovetter's (1973, 1974) definition. He suggested that a tie between two agents can be strong or weak, differing in the amount of time spent in interaction, the emotional intensity, the intimacy, and the reciprocal services. And this is precisely the approach with which Bian (1997) measures tie strength in the Chinese context. Moreover, according to Yang's (1994) three enlisted essential characteristics of interpersonal relationship (*Guanxi*) observed in China during the periods of 1980s and 1990s, the strength of interpersonal relationship (*Guanxi*)²³ means much more in Chinese society. According to Yang (1994), in terms of it being strong or weak, an interpersonal relationship can be said to differ in: 1), the frequency of contact; 2), the intensity of trustworthiness; 3), reciprocal obligation. Putting two categories of Granovetter and Yang's together, we may realize that closeness is vital in determining the strength of social ties. With terms similar to strong/weak ties, *Guanxi* is said to be made up of insider/outsider relationships: insider relationship that is characterized by niceness, trustworthiness, caring, helpfulness and empathy are defined family, colleagues and classmates, whereas outsider relationships are less worthy of trust and unstable (Gu, 1990; Chu and Ju, 1993; Gao and Ting-Toomey, 1998; Hammond and Glenn, 2004).

What is more focused in this study is the strength of interpersonal relationship, which reflects the idea of both strong/weak and insider/outsider divisions, and is characterized by kinship. Therefore, the discussion about social relationship that I am exploring below will revolve around the issue of kinship, while its particular emphasis

²³ The general understanding of *Guanxi* is 'relationship'. But the broader definition can be varied to different situations as following: 1) connections; relations; relationship; 2) relevance; bearing; influence; significance; 3) indicate cause or reason; 4) credentials showing membership in or connection with an organisation; 5) concern; affect; having a bearing on; have to do with.

is concentrated on the distinction between the kinship tie and social tie outside the kinship.

Rural-urban migration may lead to the formation of new social networks and lifestyles. For migrants, as a floating group, social networks are crucial for finding jobs and accommodation, and for providing psychological support and continuous social and economic information (Vertovec, 2002). Social networks often guide migrants into or through specific places and occupations, and provide support when they face uncertain risks. To explore a comprehensive view of the health issues and health care access of rural-urban migrants, the roles of their social network can not be neglected.

5.1.2 Hypotheses and Organisation of the Chapter

After migration, the social contacts of migrants have mostly changed from more kinship-based to work-related relations. However, when needing money to care for health and support their health services access, kinship is still the core for assistance. In terms of social support including covering the need for health services, enduring the illness as long as some migrants could, and then using own saving is still the most important source for these migrants, especially for migrants in the second and third strata. However, financial difficulties are very common among migrants, and I hypothesise that when there are financial constraints and lack of savings in migrants' access to health services access, their social networks may help them to a certain extent. on the other hand, as discussed in Chapter Four, their social networks is limited, and the assistance from their social networks on health and health services access might be also limited.

In this chapter, it will first examine the range of social networks among migrants from the perspective of social support, whilst, the discussion of social ties will be based on the potential and content of support. Before unfolding my discussion, however, it is essential to know that kinship is the centre of both social networks and social ties among migrants, that is, kin network plays the most important role in supporting migrants in the Chinese context. Thus, it is the key concept in the chapter, and the social ties will be further discussed at different levels according to their strength later on.

This chapter reports the results of exploratory research into the social networks and their impact on the health and health care access of rural-urban migrants in a migrant community. It aims to analyse the nature and composition of social networks among rural-urban migrants, to discuss the barriers/facilitators to the establishment of social networks in migration and subsequent impact on health and health care access, to assess the types of support and constraint resulting from the social networks on health care access, and to develop ideas for further research into urban social policy and health promotion to rural-urban migrants in China.

5.2 Social Networks among Migrants

The most common social networks among the rural-urban migrants interviewed comprised a range of social relationships. The availability of such relationships was found to be important, for it enabled the migrants to cope with uncertain risks

including health problems. Nearly all the interviewed migrants stated that having a good social relationship with family members, relatives, *laoxiang* (fellow-villagers), migrant friends, and colleagues is of great help when faced with a crisis.

However, the social networks of the migrants in this study were found to be relatively limited. Network size and composition were basically assessed by asking the participants to name people in their networks to whom they felt close, or with whom they had regular contact. Although all the participants in the sample named at least one network member with whom they had close contact, the network members most frequently mentioned in this regard were circled around kinship, mainly brothers and sisters and spouse's brothers and sisters. Provided that a good relationship had been maintained since migration, nine among thirty-six participants said that they felt close to their migrant friends and *laoxiang*.

In particular, a kinship-dominated network (family members and relatives) comprised the largest proportion of the migrants' primary networks. The significant role of this kinship-dominated network can be said to be 'a rich web of inter-familiar help' at a time of financial difficulty, which is identified by Chinese people (Wilding, 1997: 257). Although contact numbers vary over time, twenty participants made constant face-to-face or telephone contact with both their family members and relatives during the last three years. There was stability in the networks of these migrants and there was a primary core of significant network members who had remained in the network. This primary core was assessed by asking the participants to name three individuals with whom they would have contact if they were to fall upon hard times (such as, whom they would like to seek help from when they lacked money but needed funds

for medical treatment). Three types of persons on the list that the participants named in the entire network were composed of their brothers and sisters, their spouse's brothers and sisters, and their nephews and nieces. This finding provides evidence of the important role of kinship in their lives, on which the interaction of the participants is almost entirely based.

5.2.1 Social Ties

The social networks of the migrants in the sample are basically composed of two groups: one is the kinship-based group (family members and relatives), whereas the other is a group of people outside kinship (friends, *laoxiang*, colleagues, employers). The findings of this study conclude that within the social ties among migrants, there are three ties among rural-urban migrants, which include: 1) the first tie: family members and relatives; 2) the second tie: migrant friends and *laoxiang* and 3) the third tie: employers, colleagues, and neighbours.

In particular, kinship-based ties (the first ties) were found to be the central and strongest ties in the sample, upon which people principally depended in times of financial difficulties. All the participants except for one person (Mr. Wang) in this sample undoubtedly found it very important to keep good interpersonal relationships with family and relatives, and they further revealed that personal connections were their main approach for financial support. Twenty participants said that they would always attempt to find someone with a kinship relationship for help, rather than institutional assistance.

Twenty participants in the study admitted that they actually sought, or were given help from, someone in their kinship-based group, despite the importance of having a wide range of personal relationships. In other words, the connections with friends, fellow villagers, employers and colleagues are not enough. In fact, the migrants who needed medical services, but lacked money, said that the kinship-based group was the one from which they mostly borrowed money. Particularly, they put more emphasis on deep and close relationships with the kinship-based group than a wider circle including friends and acquaintances. When they sought assistance from the first tie group, but the family members and relatives were not available, they turned to the second tie group, and contact with people in the third tie group was weakest.

Different Social Networks in Terms of Social Strata of Migrants?

In urban areas, most migrants live among their own social circle with limited horizons (Wang, 2006). In this study, in terms of social life, many of them, mainly migrants in the second and third strata, have no contact with local city residents and city society: they are separated from city society and only live in their own community in a 'rural' manner similar to that found in their home villages. Their circle of contacts is limited to their own community and they rely on communication among themselves so as to dispel the feelings of alienation from urban society. Compared to the migrants in the second and third strata, migrants in the first stratum have wider range of social networks. Their wider range of social networks is mainly embodied from two contacts: the first is their business relations, and the second is more contacts with urban residents because of their better living conditions. The following examples can indicate the difference:

I have many friends of urban residents, and I have very good relations with them, like the buddies relations. From my shoe business, I made friends who are urban people, moreover, I am living in a nice residential district, and many neighbours are Beijing natives. (Mr. Xia, a boss of shoe business, a first stratum migrant)

I just do my small business (selling steamed stuffed buns within Dengcun Village), my customers are mostly migrants here, I do not have many contacts with urban resident, I feel they do not want to get to know with us...I have never been to the homes of Beijing natives (Mr. Shi, a owner of snack stall for steamed stuffed buns, a second stratum migrant)

I have been in Beijing for around ten years...I have no friends of Beijing origin, and have never been to the homes of Beijing natives (Mr. Liu, a pedicab driver, a third stratum migrant)

To migrants, the distinct changes in their social networks after migration have three characteristics: firstly, neighbourhoods in urban areas among migrants take a much less important role; secondly, work-related relationships play an important role although this is mainly among migrants themselves; and thirdly, *laoxiang* (fellow villagers), which was mentioned frequently in the survey, becomes popular in the social networks of migrants.

As the migrants in the first stratum have good economic status, so the discussion in this chapter is mainly focusing on the migrants in second and third strata.

5.3 Why do Migrants Rely on Their Social Networks for Support?

In this study, there are three major reasons contributing to the social networks among rural-urban migrants in Beijing, namely, the household registration system (*Hukou* system), discrimination by urban residents, and the discriminatory policy and its implementation.

5.3.1 The *Hukou* System (the Household Registration System)

In the opinion of some scholars, a meaningful analysis of social networks among rural-urban migrants in China cannot be made without making reference to the *Hukou* system, which affects the migration experiences of rural-urban migrants (Chan, Liu & Yang, 1999). The modern *Hukou* system was established in the 1950s. It registers every person at a specific place (usually their place of birth), and requires all changes in residence to be registered with and approved by both the government of the place of origin and that of the destination. This policy became even more restrictive when the Chinese government introduced the food stamp system, and provided low-priced rationing of foods to each individual residing in his or her place of residence. There were two main consequences resulting from implementing these policies. First, it became an obstacle for an individual to move from one residence place to another.

Second, the division between rural farmers and urban dwellers became wider, with rural farmers lagging behind in economic and social resources (Zhao, 2000).

As a matter of fact, the entitlement to public and social services depends entirely on which type of *Hukou* the individual belongs to. As an urban resident, a person is entitled to employment, health services, housing, pension, and food subsidies. None of these privileges, however, are available to people with a rural registration (Cai, 2003). With the introduction of socialist market economy and with the establishment of the responsibility system in rural China, it has become very difficult to restrict people in rural areas from migrating to the cities. Unfortunately, the *Hukou* system has done little to accommodate to the changing situation. As the previous analysis indicates, the *Hukou* system has been largely responsible for creating a marginalised group of rural-urban migrants who are not allowed to enjoy the same employment, housing, health and welfare benefits as the urban residents in China.

5.3.2 Discrimination by Urban Residents

Although rural-urban migrants play an indispensable role in economic growth in China, they are often discriminated against by the general public. For instance, they are frequently portrayed negatively in the media. They are perceived as a threat to social stability and are often linked to the increase in crime rates in the cities. They are also perceived as competing with unemployed urban residents who have been laid off from state-owned enterprises. Furthermore, the general public holds the view that migrants are stupid and ignorant, and should be blamed for their misfortunes (Davin, 2000). Urban residents can easily identify rural-urban migrants, especially the new

comers, through their behaviour, accents and clothes. The majority of migrant workers are employed in manual jobs.²⁴ They often wear old and dirty clothes. They have to live in low-cost accommodation that naturally segregates them from urban residents. Urban residents often consider themselves superior to rural migrants. It is not uncommon that some urban residents bully or mock migrants in public (Li, 2003). Thus, it is not uncommon for migrants to experience unpleasant social encounters such as verbal disrespect, deliberate avoidance or being looked down upon by the urban residents and urban staff (Guo, 2004).

Findings among the participants revealed that thirty interviewees felt discrimination from urban residents.

Of course, discrimination from urban people exists obviously. I always experience unfair treatment. I got this job as a maintenance worker in a stated-owned company via the introduction of my relative. But in this company, our casual workers without Beijing Hukou are working very hard but the permanent staff (Beijing natives) are very lazy. The company would go bankrupt without the work of our migrant workers. However, Beijing Natives get double payment for their salaries, but some of them look down on us, call us outsiders or casual workers...actually, we are the technical backbone and work well. They get much higher wages just because they are Beijing Natives.

(Mr. Shi)

²⁴ According to Li (2003), 41.4 per cent of rural-urban migrants in China work in construction industry. There are also migrants in industrial enterprises, government agencies, schools and hospitals as labours (31.6 per cent). Another 19.2 per cent work in catering services such as hotels, restaurants, tailor's shops, electronic and machinery repair stores.

