Equalization of Basic Health and Family Planning Services?

Chinese migrant workers as a social risk

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Abstract

The aim of this research is to explore how equalization of health is envisioned in a Chinese new policy regarding the equalization of basic health care for Chinese migrant workers in order to understand its material effects on the targeted population in terms of citizenship rights and modes of governing. The purpose is furthermore to see whether migrant workers share the health needs and values promoted in the policy, and to determine what it implies in terms of modes of governing. The theoretical framework consists of citizenship and governmentality/social management theory.

This is a qualitative study. I used semi-structured interviews, and the policy documents were analyzed using discourse analysis, the WPR-approach.

The results demonstrate that the way the policy envisions equity largely lays the burden on migrant workers themselves to improve the situation, whereas structural impediments are not taken into account. The migrant workers' ideas and health preferences do not accord with the policy, which may create perceptions of migrant workers as a social risk. It is therefore questionable whether the policy can live up to its goal of equalization. Instead, social order through innovative governing techniques seems to be the bottom-line of the policy.

Keywords: migrant workers, China, citizenship, basic health services, governmentality.

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"You have to rely on yourself in China, the country does not provide any help" (IM3, 19th Feb. 2014)

1. Introduction

China has gone from being one of the most egalitarian countries in the world to one of the most unequal (Sun et al., 2013:1). The quotes also give a view of contemporary China as a competitive environment where struggles and inequalities are naturalized and where individuals themselves achieve success or perish.

One of the most disadvantaged groups in China is said to be domestic rural migrant workers, which can be explained by the Chinese household registration system – *hukou*. Initiated in the 1950's, the *hukou* system created a rural – urban duality. Citizens were tied to their birth areas in terms of employment and social welfare. Urbanites enjoyed better welfare, which has persisted and still has a profound effect on one's possibilities in life (Wang, 2010). Despite the loosening of *hukou* restrictions and increased mobility, social entitlements and benefits are linked to household registration, which makes migrants a vulnerable group (Hesketh et al., 2008). In addition, the urban bias persists, which has led academics to suggest that only urbanites can in fact be seen as "citizens proper" (Solinger, 1999).

As a result of growing inequality, there has been an increase in various forms of public protests since the 1980s (Perry et al., 2010). In 2000s, Hu Jintao stressed that a harmonious society should be the new political goal, ideally involving less focus on economic development and a stronger focus on human development (Kelly, 2013). In line with human development goals, there has been an increase in welfare policies (Xian, 2012) and health issues have gained in importance. In the 11th five year plan, health became reformulated as a pillar of harmonious society, and various health reforms targeting weaker groups in society, such as rural *hukou* holders, have been initiated (Hsiao, 2008).

Yet, the meaning of a harmonious society does not only involve equity; mitigating risks and maintaining social stability and order are also professed goals to reach a harmonious society, and it has been noted that welfare policies intersect with anxiety over social stability (Xian, 2012). Government policies usually entail both a social order and social equity discourse, two values considered incompatible by Kelly (Kelly, 2013). Social order intersects with a new mix of governing techniques in China. For instance, "Social management" is a governing technique in which self-governing groups or institutions safeguard the interests of the nation (Pieke, 2012),

envisioning a better institutional management of the population (Feng, 2011). Another governing technique that has been promoted is self-governing, where individuals follow prescribed norms and behaviors. The self-governed individual has been promoted in China since the 90's in form of 'the quality citizen' (Anagnost, 2004). At the same time, rural migrant workers have frequently been portrayed as lacking self-governing abilities (Hai, 2013).

Thus, rural migrant workers have not only challenged the structure of the Chinese welfare system from an institutional level, they also "fail" to engage in self-governing. At the same time, they are put forward as one of most disadvantaged groups in society in terms of material assets, access to public goods, and cultural voice (Sun et al., 2013). As such, this group can be seen as potentially dangerous in terms of social stability – their disadvantaged position could induce protests and their lack of self-governing may disrupt the harmonious goal (Pieke, 2012). It is therefore of interest to scrutinize the policies which particularly target rural migrant workers – how are equality, citizenship rights and anxiety about social stability expressed in documents? Does one concern outweigh the others? What implications does it have for the targeted group?