The discrimination displayed by local residents has hurt migrants' identity and self-respect (Guo, 2004), and has widened the social gap between migrants and local residents.

In the case of health and medical treatment, migrants also encounter discrimination from local urban organizations and residents. In public hospitals, many migrants experienced the feeling of discrimination from doctors.

Doctors of public hospitals can easily identify us ...they call us the nonnative or outsider, especially through our accents and clothes. Some doctors treated us impatiently and did shoddy treatment deliberately with shortened time.
(Mrs. Fan)

Discrimination from urban residents and organizations not only leads to the narrow social networks of rural-urban migrants, but also causes directly the real constraints in their health and choice of health services access and medical treatment.

5.3.3 Discriminatory Policy Implementation

Another reason is the discriminatory or even brutal treatment by some civil servants or local police towards rural-urban migrants during everyday policy implementation.

In Beijing, also in other cities in China, urban residents do not carry ID or work permits. However, for a long time, migrants or 'outsiders' were required to present on the spot all documents upon requirement. Failing to do so, a migrant may end up getting arrested and being sent back to his or her home village, or, even doing forced labour work. As shown in the earlier sections, this regulation was abandoned

officially in 2004. Before the regulation was withdrawn, it allowed urban police to inspect passers-by in the street or carry out home inspections without prior notice (Wang, 2006). Some unqualified government officials or policemen abused their power and took advantage of helpless migrants (Li, 2003). However, if the abused migrants sought legal protection, they often faced harassment (Sun, 2002; Zou, 1996). In this respect, two migrants' experience (Mr. Shi and Mr. Huang) draw our attention:

The aim of registration with temporary ID status required by local police station in Beijing was just to get extra money and mock us non-natives. A few years ago, I lived a large shared dorm with fifteen other migrants. At intervals, the local police station raided at midnight and asked all of us to get up immediately, no matter whether you had temporary ID or not, we were all sent to the local police station-I remember it was a police station at Xuanwu District of Beijing. We were all detained unless we paid some money. We had no choice and phoned our employer, the employer came and invited the policemen to dinner and then we got released. However, we all paid the fine to the local police station finally. (Mr. Shi)

I feel that local government, including some organizations, discriminates against our migrants...for example, in the period of SARS outbreak in Beijing, the government arrested many migrants, forced migrants to go back to their home villages. Many migrants or nonnatives, who were peasants and worked hard to make a living in Beijing, were arrested. I personally experienced this and was arrested twice, we were sent to a place in Changping District which was like a prison or an asylum. Dozens of migrants overflowed in one room and could not sleep. Duvets and toilets were not available. We were also

compelled to pay some money. If you wanted to get some food, you had to buy that, but the price was quite expensive. For example, the instant noodle was much more expensive than outside, a bottle of water, usual price was one RMB Yuan, but you had to pay three RMB Yuan there...it was really a horrible experience and nightmare for me. (Mr. Huang)

The withdrawal of the regulation on arrest and eviction of nonnatives has received wide support. However, it cannot prevent migrants from other forms of discriminatory treatment. Moreover, this discriminatory policy implementation over a long time contributes greatly to the status of marginalisation among rural-urban migrants in urban areas.

5.4 Limits of Social Networks for Health and Health Services Access

As discussed above, the social networks of migrants are limited, and may bring some adverse effects on their health and health care, these include the psychological health, limited information, and Delays in Getting Help When Suffering Medical Emergencies.

5.4.1 Psychological Health

As suggested by Christakis and Fowler (2007), social relations, comprising friendship relations, are often established between people who share multiple characteristics, including their personal attributes and the environments in which they live and work.

Many of these characteristics have been shown to be related to health outcomes and psychological states. From the previous discussion, we notice that many migrants live in a socially disadvantaged position with very limited social networks, and their social circle is relatively closed. In this situation, they could easily suffer from poor psychological health. Indeed, according to the data of this study, the findings suggest that migrants have experienced, or are experiencing, some symptoms related to psychological health. The most prominent clusters of symptoms found among the interviewed migrants were long-term anxiety, unhappiness, sleep disturbance, depression, and nervousness.

When I came here, I was very lonely, I missed home very much and I could not talk to any one. It is impossible to discuss with Beijing residents my unhappiness. I called home and cried on my own. (Mrs. Sun)

I was repressed by the anxieties after long working hours as a construction worker, I always got sleep disturbance and I found that my hair loss was serious. (Mr. Su)

This study suggests that the migrant participants suffered from poor psychological health and such health conditions were linked to their much closed social circle and their closed contact with the outside.

5.4.2 Limited Information

Social interactions among network members have an impact on individuals' attitudes and behaviours (Carrington, 1988; Bongaarts and Watkins, 1996; Friedkin, 1997; Kohler et al., 2001). Personal networks have the capacity to provide individuals with

examples of behaviours that may be considered and copied. They also help migrants to meet their emotional needs and to accept instrumental assistance, information and advice (Katz and Lazarsfeld, 1955; Shye et al., 1995).

Information is valuable in the prevention and detection of diseases, management of illnesses, decision-making, improving knowledge and promoting health, administration, behavioural change, overcoming misconceptions, and community support. The use of social networks can be an effective source of information (Musoke, 2005). The information supplied by social networks usually comprises availability of services, their locations and institutional details. For instance, from the interview, the normal information of health service is illegal private clinics, which are very much welcomed by migrants for their medical treatment. As discussed in Chapter Four, these clinics do not offer high quality health services for migrants although they are regarded as an option with cheap price.

I knew and chose this private clinic because of my laoxiang, he said that the treatment costs in this clinic were very cheap. (Mrs. Yang)

Many of the clients in my dental clinic are laoxiang from Zhejiang Province. Some of the clients come here for treatment because they were introduced by their laoxiang, because they think that my skills are very good, so they recommend my clinic to their laoxiang. (Mrs. Wang, a dentist in an illegal private clinic)

5.4.3 Delays in Getting Help When Suffering Medical Emergencies

As stated by some scholars (Berkman and Breslaw, 1983; Cohen and Syme, 1985), the availability of support can be said to constitute various kinds of supportive resources that flow through the social network, and the social network provides assistance and material resources that are needed to cope with difficulties or stress.

Although the extent to which the migrants gain help through their social networks is important, once they experience illness, the practical assistance provided for their medical treatment, is normally narrow, coming from the restricted range of their first and second social ties.

When I had just settled down and started to work in Beijing, I did not have any relatives and friends in Beijing and did not get in touch with any laoxiang at that time. I remember that some years ago, I suffered from a serious fever and diarrhoea, I stayed in bed for three days, and nobody took care of me. (Mr. Wu)

Given the fact that migrants and their urban neighbours belong to different social segments, the latter in theory should not be treated as a part of the social networks for the former, so when they have medical emergence, although they can get some assistance from their limited social networks, sometimes was delayed.

I recollect that in 2002, my wife and my son almost lost their lives. When we lived in a small bungalow with poor ventilation, we used honeycomb briquette at that time, and my wife and my son got carbon monoxide poisoning. Thanks to the Mid-autumn Festival on that day, my work unit gave us some festival stuff and I brought it home. On arriving home I found my wife and son lying on the ground and they seemed to be at death's door. I was really frightened by this. I knocked at the door of my neighbour for help, but they did not

answer, although I saw that their light was on. They (being native) usually regarded us as outsiders and did not speak with us...Fortunately my nephew lived nearby. I found him and we got a platform lorry, we sent my family to the hospital...It was a bit cold during the Mid-autumn Festival, my wife and son came to their senses because of the coldness. We hurriedly sent them to the Xuanwu Hospital, and finally they got well. Oh, it was very dangerous and an experience that I will remember all my life. (Mr. Shi)

5.5 A Channel to Mediate against Medical Emergencies

As discussed above, the social networks of migrants may lead to some constraints on their health and health service access. But on the other hand, it can also be a channel for migrants to get assistance for their health care, especially when they lack savings or face financial difficulties.

5.5.1 Financial Difficulties and Health Services Seeking Behaviour

Many health care problems of migrants, to some extent, are due to their lack of the ability to enjoy or make good use of the existing health services. For example, according to a survey of migrant women in Jiading District of Shanghai, although nearly 80% of the migrant women hoped to have reproductive health checks regularly, only 17.3% did so and 55.5% did not know where they could obtain help regarding family planning (Zhang, 1999: 56).

The practical reason for the lack of health services seeking behaviour is migrants' financial difficulty. Very few migrants have access to financial assistance for medical treatment. Some cases can be found from previous research. In a survey conducted in Chengdu City (Sichuan Province) and Shenyang City (Liaoning Province), not one single migrant had medical insurance (Guan and Jiang, 2002: 258). Guan and Jiang (2002) reported that migrants could only afford about 100 RMB Yuan for medical treatment a month. According to the surveys carried out in 2000 and 2002, 46% of respondents had been ill during their stay in Beijing, 17% more than three times. Despite this, a full 93% had not received any payment for their medical expenses from their employers (Huang and Pieke, 2003). The economic polarization within the society and lack of social security system makes the poor more vulnerable in terms of affordability and choice of health provider (Shaikh and Hatcher, 2004; Nyamongo, 2002; Asenso-Okyere, 1998). Financial difficulties not only exclude people from the benefits of the health services system but also restrict them from participating in activities that affect their health, resulting in greater health inequalities (Shaikh and Hatcher, 2004).

Due to the financial constraints, access to modern health services is a problem for many migrants. One consultation for a minor problem such as the cold in a large hospital in Beijing may cost 500 RMB Yuan, almost one month's salary for some migrants. One migrant drew on his experience of spending 3,000 RMB Yuan for treating his grandson's fever and said that he would rather die than go to large hospitals (Guan and Jiang, 2002). Giving a birth in a large hospital in Beijing costs several thousands of RMB Yuan, far beyond many migrants' earning capacities. According to a survey of migrant families in Haidian District, Beijing in 2000, 20%

laboured at home rather than in hospitals, and surprisingly, among them, 22% delivered babies in their dwelling places in Beijing (the rest delivered in their hometown) (Ketizu, 2000). Financial difficulty also forces some migrant workers to stop their treatment even after they are sent to hospitals in emergency. For a case in point, in 2002, 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. But more than 10 checked out soon afterwards due to their 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 their treatment. Some hospitals now simply refuse to receive migrant patients (Cheng and Wen, 2002).

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

What compounds the situation is the rapid commercialization of medical services in China. Over the last decades, costs in medical treatment in China have risen dramatically but the quality and efficiency of services are not improved, or even getting worse (Hu, 2001). Large hospitals often have their own pharmacies or are tied with pharmaceutical companies, and a sale of medicines to patients is an important source of profits for hospitals. In many cases doctors are given kickbacks by pharmaceutical companies for prescribing more medicines to patients. As a result, over-prescription becomes endemic. Hospitals and doctors also often conduct unnecessary but expensive tests for patients. Deducing from the data of this study and other research mentioned above, one of the most urgent tasks in urban state health system right now is to reform health services 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.

The migrants in this sample were asked to signify any support available from their networks when they faced health problems, then to indicate the extent to which the members could be relied upon. The evidence suggests that the kinship-based group is the most important, and then the migrant friends and fellow villagers, from which one can derive money, i.e. financial support, and emotional support. In view of the financial obstacle and shortage of savings among migrants, especially those who belong to the second and third strata, I will start my discussion from the issue of savings and then move to support availability.

Savings- source of health services?

In the sample, twenty participants had savings, which they used for whatever actions needed to be taken; whereas the other eleven participants did not have savings. In fact, the latter group did not produce savings directly from working income. Most of the migrant participants from the second and third strata have very limited savings or no savings at all. According to the findings from this study, the primary use of the savings takes two forms: the first form (fourteen participants) is to cope with a variety of future emergencies. Examples are: purchase of personal or household items, sending money home in the countryside. However, there were not enough savings left to meet a medical emergency. If any family members were sent to hospital, the whole family would encounter severe financial difficulties with medical treatment. The situation was more serious if there was an urgent need for an operation. The second form is that six participants spend the money directly in the payment of their children's tuition fees. In the interviews, a common explanation for the use of the savings was to pay for the tuition fees of their children. However, the school often requires much larger sums of cash than they can handle, especially for migrants with their children in higher education.

My son is studying at a university in Sichuan and will graduate after two years. The tuition fees are too expensive. I try to save some money every year from this small business for the payment of my son's tuition fees. (Mr. Zhu, a owner of a small knitting shop, a second stratum migrant)

In both cases, the ownership of available savings can help to reduce financial risk but the assistance is limited.

As seen above, there was a limit to the amount of income that the migrants can generate for health problems. The limit derived from the form of small business, and manual work which usually pursued by normal migrants. Just because they were not able to increase disposable income through their jobs, they attempted to increase savings by reducing expenditure on various items. However, these activities in fact could not help to eliminate the practical challenges of medical costs. As the medical costs usually require a large amount of money, the small savings that a majority of migrants made through expenditure-centred strategies could not meet the cost of medical treatment.

The data from fieldwork in this study demonstrates that among the participants, for a number of them (n=18), they avoided medical treatment due to their financial difficulties. Overall, the migrants used quite a small subset of activities in attempting to replace the costs of hospital treatment, which can be largely classified into three groups: going without necessary medicines (n=10), taking medicine sent by relatives or migrant friends (n=6) and refusing to seek care (n=2). The most common activity that the migrants took was the first item: going without necessary medicines. This was not a preferred option but one that they took in practice due to the heavy financial burden of medical treatment. All these activities were basically related to the seriousness of financial difficulty and lack of savings; it is too expensive for them either to go to the pharmacist or to see a doctor in public hospital, which in turn leads to them declining hospital treatment.

From the survey at Dengcun Village, there were different understandings of health and illness (this will be discussed in detail in Chapter Six). One sixth of participant did not regard cold or headache as illness, because they thought these could be

endured. If they got serious work-related injuries, or very serious diseases, such as illness needing stay in bed, they finally sought medical treatment. Due to the financial difficulties, many of them usually took two choices: the first is going back to their home villages for treatment, and the second is borrowing money and getting treatment in the urban area. Mrs. Zhou is one case in the sample in that she got back to her home village for medical treatment.

Nowadays, the costs of medical treatment in Beijing are too expensive. I do not worry about cold and minor injuries such as scars. I can endure it. But the problem is that I cannot do anything with severe disease...last year my little son suffered pneumonitis, I brought him to our home village of Henan province for treatment as the cost there is much cheaper than in Beijing. (Mrs. Zhou, a vegetable peddler, a third stratum migrant)

5.5.2 Borrowing Money

In this section, the discussion will look at the ways in which the respondents borrow money. Money is really something that needs to be considered, for most rural-urban migrants it cannot be detached from everyday life. In particular, it is a critical need for those who do not have a stable regular income.

In this study, the options for money-borrowing which are taken into consideration by migrants are: the lowest possible interest rates, flexibility, loan terms, and money from family members, relatives or friends. People are much more comfortable asking for money from family members and relatives. For twenty participants, family

members and relatives were seen to be willing to lend money when asked. Of course, borrowing can be dangerous; relationships can be ruined if people are still in financial difficulties when it comes to the time to pay it back. If they borrow from relatives or friends but fail to pay them back, they could lose their relationship, friendship and further support. To avoid the emotional strain on the relationship, there should be a kind of trust between two agents in relation to the situation. That is why keeping a good relationship is the key to successful money-borrowing from close acquaintances.

Despite this potential danger, the participants revealed that they still preferred to borrow money from their family members, relatives, migrant friends and *laoxiang* when they needed money for medical treatment but lacked savings. The findings show that there is a sequence of people from whom they can borrow money. According to the data, family members or relatives are their first choice, 20 participants chose family members and relatives for financial help, while nine participants chose their migrant friends or *Laoxiang*.

Borrowing money? I will certainly ask for help from my closest relatives in Beijing. I have a nephew in Beijing. I will turn to him for help if I need money for seeing a doctor or medical treatment. I think only family members or relatives can be relied on during a crisis. (Mrs. Guo)

The case of Mr. Fan, below, indicates that *laoxiang* also plays an important role for migrants in getting assistance for their medical treatments.

I have been working as a pedicab driver in Dengcun Village and the Dahongmen area for around 10 years. I fell ill with rectocele and strained my lumbar muscles because of this manual work. This ill health has preyed on me

for years, and when I was in great pain, I only visited the private illegal clinic for pain-killers because of cheaper charges there...I do not have any friends who are urban residents in Beijing and my social circle is limited to relatives, migrant friends and Laoxiang (migrants who are from the same village, county or province). I think that discrimination against migrants is still common in Beijing, and believe that the social networks among migrants are very important for living, including health care access. For example, a few years ago I borrowed some money from my Laoxiang and bought a motor tricycle for this business, and when I need medical treatment but lack money, I usually seek financial support from my migrant friends. (Mr. Fan)

5.5.3 Emotional Support

Another aspect of support availability when coping with ill-health is emotional support from their social networks. The perception of emotional support among the interviewed migrants can be shown as reducing the feelings of isolation and insecurity and enhancing the feelings of integration and well being. The migrants in the sample perceived that both family members and relatives could be relied on to provide various forms of emotional support, such as encouragement and comfort from their brothers and sisters. It also appears that the feelings of security and belongingness provided by family members and relatives might have maintained the moderate state of mind of those participants who were exposed to the risk of social exclusion. This finding suggests that social networks, which have the effect of being encouraging, affirmative and constructive, must be very supportive to the participants in alleviating ill-health and keeping them from social exclusion. It is quite consistent with Wellman

and Wortley's (1989) statement that highly interconnected networks, especially kinship-dominated networks have a number of advantages because they may foster an intense social support system, thereby reducing the feelings of isolation and decreasing the risk of relapse.

Moreover, from the participants it can be seen that not only the kinship relationship can provide emotional support, but support can also be available from a group of people outside of a kinship relationship. In the case of Mr. Shi, emotional support from outside a kinship relationship is also an important help in his restoration to health.

I remember that I got a serious health problem, pleurisy, in 2004, I received an operation in the Tiantan Hospital in Beijing and spent almost ten thousand RMB Yuan at that time. I borrowed some money from my laoxiang to pay for this treatment. During that time, I had to stay in bed for two months. My wife gave me much emotional support and she covered everything including housework. Besides, I normally kept on good terms with my employer, and he gave me kind help during my illness. He visited me and promised that he would keep my job open until I got well. My employer's support made me feel good and also helped me to get better sooner. (Mr. Shi)

5.6 Conclusion

In conclusion, the study highlights the nature of social networks and the findings also highlight that social networks, although helpful, are limited given that they are based on small kinship and friendship networks. The findings indicate that the social

networks resemble a double-edged sword to rural-urban migrants in terms of health care access. The fact that the migrants lack savings may not be the sole and essential reason to make them extremely vulnerable in times of illness. Some migrants, who are in financial difficulties though, may have some assistance, including financial support and emotional support from their social networks. But on the other hand, the assistance from social networks on their health and health care access is limited, not only because their social networks is limited, but because the social networks should not bear the responsibility to support the health services access of migrants, similar to or more than the state and migrants' employers.

It is viewed that the social network among migrants is formed by several factors, which include the *Hukou* system, unfair treatment and discrimination from urban residents and organizations, and discriminatory policy implementation by urban administrative officials. These factors will exist for a long time. In recent years, many people have urged the Chinese central government to abolish the *Hukou* system, however, this does not seem to be possible at present, in my opinion, for two important reasons: firstly, the disparity of rural-urban income still exists, and the gap is getting wider. In such a situation, it is likely that a large scale of rural people will continue to drift to the urban areas. Secondly, the ongoing trend of closing down state-owned enterprises will result in a large number of unemployed urban residents (Wong; Li; and Song, 2007).

One way suggested to improve the lives of migrants and protect their rights is to organize them and help them to be involved in effective networks of support. As stated by Zhao (2000), there are various types of informal mutual-aid organizations being run by migrants. Some of these organisations are economically oriented (e.g.

informal organisations for migrants in the transport and loading industries), and some are socially oriented (e.g. fellow villagers, kinsmen or relatives). Apart from satisfying basic material needs, such as food and housing, these organisations facilitate the collection and exchange of information and provide a sense of security for migrants. At the current stage, some of these organisations are loosely operated, and they can be a sensible alternative for the central and local governments to care better for the migrants. If the government can guide and prompt the development of these organizations, they can substantially help the migrants with regard to health services in the city.

In regard to the aspect of governmental administration, rural-urban migrants should be incorporated into the urban neighbourhood of the community where they live. Considering their floating characteristics, registration with the neighbourhood committee at the grassroots level is necessary. And the registered neighbourhood committee should play a more active role and should integrate migrants into the whole local community.

To broaden the social networks of migrants, it is a practicable idea to get them covered by the community-based medical services. As a part of social network, the community-based medical services can be a new means for health support to migrants. With the development of grass-roots public hospitals²⁵ in residential communities, comprehensive preventive services and treatment for common and minor diseases within the neighbourhood can be provided to all the registered residents, including migrants.

²⁵ In some communities such as ...Districts in Beijing, the small public hospital is also named as 'community medical services station'.

Chapter Six

Understanding of Health-related Issues: Health Constraints among Migrants?

6.1 Introduction

Having analysing the health constrains in terms of social strata in Chapter Four, and the role of social networks in health in Chapter Five, the central concern of this chapter is to understand migrants' health and health care from the migrants' point of view. Although there are a few studies on the health-related issues of rural-urban migrants, such as Liu (1996), Chen (2001), Shi (2004), Fang (2006), Zhang and Tan (2006), Lin (2007), and Chen and Yang (2007), most of their interest is concentrated on medical analysis and education (has been discussed in Chapter Two). Very little discussion has been done to explain the impact of the internal factors of migrants themselves and the external factors of their social environment on the issues of health and health care from the migrants' point of view.

Some previous studies focused on the influence of health understanding on health behaviour. Rosenstock's (1974) Health Belief Model (HBM) proposes that people will change their health behaviour under certain circumstances and stresses the use of

individual attitude and belief to explain and predict various health behaviours. Rogers (1996), based on HBM, discusses health behaviour from the perspective of motivational factors. His theory proposes that the relevant information about health threats from environmental and individual sources trigger two cognitive processes in individuals: threat evaluation and response evaluation. In the 1970s, Fishbein and Ajzen (1975) presented the theory of rational behaviour or planned behaviour, holding that people's performing of certain behaviours is based on rational thinking, people's motivation of behaviour depends on a series of reasons, and individual's motivational factor shapes the performing of certain behaviour. The "theory of planned behaviour (TPB)" is the main theory of improving health behaviour at present, which evolved from the "rational behaviour model". It introduces behaviour control variables and develops into "expanded theoretical model of rational behaviour", and is also called "theory of planned behaviour (TPB)". However, these theories seem to put all the responsibility on individual failure of health understanding, and I will argue that for understanding health and health care, we can not simply depend on the individualist approaches such as the Health Belief Model, more socio-economic approaches, which understand health and the use of health services from a broader vision of economic, social and policy constraints, should be adopted as well. In this study, I will argue that although the discussion is based on the migrants' point of view, migrant's health and health care should still be comprehended from the contexts of social and economic environment.

In this chapter, based on the first-hand findings from interviews, empirical description will provide a clear and full-angle introduction to migrants' understanding of health and health maintenance, and discuss whether the migrants' understanding of health is

in the same level or not. And the further analyses will try to fill in the blank of previous research. I will analyze the internal factors of migrants themselves, and the external factors from the social environment, which include their conception of traditional culture, weak capability of accepting information, exclusion from the social system and the possibility of health participation, exclusion from social networks and obstructed channel of health maintenance, exclusion of crowd psychology. I would like to point out that the external factors actually impact heavily on migrants' understanding of health and health behaviour.

The results of migrants' understanding of health related issues from the interview include their understanding of health and their understanding of health maintenance. In this research, the understanding of health among migrants is categorized into three sub-sections: understanding of the connotation of health, understanding of the importance of health, understanding of health forming, and understanding of disease spreading routes. The understanding of health maintenance includes the understanding of the ways of disease prevention, self-health demand status, concept of self-conscious participation in health maintenance, health service choices, and access to public health services.