1.2 Statement of problem

Government policies are tools to understand how modern governing takes place; policies present what is considered a problem and reflect a particular knowledge enlisted for governing. Bacchi holds that policies can be seen as problem representations. Studies of problem representations hold that by framing an issue as a particular sort of problem, complexities are reduced and replaced by simplifications. Therefore, analyzing what is constituted and framed as a "problem" gives us deeper understanding of how we are governed. At the same time, policies also have material effects on the targeted population (Bacchi, 2009).

In 2012 the Chinese State Council issued guidelines for a comprehensive restructuring of all basic public services through *innovative governance*, meant to create an *equal society*. In line with former policies, peasants and migrants are mentioned as disadvantaged groups in society, and in order to promote the urbanization of these groups, basic public services should be equalized (State Council, 2012; Li, 2014).

One policy which seemingly follows the guidelines issued by the State Council is called "Equalization of Basic Health and Family Planning services for Migrants" (NHFPC, 2013a). The stated goal of the policy is to equalize the access to, and usage of, health and family planning services for migrants, especially inviting migrants which have stayed longer than 6 months in the cities to take part in health services. In addition, it is meant to improve the social management of

migrants (ibid). The policy designates 40 cities around China to be part of a pilot project which is meant to be initiated in the first half of 2014. In Beijing, Fengtai och Chaoyang area are designated areas for the pilot work (NHFPC, 2013a). The policy as an indicator and initiative towards equality is furthermore discussed in the media and in news articles (Li, 2013; Hu, 2013), outlining the hardships migrants face in terms of health care and how this problem will be dealt with by the new policy. Yet, can issues of social management and issues of equalization be aligned effectively? What values inform the policy and does the targeted group share such values?

1.3 Research Question

In this thesis I analyze the policy "Equalization of Basic Health and Family Planning services for Migrants" in order to explore goals of equality and social management/order in the Chinese society. The policy consists of two documents; one which describes the purpose of the policy, another which outlines an action-plan concerning equalized services.

By analyzing the problematizations in the policy, one gains insights into how equalization is envisioned and how migrants are governed. This is relevant as it has material effects on the targeted population, both in terms of equality and citizenship entitlements in health issues, but also in terms of social management, and how different groups in society are governed.

In addition, it is relevant to ask whether the targeted group in the policies shares the ideas and values promoted in the policy, since health is not only a political issue but also a personal matter. Rural migrant workers may for instance define their health problems differently from the policy, which call into question the sincerity of the policy. Furthermore, I interview a control group consisting of urban professional migrants who are not targeted by the policy. The purpose is to see whether their views of health differ from rural migrant workers and what it might suggests in terms of policy representations.

My main research question is:

• How are migrant's health problems understood in the policy, and what implications does it have in relation to equality, citizenship and social management?

Sub-questions:

- Are the values in the health policy shared by rural migrant workers, and what implications does it have in relation to citizenship and governance?
- Apart from equalization, how can one explain the exclusive focus on rural migrant workers in the policy?

1.3 Disposition of the thesis

In chapter two I outline the theoretical framework which helps to explain the problems I am studying. In chapter three, I explain how I investigated the questions and I define groups and core concepts. In chapter four, I use the WPR approach: I outline the history of health care since Maoist times and issues of health equality to shed light on the possible roots for contemporary policy representations and understanding of rural migrant worker's health issues, and present the results of the policy analysis regarding health equalization. In chapter five, I present the results of the interviews with rural migrant workers and urban professional migrants and in chapter six, I conclude my findings.