6.2 Understanding of Health

6.2.1 Understanding of the Connotation of Health

A commonly adopted definition of health is in the World Health Organization's Constitution as 'a state of complete physical, social and mental well-being, and not

merely the absence of disease or infirmity'. Thus health 'is a positive concept emphasizing social and personal resources as well as physical capabilities' (WHO, 1946). A healthy person needs to maintain healthy habits such as taking regular exercises and adequate rest, adopting a high level of personal hygiene, eating a nutritionally balanced diet, abstaining from the abuse of drugs and alcohol, taking care of one's mental well-being and developing social skills to interact in a positive manner within society. To be healthy is to be in a state of homeostasis (balance) with one's surrounding: to avail oneself of the advances of medical treatments and preventive measures such as immunizations which further boost one's health.

In this study, the concept of health above is utilized to reflect the rural-urban migrants' understanding of the connotations of health. The results from the interviews show that, among all thirty-six respondents, some (n=7) think that health means "being stronger and spirited"; some (n=6) accept the viewpoint that health is "strong immunity without illness"; some (n=10) hold that health should refer to both physical and mental health; others (n=13) agree with the idea of "health in physical and mental being and social adaptation". In view of this, while many migrants still hold that health means relatively normal physiological function, psychological and social adaptation are part of most of the other migrants' understanding of health. In many cases, from respondents' perspectives, the individual's health condition is sometimes uncontrollable by the individual and his/her family, and in addition to the individual factors, their health level also depends on the external social environment to a great extent.

6.2.2 Understanding of the Importance of Health

As for the importance of health in the understanding of migrants, the study shows that, among the respondents, most (n=26) believe that health is very important; some (n=8) hold that health is important; and one and other one respectively choose that health is not so important and that health does not matter. The point of view that health is very important is mainly from following three points:

For their Business

Obviously, health means much to the migrants because they are deeply concerned about the chances of working and money making which might be affected by illness.

An interview exemplifies the results:

Health is very important to us because in our business, we must open the shops before 7 a.m. and close them at 3 a.m. One without a strong body cannot keep on doing it. (Mr. Wang, an owner of a printwork)

For Their Well-being

Migrants think that health is very important because they feel some serious diseases seriously affect their happiness in life.

Mrs Sun (a stall peddler of socks): I suffered from cerebral thrombosis two years ago, as you know, that was a fatal disease. It was a major blow to me, after the treatment, I feel it is very important to have a healthy body.

Interviewer: You paid treatment by yourself? And did you claim some back, such as from medical insurance, or from the new Rural Cooperative Medical Scheme (RCMS)?

Mrs Sun: I spent 6700 RMB Yuan for treatment at the General Hospital of People's Liberation Army (PLA) in Beijing, and paid by myself. That was a fatal disease, and I had to seek treatment here. I do not have any medical insurance in Beijing... the new Rural Cooperative Medical Scheme? I do not know that at all, actually nobody told me about that.

For Their Family Life

Another understanding of the importance of health is from the influence over their families' daily lives.

I had hepatitis previously which brought much inconvenience to my daily life with my family. I was worried that this infectious disease would transmit to my wife and children. I was very careful even did not eat together with them. (Mr. Feng, a construction worker, suffered from the acute illness that can be treated but the subject remains weaker-hepatitis)

6.2.3 Understanding of Health Forming

The findings show that there is some link between the understanding of health forming among migrants and their individual experiences. Here below are the causes and types of diseases suffered by the migrant participants of this study:

From Work (n=10)

As discussed in Chapter Four, poor working condition of migrant is a main reason leads to health problems, such as:

- Chronic illness that can be treated temporarily but may reoccur (for instance in this study, strain of lumbar muscles and gynecopathy)
- Acute illness that can be treated and a full recovery can be made (for instance in this study, slight industrial accident)
- Recurring often weakness without any diagnosed illnesses

From Infection (n=8)

Poor living condition can transmit disease or cause infection, such as:

- Acute illness that can be treated and a full recovery can be made (for instance in this study, bad cold and flu)
- Acute illness that can be treated but the subject remains weaker (for instance in this study, hepatitis, pleuritis)

From Lifestyle (n=7)

Migrants' lifestyles are also a reason for illness, such as:

- Chronic illness that can be treated temporarily but may reoccur (for instance in this study: pharyngitis, chronic stomach trouble)

From Heredity (n=3)

Some migrant's illnesses are from heredity, such as:

- Chronic illness that can be treated temporarily but may reoccur (for instance in this study: hypotension and hypertension)

In this study, migrants understand clearly the importance of their behaviour in terms of health forming as their individual experiences push them to pay attention to the

issue. Many participants suffer from the diseases because of their occupations, poor working conditions and unhygienic living environment, and they believe they need more aids and education from the government and society to get some protection and improvement. Apart from that, among the thirty-six respondents, most of them (n=22) believe that daily lifestyle and habits play an important role in the improvement of health; five and four respectively think that health forming mainly depends on body's developmental cycle and physical exercise; and three and two respectively hold that health is determined by medical level and innate physique.

When it comes to the six particular items relating to health conditions, namely, paying attention to food and drink, guaranteeing sleep quality, living regularly, having physical exercise, taking nutrition drugs, making time to attend to health maintenance, among the respondents, twenty-eight prefer the first four items to improve their health, and only one chooses having no time to attend to health maintenance.

However, as a matter of fact, many migrants feel difficult to take their understanding into practise as the heavy burden from lives has occupied most of their attention and energy. In this study, very few migrant respondents have ever taken any active action to search for the information of disease and infection prevention, and they usually show passive attitude on it. Very few respondents in this study do physical exercises regularly although they think it is good and necessary. Poor condition and severe status quo have actually constrained them from getting substantial improvement despite the clear understanding of health forming they have.

6.2.4 Understanding of Disease Spreading Routes

There are concerns that migration may raise the risk of disease epidemics. The problems with disease caused by the conditions in rural areas may be easily spread with migrants floating as carriers, as the remaining restrictions from the household registration (*Hukou*) system have limited the opportunity for permanent settlement of rural migrants. As a floating group of population, such floating may be identified as one of the most dangerous risks of epidemic factors (Hansen, 2001; Zheng and Lian, 2005; Holdaway, 2008). So the understanding and awareness of infectious diseases among migrants are important.

When discussing the understanding on health knowledge, this study focuses on the understanding of disease spreading routes. The results show that the level of migrants' knowing about communicable diseases is generally low (Table 6.1). One respondent replied:

I also know our migrants are vulnerable to communicable diseases, but we don't have the relevant knowledge, and nobody ever told us about it. Since there are so many communicable diseases, it is useless to get known about them. I think a little attention will help us avoid the attack of communicable diseases. (Mr. Zhang, an employee of a furniture store)

The lack of knowledge of communicable diseases directly affects people's health condition and increases the risk of getting sick. Consequently, the top priority should be the popularization and education of the knowledge of communicable diseases among migrants, so as to help this group master the relevant health knowledge. The local government should play more active role to meet the shortfall. Health education

among migrants should be given more priority since it can have effects on migrants' health status (Xiang, 2005). For instance, when the participants were asked whether they have received the "Beijing Citizen Handbook for Emergency Events"²⁶, which were published in 2006 and were distributed free of charge to Beijing residents by the Beijing Municipal Government, none of the interviewed migrant has received this handbook from the Neighbourhood Committee or District government.

Table 6.1

Awareness on disease spreading routes

	Absolutely correct		Partially correct		Completely mistaken	
	Number	Percentage (%)	Number	Percentage (%)	Number	Percentage (%)
Tuberculosis	0	0	16	44.5	20	55.5
Hepatitis	0	0	21	58.3	15	41.7
Dysentery	7	19.4	25	69.5	4	11.1
AIDS	2	5.6	10	27.8	24	66.6
Avian Flu	4	11.1	29	80.6	3	8.3
Cold	31	86.1	4	11.1	1	2.8

Note: (1) The interviewees were asked about the disease spreading routes through multiple-choice question. For example, the spreading routes of AIDS, there are three means of transmission including sexually transmitted, blood transmitted, and maternal-neonatal transmission. The results were developed according to the choices of respondents.

(2) 'Completely mistaken' includes the answer of 'Do not know'.

²⁶ From April 2005, the Emergency Office of Beijing Municipal Government organized relevant Departments and experts to compile 'Beijing Citizen Handbook for Emergency Events '. This handbook divides emergencies including infectious diseases, into 12 topics and 62 sub-topics. And it aims to offer Beijing residents with knowledge in first aid, prevention of disaster and diseases.

6.3 Understanding of Health Maintenance

6.3.1 Understanding of the Ways of Disease Prevention

As for the understanding of the ways of disease prevention, among the thirty-six respondents, more than one half (n=20) prefer strengthening awareness; some (n=10) think cutting disease spreading routes; a few (n=4) think isolating patients; and two prefer other ways.

I think, for us, it's enough to know some serious diseases such as AIDS, etc. We have not paid much attention to others. We are generally uneducated, so we don't need trouble to worry about them. The government should be responsible for communicable disease control, and we ordinary people only need to pay a little attention. (Mrs. He, a shoe shiner)

In this study, most of the migrants have not well learned of the transmission routes of some common communicable diseases, and in fact, cutting transmission when the understanding of the spreading routes is not clear does not give full play to the preventative measures. In addition, migrants' poor living and working environment, where the potential troubles related to communicable diseases are hidden, is the decisive factor for contact with communicable diseases. In the meanwhile, the work units and governmental organizations should adopt more series of countermeasures in disease prevention.

6.3.2 Health Needs

In this study, the approaches for migrants to get health for themselves are taken down and fall into demands for health education and health services. Among 36 respondents, most (n=29) think that it is necessary for them to receive health education; few (n=6) think it is not necessary; and one shows indifference. Among them, six hope to learn about the knowledge of preventing communicable diseases; nine hope to get the knowledge of food safety; eight of preventing chronic diseases; seven of rational diet; and six others. As for the channels to obtain health knowledge, also most half migrants (n=15) prefer TV, which is regarded as the most influential means of popularization; some (n=11) choose the distribution of paper materials and two hope to get the knowledge via newspapers, and eight choose courses of instruction, which are easily understood and accepted by the migrants with little educational background.

Moreover, as for the demands for health service, most (n=33) of the respondents feel the needs for health services; only two think it is unnecessary; and one shows indifference. Meanwhile, in explaining the needs they feel, half of the participants hope to get regular free-of-charge medical examination; some (n=11) hope to have health insurance; six hope to be offered free medicine; and one needs basic medical service.

I would be relieved to get regular free-of-charge medical examinations. Two years ago, the government organized a free-of-charge medical examination for us, but it was very limited to a few simple items such as taking blood and the like. Now I would not like to do so because I don't see its value. I hope the government can offer more and regular free medical examinations. (Mr. Li, a chef in a restaurant)

In the survey, hardly any of the migrants have access to financial assistance for medical treatment. Almost all the interviewed migrants do not have any health insurance; only one man out of the total participants has health insurance in Beijing.

I am working as a maintainer in a state-owned network corporation. I got this job through one relative in Beijing. My work-unit buys insurance for me every year, and according to the contract, the cost is deducted from my salary. (Mr. Shi, a maintainer)

As to the migrants without health insurance, the excessively high charges of insurance premium make more than half of them feel difficult to afford it with their relatively low income; some think that medical insurance is only for city residents and they thus neglect it; a few think that the insurance is not important at all so they have no intention of buying it.

Of course we need health services and would prefer to have health insurance and regular free-of-charge medical examination. Presently, we don't have any insurance and, as a matter of fact, some insurance may not be useful for us. Because of having no fixed job, we have to buy insurance by ourselves. Therefore, if we buy insurance for the whole family, we have to spend a lot of money on it. (Mrs. Sun, a stall peddler of socks)

It can be seen that migrants have relatively strong will for health maintenance and a certain degree of awareness about being insured, but they do not enjoy the necessary

health services due to their own realistic concern or other reasons from their situation and social environment. They are unwilling to buy health insurance because they have to afford a part or the whole of the insurance expense. In view of this, regular free-of-charge medical examination offered by the government is deemed as an effective and beneficial way for health maintenance among migrants. However, migrants have more demands on the items of free medical examination offered by the government, not merely confined to the simple examination (such as just taking blood for hepatitis test).

6.3.3 Concept of Self-conscious Participation in Health Maintenance

Smoking

In this study, the findings on the migrants' concept of self-conscious participation in health maintenance show that twenty of all the thirty-six respondents smoke, and among the nonsmokers, two smoked in the past and has quitted smoking. As to the reason for smoking, some (n=8) replied that they felt stressful, bored and also because they were separated from their families. The main reason for quitting is that smoking is not good for themselves and their families, and not good for their domestic economy. As one participant mentioned,

I got the problem of pharyngitis because of smoking, so I stop smoking and also could save some money. (Mr. Zhang, an employee of a furniture store, suffered from the chronic illness that can be treated temporarily but may reoccur-Chronic pharyngitis)

Food and Drink

In respect of food and drink (table 6.2), male migrants prefer eating to fill themselves, while female counterparts pay more attention to nutrition, which indicates that the female may be more careful than the male in terms of choosing food and drink.

Table 6.2
Food and Drink

	Taste (n)	Nutrition (n)	Appeasing hunger (n)	Indifferent (n)
Men	4	2	10	3
Women	6	7	3	1
Total	10	9	13	4

Note: With respect to the diet, the interviewees were asked to sort order among four choices according to concern.

It is noteworthy that in this study, compared to the migrants in the second and third strata, migrants in the first stratum are much more concerned and careful for healthy diet than those in the second and third strata are.

Although I am usually very busy on my garment business, I pay much attention to guarantee my healthy food, including the nutrition of my child's food, because I know the healthy diet is very important to our health. I do not care how much money to spend, the health is the most important. (Mrs. Bai, a boss of a garment business, a migrant in the first stratum)

I know healthy food and proper nutrition are very important, but I really can not pay more attention on those, after I pay the rent and send some money back to my family in the home village, I do not have much savings every month. (Mr. Song, a security personnel, a migrant in the third stratum)

Physical Exercise

The findings about willingness to have physical exercises reveal that, because migrants mainly consist of young and middle-aged people, in general, they have needs for physical exercises which, however, are hardly satisfied. Among all the 36 participants, more than one half (n=23) never take any physical exercise, The data indicate that among these twenty-three migrants, thirteen and eight respondents who don't take physical exercise respectively choose having no time and being unable to afford it, and two note that their working is actually a kind of physical exercise and they seldom take extra physical exercises. In sum, long working time is possibly an influential factor in weakening migrants' motivation of taking physical exercises. In physical exercise, one finding is that the migrants in the first stratum care more on it. As described by some migrants:

As the saying is, 'the body is the capital of revolution', so I try to find some time after my business to get physical exercise. I bought the swimming card and fitness card in my residential district. (Mr. Xia, a boss of shoe business, the first stratum)

Currently, I attend little to my body. That is mainly because I have no time. I have to do accounts after a whole day of working. If I have extra time, I'd like to do physical exercise, because obesity is not good. (Mr. Zhang, an owner of a small shop, the second stratum)

The reason is just shortage of money, whenever you go in Beijing, you need to spend money. Since I came here, I have never been to any scenic spot, such as the Summer Palace, because you will be charged for the entrance. I have been to the Tiananmen Square sometimes as it is free to access there. (Mr. Fan, a pedicab driver, the third stratum)

I'd like to practise yoga in gymnasium, but it costs a lot and I have not enough time either. (Mrs. Guo, an owner of a barber shop, the second stratum)

Spending Spare Time

The interviews also reveal problems regarding what one could do during spare time. Around three fourth (n=27) participants responded that they never went out after work.

Many (n=20) reported that they were usually exhausted and wanted to take a break. Most of the interviewees (n=30) did not want to spend money on socializing. Reading newspapers was one of the most popular activities as it was not difficult for them to find second-hand newspapers. Sometimes they also rented second-hand books, and books were shared among *laoxiang* (fellow-villagers). When they occasionally met friends outside work, the main activities were wandering in the street, chatting, or playing cards. Only one respondent among participants went to internet bars and played computer games regularly. In general, they were not willing to spend money on leisure-time activities, including physical exercises.

6.3.4 Health Service Choices

In this study, of all the thirty-six participants, ten did not take any treatment when falling ill and typically, they would wait and see, hoping the illness would go away by itself. Eight of the migrants chose self-medication because of the low costs. And although eighteen migrants sought treatment, ten chose illegal private clinics. The findings also indicate how the migrants use medical services for illness. If they get minor ailments, for instance, a cold or headache, generally they buy medicine from a pharmacy. If they are unable to treat the illness themselves, for a cheap health service, their first choice is to go to a private clinic, followed by a small public hospital, then a city level hospital. In Dengcun Village, there are many small private clinics which are all illegal. Many migrants are mainly attracted by the private clinics because of the low prices there. The high costs of public hospital services make their use by the

migrants prohibitive. More details about the private clinics were discussed in Chapter Four.

In addition to the financial constraints, the different feelings on diseases also affect the health services choice among migrants, for example, some migrants especially from the second and third strata, regard serious industrial accident and sick staying in bed as illnesses, cold and headache are not illnesses at all. But to some migrants, especially from the first stratum, they look upon common cold and headache as illnesses.

The economic polarization within society and the lack of a social security system makes the poor more vulnerable in terms of affordability and choice of health service providers (Shaikh and Hatcher, 2004; Nyamongo, 2002; Asenso-Okyere, 1998). Financial difficulties not only exclude people from the benefits of the health care system but also restrict them from participating in decisions that affect their health, resulting in greater health inequalities (Shaikh and Hatcher, 2004). In sum, financial constraints do affect the health seeking behaviour among migrants when they face health problems. Especially under the current policies, they can not obtain financial assistance from their employers and governments.

On Children's Health

Many migrants try hard to reduce the cost of their health; however, children's health is a great concern of many migrant parents. While eighteen participants in the study said they had always attempted to avoid medical treatment, they made the opposite

point with regard to their children's health care. The migrants expressed the belief that parents inherently favour their children over themselves, not only in taking medical care, but also in keeping good health: children are virtually seen as getting the better conditions.

There are thus two extremes in the account that the migrants gave, in terms of behaviour that they showed to deal with their diseases (or injuries) and those of their children. One typical case in the sample was about Mrs. Lin who has been discussed in Chapter Four, she is passive when dealing with their diseases (or injuries), but she goes to the opposite extreme for her children's disease (or injuries). Another example reported by Mr. Zhang:

My wife and I are indifferent, and we do not seek medical treatment usually, because it is very expensive. But our two children are very important. If they get health problem, I take them to the hospital for treatment, including Beijing Children's Hospital, no matter how much money for that. (Mr. Zhang, an owner of a small shop)

6.3.5 Access to the Government Health Services

Of the thirty-six participants, thirty-five had not signed a contract and, therefore, did not have any insurance for industrial accidents. There are two main reasons to cause the low rates of signing the contracts, one is the lack of supervision on the labour market from the government, and many employers do not sign the contracts with migrants for the purpose of escaping the responsibility. Another reason is the insufficient propaganda of policy from the government; many migrants do not have

enough knowledge of the relevant regulations, and do not know how to protect their rights either.

Just as one participant states:

When I came to Beijing, the most important thing to me was to get a job, no matter what job it is. I was lucky to get this job as a construction worker two years ago. Many migrants wanted to get this job but did not get it because there were too many people applying the limited vacancies...I did not know I could sign a contract to get the insurance, nobody told me about this, including the employer. (Mr. Feng, a construction worker)

Under the current social security scheme, rural-urban migrants are not entitled to urban public health services. If they are ill, they need to pay for the medication or health care by themselves. As hospitals are increasingly profit-driven, the costs of health services are unaffordable to many rural-urban migrants. In the participants, only one who worked as a maintainer for a state-owned company was covered by health insurance (the expense is deducted from his salary). Others had to pay for the health care totally by themselves. The person who is not covered by the health insurance usually has to spend a whole year's earnings on an operation.

I got the acute pleurisy one year ago, and had an operation in Tiantan Hospital. It charged me 10000 RMB Yuan which was more than my one-year savings, and I had to pay for it by myself as I do not have any medical insurance. (Mr. Shi, a maintainer)

There had been some changes in handling of industrial accidents during the recent five years. Beijing is one of the earliest cities which introduced insurance against industrial accidents for rural-urban migrants. By the time of the interviews, according to the local regulations, when an employee was seriously injured at work, the employer should pay for the health care of the injured worker and pay their salary during the sick leave. If the employer refused to pay, the employee could report to the local authorities, who would help the employee claim compensation. However, such cases could only be processed when there was a formal labour contract between the employee and employer.

6.4 Analysis of the Factors That Influence the Health Consciousness of Migrants

Understanding of health related issues is an individual-level variable that differentiates among individuals based on the extent to which they participate in healthful life choices (Moorman and Matulich, 1993; Walker et al., 1987). In other words, understanding of health issues is an indicator of a person's intrinsic motivation to maintain good health and is a reflection of his or her responsibility towards health (MacInnis, Moorman, and Jaworski, 1991; Moorman and Matulich, 1993; Park and Mittal, 1985). It influences an individual's health preventive behaviours and health maintenance behaviours (Moorman and Matulich, 1993). A person with strong understanding of health and health maintenance actively seeks information and resources that are oriented toward enhancing health, and engages in those activities

that lead to better health, including eating healthily, searching for health information, and engaging in physical activities (Moorman and Matulich, 1993). The factors that affect health may include inherent factors and extrinsic factors. Inherent factors comprise age, ethnic origin, genetic makeup or inherited, education, nutrition, habits, and sex; extrinsic factors include social class, occupation, habitat and environment. Among the extrinsic factors, social-economic factors play an important role in affecting the people's health in contemporary society (Milio, 1986; Chiu, 2002).

Drawing on the survey on the understanding of health related issues among rural-urban migrants, their understanding presents the following characteristics: first, rural-urban migrants have limited understanding about the meanings of health and limited knowledge of health; second, although they express strong needs for health, many of them have a weak conception of participating in health; third, they universally pin their hopes on national health services and hope to get more assistance from the government. The following section will explain factors of social environment drawing on the questions about the understanding of health related issues of migrants.

6.4.1 Exclusion from the Social System and the Possibility of Health Participation

China has a long history and tradition of the Household Registration System (*Hukou* system). After the People's Republic of China was founded, the Household Registration System was continued since the end of 1950s. For a few decades, it played a positive role in reducing the pressure and burden of cities, slowing down the

speed of urbanization and maintaining social stability. Along with this persisting role of the system, it has gradually become a barrier for people in rural areas to share opportunities and resources with urban residents and has shut rural-urban migrant workers out from the formulation of urban “rules”. Rural-urban migrants have no say in health policies and no rights in using government health facilities (Li, 2004). Therefore, it is not difficult to understand the low rate of health participation among migrants. However, the migrants have strong demands to make their own voices in urban society, and they hope their rights can be properly protected. In this study, most of the participant (n=31) hope there could be labour unions for rural-urban migrants and they are eager to join them.

If there were labour unions for rural-urban migrants in Beijing, that would be great, and I really want to join them. I think they can represent our migrants to protect ourselves, but currently there lacks this kind of union in Beijing. (Mr. Ding, a security personnel)

The existing social security system also excludes rural-urban migrants. The health care system in China is based on the rural-urban dualist structure. The services provided in rural areas are very different from those in urban areas. The rural-urban division has moulded discrepant health-care institutions and different quality of administration in health services between rural and urban areas. In urban areas, rural-urban migrants are not entitled to much social welfare or many public benefits that urban residents enjoy, and during the last two decades, there was no obligation on collective or private enterprises to provide health-care allowances to their rural-urban migrant employees. Documents issued by the Ministry of Labour and Social Security

and the State Council refer the new health-care system to a scheme for 'urban employees' (Chengzhen zhigong) (Zheng, 2005). Though the term 'urban employees' is not clearly defined, it is universally interpreted as those working in urban enterprises and with Urban *Hukou* status.

At present, migrants have two channels to participate in health care security: first, the individual and his unit jointly assume the insurance expense; second, the individual assumes the insurance expense totally on his own. However, the existing policies related to the unified insurance planning for units are different, so it is difficult to achieve interconnection. Therefore, insurance relationships can not be transferred smoothly and migrants' frequent floating and changing of working place directly causes them to be unable to enjoy rights and benefits of social security. What is more, it also influences employers' willingness to participate in insurance, thus leading to a vicious circle.

Starting from mid-2004, the government issued a document to grant rural-urban migrants the right to participate in insurance against industrial accidents in cities (Ministry of Labour and Social Security, 2004). At the time of the interviews, the expansion of social insurance against industrial accidents was mainly enforced among workers who were the most likely to suffer from heavy injuries, such as construction workers. The practice of imposing standardized labour contracts between workers and their employers in the construction industry was then under discussion, and a new local regulation²⁷ came out in October 2004. However, many migrants worked outside these sectors. In some other occupations, such as catering where serious injuries were

²⁷ "The Provisional Measures for Beijing's Rural-urban Migrants to Participate in Work Injury Insurance", available at: <http://www.bjld.gov.cn/LDJAPP/search/fgdetail.jsp?no=238>, accessed on 04/03/2010.

less likely, minor injuries such as burns happened quite frequently, in many cases actions have rarely been taken to fix the problems.

I was burned at work several times while cooking dishes in the restaurant. My boss did not give me help on that, including simple medication, if I felt very painful, I went to a small pharmacy to buy some simple medicine and some medical cotton for myself (Mr. Li, a chef in a restaurant)

In addition, low salary, poor working condition and weak stability are the major causes of poverty among migrants. In order to survive in the hard environment, migrants have not much attention to pay to their health.

6.4.2 Exclusion of Social Networks and Obstructed Channels of Health Maintenance

In Chapter five, more detailed analyses on the social networks and health among rural-urban migrants have been discussed. Viewing from the understanding and experience of health among migrants, it is necessary for rural-urban migrants to rebuild their social relations when they migrate to urban society so as to broaden their education and their channels of information gathering, and to build up understandings of health among themselves. However, they have far fewer opportunities to associate with urban residents due to the restriction and marginality of their lives and work. So, it is hard to establish personal networks between migrants and urban residents. Consequently, “urban residents’ circle” and “rural-urban migrants’ circle” come into being in urban society (Wang, 2006). Migrants are entirely different from urban

residents in occupational distribution, consumption and amusement, ways of assembling and social psychology. Local residents and incomers are divided into two groups in the health system. The isolation of networks between rural-urban migrants and urban residents leads to little association between them and migrants still believe in the primary relation networks based on blood relationships and rural identity in cities. The primary reason for this isolation is the long duration and two-dimensional segmentation of rural and urban areas. Urban residents express discrimination and prejudice against migrants while migrants have difficulty in establishing a sense of trust for urban residents.

As rural-urban migrants are excluded from the urban social security scheme, they depend more on their primary social relation networks. However, the resources they can obtain from these primary social relation networks are very limited in the urban area. Moreover, their close contact with the primary relation networks actually widens their distance from urban society. As a result of their isolation from personal networks and exclusion from social organizations, even if rural migrant workers have strong demands for health and strong will for participation in health, they are hindered.

6.4.3 Exclusion of Crowd Psychology

Some researches divide social classes in the light of economic level, degree of education, social prestige and political rights (Lu, 2001; Li, 2005), and based on such measures of division, both rural-urban migrants and urban residents have a strong sense of social status and identity. Both urban residents and migrants have conceptions about “urban residents” and “peasants”. In the urban society, migrants are

always supervised as outsiders, and in the opinions of urban residents, migrants are largely the products of incivility, poor education, poor culture, even crime (Li, 2004). Therefore, migrants are prone to the feelings of discrimination and exclusion. They may feel that they not only have a distance from urban residents in social status and living environment, but also have a distance at a spiritual level. Such feelings have evolved from perception into cognition, which engenders a kind of identification among migrants about their own 'incomer' identities.

I usually do not talk to urban residents, and I feel they do not like us because we are incomers. Even when I am doing this small business, the municipal administration staff always confiscate our migrants' stuff, but they ignore the peddlers who are Beijing natives. (Mr. Liu, a stall peddler of fruit)

Under circumstances of growing discontent, rural-urban migrants tend to attribute all responsibilities to external factors, and believe that they get less health service than urban residents, or don't get the service they deserve, so they psychologically feel that their own rights and interests of health right have been deprived by others. Such feelings not only strongly affect migrants in evaluating health services, but also hinder their enthusiasm for participating in health services. However, the internal factors of migrants themselves and the external factors from their social environment are tightly linked together and frequently complement and interact with each other. Particularly, the external factors from social environment and tradition play an essential role in the forming of migrants' understanding of health related issues.

6.5 Conclusion

In conclusion, it is discovered through this study that: rural-urban migrants have relatively weak understanding of health. Many migrants' understandings of health and health maintenance are limited to the physiological level of understanding and they have limited knowledge, even misunderstandings about the ways diseases spread. They have strong demands on health, and they also pin their hopes on public health services, but actually can not enjoy them due to the shortage of social protection from the government.

Some factors contribute to the current situation. The exclusions in social systems, social networks and crowd psychology in cities mean that migrants are over-exploited, eventually leading to a series of problems such as low income, disease, insufficient human capital, weak social security system, and social discrimination. In this situation, lacking the opportunity for sharing the health services equally with urban residents, migrants more easily experience feelings of discrimination.

Along with the advance of urbanization, people's behaviour and lifestyle are diversified, which brings about new ways for diseases to spread. The vulnerable nature of rural-urban migrants is one of the main causes for them to face the threats from various diseases. However, it is necessary to keep in mind the inseparable links and interactions between the internal factors and external factors, and the prime responsibility should not be put on migrants. More attention should be paid to the relations between people's understanding and the impact from the social environment

and institutional dimension as people's perception and perspective are highly situational and therefore socially structured. Although each person has his or her understanding and perspective, they are all affected by circumstances, by common patterns of meaning in society, and by the impact of social structures on their emotional and psychological life (Wilkinson, 2005). In this study, the migrants' insufficient understanding of health mainly results from the socio-economic environment in which they live and work. Migrants have weak voices in health policy making and insufficient access to the government health facilities.

The health of rural-urban migrants not only concerns urban residents, but also is closely linked to the long-term and sustainable development of the whole society, so, more panoramic and comprehensive attention, including the concerns on their health constraints and psychological health, should be paid by the whole society.

Chapter Seven

Conclusion

The primary concern of this study is to investigate issues in regards to the health constraints and health services access of rural-urban migrants in the absence of an equal social protection by the government. This research focuses on the multifaceted reality of health constraints among migrants by exploring the social strata, social networks, and the understanding and experience of health and health services among migrants.

This study begins by providing an introduction. Then it moves on to the discussion of the recent studies on the issues of migration, migrant health, and institutional factors. And the methodology part in Chapter 3 provides a detailed summary of the links and rationale between the aims of the research and the research methods used. As noted in Chapter 4, a preliminary sketch of the social strata among rural-urban migrants is established. This full spectrum of the social strata under the three headings provides us with a sort of social classification and the health constraints among migrants. In chapter 5, a detailed examination of the social networks is set up and the impact of social networks on health and health services access is explored. Then our task in Chapter 6 is to discuss the understanding and experience of health and health services access among migrants.

From now on, rather than a simple summary of all the previous chapters, I would like to conclude by focusing our attention on the implications for social policy. As the study has explored the health constraints in terms of social strata, the impact of social networks on health and health services access among migrants, and the understanding and experience of health and health services access among migrants, the conclusion should be focused on the main issues drawn out from the following: social strata, social networks and the understanding of health and health services access among migrants.

7.1 The Health Constraints and Policy Implications: Migrants Are Not one Group

The study starts with a detailed profile of social strata among the rural-urban migrants. Regarding the social strata of migrants, the study explores a general picture of social strata that migrants have in the community. Detailed findings of social strata among migrants have been discussed in three points, based on the types of occupations: first, the owner, who holds the relative productive capital and employs other people; second, the self-employed workers, who hold little capital and run their own private businesses; and third, those who are totally dependent on others for work and self-employed manual workers. These three categories have different financial resources and their access to medical treatment appears a hierarchical structure. The latter two groups actually comprise the majority of migrants and have more constraints in medical services access.

Based on the data collection in Dengcun Village of Beijing, the study further investigates issues concerning environmental health risks of migrants, their health seeking behaviours, and the constraints they encountered in accessing health services with respect to the social strata among them. It is argued that the main obstacles to accessing health services are not only the shortage of financial resources among rural–urban migrants, but lie in the institutional blind spot regarding health security provision, rural–urban dualism and a unique household registration system in China.

7.1.2 Inequality of Social Medical Insurance System

On September 1st, 2004, the Beijing government issued the Interim Procedure of Basic Medical Insurance for Rural-urban Migrants, which was designed to sort out the problem of medical insurance for migrants working in Beijing. This regulation, however, has been widely ignored (Hu and Zhang, 2006). Some enterprises underreport the number of employed migrants or the total amount of wages, and make the excuse that their employed migrant workers have extremely with high mobility or that the employed migrants are unwilling to buy insurance (Chinese Jurisprudence Daily, 11th April, 2008). Furthermore, the current administrative system lacks related legal or regulatory support, in accordance to the stipulation of this ‘Interim Procedure’ in Beijing. The enterprises should buy basic medical insurance for their employed migrant workers, but actually, most enterprises are unwilling to pay the expense for their employed migrants’ medical insurance. For example, Mr. Shi, in this study, was employed as a maintenance worker in a network enterprise last year, the enterprise claimed that the medical insurance was bought for him, but in fact, the cost of medical

insurance was deducted from his wage monthly. Mr. Shi stated that the fellow migrant workers in that enterprise and some migrant acquaintances employed in other enterprises were in the same situation.

Moreover, there is an apparent flaw of this Interim Procedure that it does not involve self-employed migrants into the medical insurance system. Thus, I will make the following policy suggestions:

First, a general perception is expected to establish that the legitimate rights and needs of migrants should be respected and protected. Governmental divisions working with migrant administrative matters should change from the old role of extensive control and management, to that of service, and the awareness of equal treatment between migrants and resident needs to be promoted.

Second, enhance the support from government further, and improve collaboration between the health sectors and other governmental divisions. As to government branches, especially the health divisions, their function should cover both medical services and administrative work among migrants. Community medical services for migrants are also expected to be integrated with local health planning, and the employment units or neighbourhood committees should be placed in charge of the planning work. The National People's Congress and government should impel well-integrated regulations and policies, develop social security rules and schemes, establish social security funds for rural-urban migrants, and offer aids and relief to migrants in times of severe illnesses and epidemics. Specific legislation is needed to establish so as to secure and protect the rights of migrants.

And third, promote the variety of the community medical service providers. The shortage of governmental financing is the main obstacle when developing community medical services for migrants (Hu and Zhang, 2006). So market competition can be introduced, with sector monopoly and ownership limitation reformed. Existing medical institutions need to improve their usefulness in serving migrants, and the number of staff and the level of technology at community medical institutions need to be increased.

7.1.3 The Role of Illegal Private Clinics

Another important finding of this study indicates that illegal private clinics have taken root in the migrant community studied and played a significant role there. Illegal private clinic is the main choice of migrants in the third stratum for medical treatment. It is also an option of some migrants in the second stratum.

Financial constraint is the chief reason why migrants chose the illegal private clinics for medical services. As far as the medical services system is concerned in China, there is an urgent need to increase access to basic medical treatment services for the poor. New mechanisms need to be introduced so that targeted subsidies can be provided for migrants who are unable to pay for the high medical costs.

The surveillance and supervision over the illegal private clinics should be strengthened. One problem of these private clinics is their lack of formal licenses. Health authorities in Beijing often turn down applications from private clinics for

licenses on the ground that they fail to meet the basic standards in facilities and fail to provide acceptable qualification of doctors. Medical services for migrants could be used as an effective means to consolidate the migration management, and local government should adopt more flexible measures to channel the emergence and development of private clinics, rather than simple prohibition. Despite various problems shown along with those illegal private clinics, their positive function and services to migrants cannot be ignored. Local government, on the one hand, can help to integrate the migrants into the urban communities through medical services of good quality and affordable prices. On the other hand, medical services can also be used by the local government to collect basic information of floating migration. Based on the actuality of the increasing costs in medical treatment and the widening gap between the rich and poor in urban China, the government should consider encouraging the reasonable development of private clinics based on the migrant communities. In the mean time, for those private clinics with quacks and fake medicine, firm enforcement must be adopted by the governmental authorities to crack down on them.

7.1.4 Health Education in Community: An Administrative Approach

Although migrants have different social strata, they should be included into the urban medical services system. However, it may not be very realistic to achieve this in the near future. The reasons include: first, the gap between the urban and the rural in health services system makes it impractical to provide migrants with formal health services in cities. Second, the vested interest associated with the existing social security system has become another constraint to migrants getting involved in the

urban medical service scheme. And third, there are concerns that migrants would bring extra difficulties to the management of the health-care system. And finally, some institutional factors, such as the *Hukou* system and the rural-urban economic divide, will remain for a long time and continue to impede migrants from being included in the urban health services system.

However, community-based health care could be a new means to provide health care support to urban-urban migrants. In the migrant community where migrants aggregate, administrative points and medical service stations can be established. Firstly, a health care information network for the migrants is needed. Secondly, health education among migrants is required, and their educational background and their capability of learning and understanding need to be taken into account so that health knowledge can be best absorbed by the migrants. The education needs to include an introduction to knowledge about imaginable health problems among migrant groups and relevant training on coping with those problems. It is important to have the perceptions of migrants on health and sanitation transferred and improved, by means of relevant education and training. Last but not least, it is a good channel for the local government to encourage the migrants to go to the existing public health centre within their own communities for medical treatment, especially treatments for common diseases. As most of the common diseases can be treated in community health centres, and the cost there is generally cheaper than that in public hospitals, it will be more efficient to secure the quality of medical services provided to the migrants and reduce the negative side-effect or, even potential danger, from illegal private clinics. By doing so, it can gradually bring about the migrants' access to basic medical services and build up their understanding of basic health knowledge.

7.2 The Social Networks: Help and Limit

The function that social networks substantially play on the issue of health among migrants in China has rarely been discussed in studies. Actually social networks have important impacts on health and health services access among migrants. This study reports the results of an exploratory research into the social networks and their impact on the health and health care access of the rural-urban migrants. It analyses the nature and composition of social networks among rural-urban migrants, from which they can acquire financial and spiritual support when they are dealing with health problems. So the study tries to find out the answer of these questions: what are the social networks among rural-urban migrants and what reasons lead to the formation of such social networks? The finding provides evidence of the important role of kinship in the lives of migrants. To migrants, the distinct changes of their social networks after migration are represented with three characteristics: first, neighbourhoods in urban areas take a much less important role; second, work-related relationships play an important role although this is mainly among migrants themselves; and third, *laoxiang*, which was mentioned frequently in the survey, becomes very popular in the social networks of migrants. According to the findings, this is because of the following three reasons: the household registration system (*Hukou* system), discrimination by urban residents, and the discriminatory policy and its implementation.

This study also discusses the barriers and facilitators to the establishment of social networks among migrants and the subsequent impact on health and health care access of them. The study also assesses the types of support and limits resulting from the

social networks on health care access, and develops ideas for further research on urban social policy and health promotion to the rural-urban migrants in China.

Social networks resemble a double-edged sword to rural-urban migrants in terms of health care access. The fact that migrants lack savings may not be the sole and essential reason for their extreme vulnerability in times of illness. Some migrants, who are in financial difficulties though, may have some assistance, including financial support and emotional support from their social networks. But on the other hand, the assistance from social networks on their health and health care access is limited, not only because their social networks is limited, but because the social networks should not bear the responsibility to support the health services access of migrants, similar to or more than the state and migrants' employers.

Considering the limited social networks of migrants, one suggestion to improve the lives of migrants and protect their rights is to organize them and help them to be involved in effective networks of support, including helping them to be incorporated into the urban neighbourhood of the community where they live. Moreover, this study suggests that migrants might be covered by the community-based medical services. As a part of the social network, the community-based medical services can be a new means for health support to migrants.

7.3 The Understanding and Experience of Health and Health Services Access: Prime Responsibility Should Not Be Put upon the Migrants

Principally, “understanding” is a concept to describe the perceptions and consciousness of an issue or event. In this study, what I try to find out is to examine the understanding and experience of health and health services access among migrants, and go further to explain the impact of the internal factors which exist in migrants themselves and the external factors of social environment, especially from a sociological perspective.

In this study, the empirical description provides a clear and full-angle introduction of migrants’ understanding of health and health maintenance. And the further analysis tries to fill in the blank of previous research, to analyze the factors from the social environment, such as exclusion from the social system and the possibility of health participation, exclusion from social relation networks and obstructed channel of health maintenance, exclusion of crowd psychology, which impact heavily on their health understanding and health behaviour. Sometimes the internal factors and the external factors are linked together closely and interact as reciprocal causation. But more likely, the social environment should take the main responsibility.

In this study, the understanding of health among migrants presents the following characteristics: first, migrants have little understanding about the connotation of health and have inadequate knowledge of health; second, although they have strong demands on health and health services, they are weak in the conception of participating in health activities and maintenance; third, they universally pin their hopes on government health services, but due to the shortage of social protection, in

reality they encounter many difficulties and constraints in access to proper health services.

There are some reasons on socio-economic circumstances leading to this situation: The exclusions in social systems, social networks and crowd psychology in cities cause the over-exploitation to migrants, which eventually lead to a series of problems such as low income, diseases, insufficient human capital, weak social security system, and social discrimination. In this situation, lacking the opportunity of sharing the health services equally with urban residents, migrants more easily experience the feelings of discrimination and shame. Although they have strong needs for health services, their health is paid insufficient care and attention, and their needs are not met.

To sum up, prime responsibility should not be put on the migrants because their poor understanding of health is mainly resulting from the socio-economic environment in which they live and work. The study reflects the consequences of the current discriminatory policies toward rural-urban migrants. One that must be mentioned is the Household registration system (*Hukou system*), which has a long history in China. Along with the fundamental social transformation in contemporary China, this system has gradually become a barrier for people in rural areas to share opportunities and resources with urban residents and has shut the rural-urban migrants out from the formulation of urban rules. Rural-urban migrants have weak voices in health policy making and insufficient access to the government health facilities. Thus, there are some implications for the policies: first, a general perception is expected to establish that the legitimate rights and needs of migrants should be respected and protected. Governmental divisions working with migrant administrative matters should change

from the old role of extensive control and management to that of service. Moreover, the awareness of equal treatment between migrants and local urban resident needs to be promoted. Second, it is necessary to enhance the support from government, and to improve the collaboration between the health sectors and other governmental divisions. To the government, especially the health divisions, their function should cover both medical services and administrative work among migrants, so as to satisfy substantially their demands in health and keep their rights efficiently protected.

Finally, to understand the complexity of the issue of rural-urban migrants in China is the prerequisite to improve their social status. It needs long-term pushing and persistence in policy reformation and multi-approach strategies to improve their realistic situation. However, once the first step is made, the meaning is far reaching and the future prospect can be optimistic.

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Appendices

Appendix 1. The Participants

● Migrants (N=36)

No	Surname	Age	Level of Education	Y. M.	Employment Status at the time of interviews	Health Problems
1	Mr. Fan	37	E.S	2000	Pedicab driver	Strain of lumbar muscles
2	Mrs. Yang	40	E.S	2002	Shoe shiner	Gynecopathy, Delivery
3	Mrs. He	38	E.S	2000	Shoe shiner	Rectocele
4	Mr. Wu	35	J.H.S (second-year)	1999	Decoration worker	Diarrhea
5	Mr. Shi	39	S.H.S	2001	Maintainer	Pleuritis and industrial accident
6	Mr. Tian	30	J.H.S	1998	Owner of a clothing stall	Bad cold
7	Mr. Hou	20	J.H.S (first year)	1999	Owner of a barber shop	Toothache disease
8	Mr. Zhang	26	E.S	1996	Owner of a snack stall	Pharyngitis
9	Mr. Wang	56	E.S	1995	Parking attendant	Hyperthyroidism
10	Mr. Zhu	55	E.S	1996	Owner of a knitting shop	Chronic stomach trouble
11	Mr. Feng	28	E.S	2001	Construction worker	Hepatitis
12	Mr. Zheng	32	E.S	2000	Construction worker	pulmonary disease
13	Mr. Su	20	E.S	2002	Construction worker	Tonsil inflammation
14	Mrs. Sun	54	E.S	2003	Stall peddler (socks)	Cerebral thrombosis
15	Mrs. He	40	E.S	2004	Pedicab driver	Hypertension

16	Mr. Wang	25	J.H.S (second-year)	2002	Waiter in a restaurant	Enteritis
17	Mr. Liu	40	E.S	1990	Pedicab driver	Eye disease
18	Mr. Wang	50	J.H.S	1996	Owner of a printwork	Rheumatism
19	Mr. Shi	41	E.S. (not graduate)	2000	Owner of a snack stall	Hypotension
20	Mrs. Guo	31	J.H.S (second-year)	1997	Owner of a barber shop	Delivery
21	Mrs. Wang	49	E.S	1998	Dentist of a private dental clinic	Cough and fever
22	Mr. Zhang	39	J.H.S	1999	Doctor of a private clinic	Wife's delivery
23	Mrs. Zhou	38	E.S (fourth-year)	1995	Vegetable peddler	Lumbar disc herniation
24	Mrs. Liu	34	E.S	1998	Waitress	Often weak (backache)
25	Mrs. Fan	38	E.S	1998	Worker of a garment factory	Often weak without any diagnosed illness
26	Mrs. Lin	40	E.S (first-year)	2003	Cleaner	Lipoma and hand joint injuries
27	Mr. Zhang	31	E.S	2000	Owner of a small shop	Acute pneumonia
27	Mrs. Bai	38	E.S	1987	Boss of a garment business	Child's pneumonia
29	Mr. Zhang	42	J.H.S (not graduate)	1993	Boss of garment business	Bad cold
30	Mr. Liu	43	J.H.S	1993	Stall peddler (fruit)	Duodenal ulcer
31	Mr. Xia	35	J.H.S	1997	Boss of shoe business	Wife's delivery
32	Mr. Song	24	J.H.S (not graduated)	2001	Security personnel	High fever
33	Mr. Zhang	37	E.S	1988	Employee of a furniture store	Chronic pharyngitis
34	Mr. Ding	27	J.H.S	1999	Security personnel	Beriberi
35	Mr. Li	31	J.H.S	1992	Chef in a restaurant	Industrial accident (hand injuries)
36	Mr. Huang	48	E.S	2001	Refuse collector	Hepatitis

Note:

- 1) The names given above are not real names of the participants.
- 2) Level of Education: E.S=Elementary School; J.H.S=Junior High School;
S.H.S=Senior High School
- 3) Y.M. =Year of Migration to Beijing

Appendix 2: Interview Guidelines

Questionnaires for all interviewees (rural-urban migrants):

■ (D-code) --- (Consecutive No. of the interviewees)	Notes
Interviewee's background:	
1, Age	
2, Gender	
3, Marital status	
4, Ethnicity	
5, Hukou location: Whether you have registered with temporary ID status in Beijing and for how long? Please give details	
6, Political affiliation If yes, when joined?	
7, Educational level	
Current employment status: 1, Are you doing fulltime or part-time job? Or house-work or retired. 2, If you are not fully employed, are you seeking for job? Or not seeking for jobs? 3, Are you working formally, informally, casually, or self-	

employed?	
4, I need to know details (causes, relationship with the formal employer, any funding provided to set up businesses, and other stories about current situation, job-seeking, cost of job-seeking; consequences of the current unemployment and etc)	
5, If you are not doing full-time employment, your typical time allocation of the latest week? (what you did by mornings, afternoons, and evenings?)	
Employment history:	
First (non-farming) job:	
1, duration	
2, occupation	
3, ownership	
4, Size of firm	
5, Whether export / import	
6, Profit-making	
7, Final wage/month	
8, Pension	
9, Medical insurance	
10, Housing allowance	

11, How did you get the job?	
12, Why lost the job?	
Current job:	
1, Duration (Since -)	
2, occupation	
3, ownership	
4, Size of firm	
5, Whether export / import	
6, Profit-making	
7, Final wage/month	
8, Pension	
9, Medical insurance	
10, Housing allowance	
11, How did you get this job? And do you have any formal contract with your employer?	
12, How many days work per week? (on average in the last period - month)	

13, How many hours work per day? (on average in the last period - month)	
14, How many jobs did you hold between you first and the current jobs?	
15, How easy for you to find another job between jobs?	

About Health :	
<p>1, Health status(self-reported): General health, physical and mental abilities</p> <ul style="list-style-type: none"> • Compared to people of your age, do you think your health status is: excellent, very good, good, fair, and poor (5 scales)? • Compared to the period before migration, do you think your health status is different? Better or worse? And why? 	
<p>2, The last time when you were seriously sick (stayed in bed or off-sick) was?</p>	
<ul style="list-style-type: none"> • Did you seek for any medical assistance (treatment, medication and etc)? • If yes, any diagnosed illness, cost of treatment, where got funds, and etc. • If you didn't see a doctor, why? [economic, distance, cultural (thrifty), explore further] • And how long did you stay in bed, or off-sick? • Anyone looked after you, and how much you need assistance from others? 	<p>-- Month -- year --- days</p>
<p>3, What kind of medical service do you usually use (level, type, price; if more than one, ask when to use for what)</p> <p>Which medical service would be your first choice if having health problems (for different illness categories)? Why?</p>	
<p>4, Do they have any known (diagnosed) illness? Names of the illnesses, and treatment details. This should include all undiagnosed illness (e.g., cough, chest pain, headache, and etc.)</p>	
<p>5, Whether you drink alcohol? (units per day)</p> <p>6, Whether you smoke? (cigarettes per day) Any other HH members drink, or smoke; (details may be useful)</p>	

7, Whether you pay attention to your diet (ask whether you have any concerns about your diet, e.g., short of anything, or too much of anything, and etc)	
8, 5 scales – whether you have faith in modern medical treatment (Very trustful, trustful, ordinary, distrustful, very distrustful)	
9, Whether you have any kind of medical insurance –if yes, please give details. If no, why? 10, 5 scales – the importance of medical insurance? 11, Do you know the new Rural Cooperative Medical System? 1), Have you registered with this system? If yes, please give details, if no, why? 2), Have you benefited from this system? If yes, please give details, if no, why? 3), 5 scales-do you think this system is helpful? Please give comments.	
12, 5 scales – how much you depend on modern medical system? 13, Did you consider the constraints of not using the medical system? 14, Do you have savings? 15, Have you used your savings for health services in Beijing? If yes, please give details, if no, why? 16, Do you send money (such as income or savings) back to your family in your home village? If yes, how often and how much? If no, why?	(economic, institutional, social, distance, etc), and find out any uncommon /unobserved reasons?)
Social networks: 1, looking back over the last six months, with whom have you contacted for help (those based on kinship, those in the workplace, those embodying friendship or others)?	

<p>2, Have you been provided any support from them?</p> <p>1) If yes, what kinds of support have you got? How long has it been help up? What would you describe good things and bad things about it?</p> <p>2) If no, why do you think they refuse to help you?</p> <p>• Have you ever borrowed money from others? Whose idea is it? What is it for? Is it reluctantly to avoid risks or is it voluntarily to invest them? What is the problem with it?</p> <p>3, If you need money for seeing a doctor/medical treatment and could not collect enough money, who do you normally turn to for help? (immediate family members, relatives, friends, colleagues, employers, and etc, details)</p> <p>4, I wonder if you could let me now whether you belong to any forms of organisations (including local government authorities) or you engage in reciprocal or unpaid exchange for social networks.</p> <p>1) If yes, what are the functions of these organisations? What do you do in these organisations? Are these organisations of any potential use or value to you, your family members, or your neighbourhood?</p> <p>2) If no, why do not you engage in?</p> <p>5, What would you describe the best case and the worst case of social networks activities in your neighbourhood?</p>	
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About family:	
No. of family member in 2004 No. of family member in 2005 No. of family member in 2006 No. of family member in 2007 No. of family member in 2008 (tracing the change over this period)	
1, Who is the household head or your relationship to HH?	
2, Where other family members are? (especially about parents,	

children)	
3, Could you let me know the transfers of income/spending among members?	
4, Could you let me know the different roles members play in family economy	
5, Household income of 2008 (last month, and also ask for the average monthly income in 2008 – to make 2008 HH income comparable with other years):	
6, Total household income 07 (ask how many people share the income in 07)	
7, Total household income 06 (ask how many people share the income in 06)	
8, Total household income 05 (ask how many people share the income in 05)	
9, Total household income 04 (ask how many people share the income in 04)	
10, Household spending last month: (items referring to Interviewers' Manual):	
11, Household spending last week (if they don't remember items in month):	
12, Has household spending on food increased in the past few years?	
13, Has household spending on children's food increased in the past few years?	
14, Has household spending on children's education increased in the past few years?	

15, Has household spending on children's education increased in the past few years?	
16, Any household members have diagnosed or undiagnosed illness, what they are, the treatments, funds, time and type of care, and etc	

Current living conditions:	
1, Ownership of the house /flat you live <ul style="list-style-type: none"> ● If rented, monthly rent paid ● If owned, whether mortgaged and monthly mortgage payment ● If owned, current market value of the flat / house 	
2, Number of people live in the house, number of rooms? 3, Size in squared metre? 4, Whether have private toilet? 5, Whether have own kitchen? 6, Whether have own tap water in the house/flat?	
7, Toilet condition: <ul style="list-style-type: none"> ● Where is the toilet you use? ● Number of people use the toilet? ● Whether with modern piping system? ● Whether with basin? ● With bath/shower? 	
8, Kitchen condition: <ul style="list-style-type: none"> ● Whether have your own kitchen? ● Number of people use the kitchen? ● Where is the cooking facility you use? ● Where is the nearest tap-water for cooking? ● Type of fuel used for cooking? ● Type of food storage you use? 	
9, Where do you usually have shower /bath?	

10, How often do you have a shower/bath (winter, summer and etc)	
11, Lighting condition in accommodation: <ul style="list-style-type: none"> • The sunshine conditions: (Without sunshine at any time; poor sunshine condition; good sunshine conditions; excellent sunshine conditions) • Ventilation conditions: (No ventilation facilities; poor ventilation condition; good ventilation; perfect ventilation condition) 	
12, Do you face the problems of environmental pollution within the community? If yes, details. 13, Do you think there are problems on community security in your living area? If yes, details.	
14, 5 scales - please compare your living condition (1) now and (2) before. (Much better, better, same, worse, much worse) Please give details. 15, The age of the house/flat, or the condition of the flat	
Working conditions:	
1, Current working condition: outdoor or indoor?	
2, Heating facility (and type) in winter	
3, Air-conditioning (type) in summer	
4, How many people in one room/office work-shop?	
5, Do you usually contact with toxic elements when doing your work?	

6, Exposed to other dangerous factors: <ul style="list-style-type: none"> • Did you get any health problems caused by your work (place or conditions)? If yes, details. 	
7, Whether your workplace provide you with: <ul style="list-style-type: none"> • fire-protection facilities (how satisfied are you? 5 scales) • Sanitary facilities (how satisfied are you? 5 scales) • Dining facilities (how satisfied are you? 5 scales) • Dormitory facilities (how satisfied are you? 5 scales) 	
8, 5 scales of overall satisfaction with current working condition	
9, 5 scales to assess your current work (place) how much it is likely to dispose to any accident?	
10, 5 scales to assess your current work (place) how much it is like to dispose to any dangerous hassles?	

<p>General Knowledge of disease spreading routes:</p> <p>1, Do you know what causes SARS?</p> <p>2, Do you know how Tuberculosis is passed on?</p> <p>3, Do you know how Hepatitis B is passed on?</p> <p>4, Do you know how Dysentery is passed on?</p> <p>5, Do you know how AIDS is passed on?</p> <p>6, Do you know how Avian Flu is passed on?</p> <p>7, Do you know how to prevent diseases mentioned above?</p> <p>8, Who should take more responsibility for preventing diseases, The Government or yourself?</p> <p>9, How you now understand other epidemic risks? (test with cases, e.g., TB or etc)</p>	
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5 scales assessing their fear for the Bird-flu (Very fearful, fearful, ordinary, unfearing, very unfearing)
5 scales assessing their fear for catching HIV positive
5 scales assessing their fear for catching TB, and etc.

10 What is your understanding about the connotation of health?

- being stronger and spirited
- strong immunity without illness
- both physical and mental health
- health in physical and mental being and social adaptation
- or others

11, Do you think whether health is important or not? And why?
(very important ,important, ordinary, unimportant, very unimportant)

12, What is important for health forming?

- daily lifestyle and habits
- body's development cycle
- physical exercise
- medical level
- Innate physique
- or others

13, Do you think it is necessary to receive health education?

If so, which knowledge do you hope to receive?

Which channel you prefer to take to obtain health knowledge? (Such as TV, Newspapers, etc)

14, Do you usually take physical exercise?

If so, which exercise and how often?

If not, why?

15, What do you usually do during your spare time?

<p>Information flow and to assess the quality of information:</p> <p>Channels:</p> <p>1, How and when did you first know your illness?</p> <p>Through what channel?</p> <p>2, What websites did you use? Official government ones? Other Chinese ones? International ones? If no, why?</p>	
<p>5 scales – to assess whether “government /community measures for disease prevention and treatment were effective”;</p> <p>1, Do you know whether there is any relevant health policy adopted by the central government for rural-urban migrants recently? Please give your comments.</p> <p>2, Do you know whether there is any relevant health policy adopted by the local government for rural-urban migrants recently? Please give your comments.</p> <p>3, Do you know whether there is any relevant health policy adopted by the local communities for rural-urban migrants recently? Please give your comments.</p> <p>4, Can you get any compensation, treatment and protection from you employer? If you have industrial accident or health problems. Please give your comments.</p> <p>5, Have you used the health services from the public health service station within your community? If yes, please give comments, if not, why not?</p> <p>6, Have you used the services of private clinics? Do you trust their services? Why?</p> <p>Interview with owners of private clinics:</p> <p>7, Do you have license?</p> <p>8, Which health services do you usually offer?</p> <p>9, Who are your main customers?</p> <p>10, Which channels do you use to purchase you clinic’s medicines?</p>	

11, Do you think whether your customers or migrants trust your services? If so, why?	
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<p>Liberty, constraints and emergence policy:</p> <p>1, 5 scales – do you think whether central government’s health policy was overall good for you/ your family/ the society? Please five comments.</p> <p>2, Central government’ health policy was overall good for the urban residents, but not necessarily good for yourself or your family. Do you agree? If yes, please give comments. If not, as to the government’s health services policy, what do you think should be improved?</p> <p>3, Did you have any contact with your neighbourhood committee when you have health problems?</p> <p>4, Did they pass on any information to you?</p> <p>5, Did you get any help from them in the time of trouble in anyway?</p> <p>6, Whether you have received the “Beijing Citizen Handbook for Emergency Events” (published in 2006). If yes, how useful it is? (5 scales).</p>	
<p>7, Do you think the government paid sufficient attention to:</p> <ul style="list-style-type: none"> ● Migrants’ health? ● Health protection of migrants? 	
<p>Economic behaviours and losses:</p> <p>1, Whether your employer paid you during your sick-off and industrial accident?</p> <ul style="list-style-type: none"> ● if self-employed, did you continue to work? What you did for living? ● if employers, what you did with your employees? <p>(3) Did you have any problems of wage arrears? If so, pleased give details.</p>	

<p>Social issues:</p> <p>1, Do you feel any discrimination from urban residents? If yes, please give some cases.</p> <p>2, 5 scales- how much do you agree that, in general, migrants are treated equally with Beijing citizens?</p> <p>3, If there is a trade union for rural-urban migrants, are you willing to join in?</p>	<p>[Explore whether some people they know who were treated more harshly than others due to their status (rural versus urban; educated versus less educated; and etc)];</p>
<p>Other questions:</p> <p>5 scales to assess their satisfaction over their quality of life now in Beijing (after considering all aspects of life)</p> <p>1, Do you plan to buy your own house in Beijing? If not, why?</p> <p>2, Do you think whether <i>Hukou</i> is important or not? Why?</p> <p>3, Do you think whether you are a Beijing resident, or an incomer? Why?</p>	
<p>To write down on the same day of the interview my impression of this interviewee. To draw my attention on anything unique, interesting and not in the semi-structured question list.</p>	
<p>Record observation after the interviewing –</p> <p>5 scales to assess the interviewee's physical abilities</p> <p>5 scales to assess the interviewee's mental abilities</p> <p>5 scales to assess the interviewees' intellectual abilities</p>	