2. Citizenship, governmentality, and social management

2.1. Citizenship

The equalization of basic health services places citizenship as a core question in the intended reforms. Citizenship is generally defined as a "formal legal status that regulates the relationship between a state or a political community and an individual" (Stoltz et al., 2010:5). Thus, there are three constitutive elements of citizenship: the citizen, the polity, and the relationship between the polity and the citizen, also called the practice of citizenship (ibid.). In addition, the question of what constitutes citizenship is commonly divided into three spheres: political rights and duties; distributive rights in terms of access to health care, education, and other resources produced; and social membership (Solinger, 1999:6). Social membership is often informed by normative values of conduct. Patriotism is one example of such values, but they could also imply more regulated ways of being, e.g. being male, middle-class, and employed full-time (Ong, 2006: 141-146). In Western societies, citizenship is usually spoken of as comprising all these spheres. At the same time, the content of citizenship is not fixed but is negotiated; it can be different at different times (Solinger, 1999:6).

Legal statuses and rights are generally exclusive to those who are legally residing within designated borders (Solinger, 1999:6). As such, citizenship has been defined by a nation state; only the nation state can implement citizenship entitlements (Ong, 2006:15). At the same time, the declaration of universal human rights may be in tension with national definitions of citizenship in that rights to groups which are excluded in a national definition of citizenship are advocated (Stoltz et al., 2010). Similarly, market forces may also challenge national definitions of citizenship: people with marketable skills gain access to distributive rights and social membership (Ong, 2006:11). Ong defines these skills as primarily linked to self-entrepreneurship and the internalization of neoliberal values such as individual responsibility (ibid.).

In China, the constitution from 1982 stipulates that all holders of a Chinese passport are Chinese citizens and equal before the law, enjoying the rights and performing the duties as stipulated in the laws (Solinger, 1999:7). Thus, the particulars of what constitutes citizenship are rather vague. However, the *hukou*, household registration, comes with different distributive rights and entitlements and has produced two types of informal citizenship, where the urban *hukou* is more desirable. Therefore, the urban *hukou* could be seen as an emblem of *citizenship proper* (Solinger, 1999:3).

Not only is the allocation and distribution of resources constitutive of this urban-biased definition of citizenship, but social membership is also based on urban values and bonds. The city is generally viewed as a place where such values can be obtained (Wallis, 2013).

Since political rights are weak in China, the best definition of citizenship in China is, to Solinger, the notion of urban social membership together with distributive rights of public resources, such as health care, education and so forth (Solinger, 1999:7).

Although Solinger's urban-biased notion of citizenship is vital for understanding the larger framework of citizenship in the Chinese context, other issues such as ethnicity, age and gender also influence citizenship entitlements. In terms of gender, women face discrimination in different spheres such as politics, employment market, education, cultural voice (Attané, 2012). At the same time, gender inequality is influenced by the rural and urban divide – rural women are among the poorest in society (Attané, 2012) and rural women were the hardest hit women in one child policy campaigns (Greenhalgh et al., 2005).

The policy I am analyzing openly states its dedication to equalization of health services concerning the rural and urban divide. Thus, although I will remain open to gendered power relations, my main focus regarding citizenship is the household registration and the urban/rural framework of citizenship, its implications for distributive rights and social membership. Do the suggested actions in the policy effectively battle rural/urban inequality? If so, is it mainly distributive rights that are equalized, or does it help to open up the *social boundaries* to the city?

The citizenship framework helps to analyze the health policy in relation to rural/urban equality and citizenship and to see whether migrant workers themselves share the social membership values related to health that are promoted in the policy.

2.2. Governmentality and social management

Social membership presupposes adherence to values and norms. Likewise, adherence to norms are important aspects of self-governing. Self-governing is one governing technique in the field of governmentality. Governmentality can be explained as "more or less calculated means of directing behaviour" (Jeffreys et al., 2009:1). The practice differs from other types of governing not only in its techniques, such as disciplinary power and sovereign power, but also in the thinking and rationalities. Governmentality primarily concerns itself with population management through social and economic policies and views power as a positive force that makes things happen (Bacchi, 2009). It is a rule from afar, in that populations may adhere to certain types of desired behavior. To

Foucault, adherence to norms is achieved by discourses. Discourses are defined as meaning systems; a specific type of knowledge which we take as truth and live by (Foucault, 1980: 93). Both individuals and institutions are enlisted in the practice of governing through knowledge regimes (Greenhalgh et al., 2005: 23). Although governmentality theory intersects with a liberal and neoliberal economic organization of the socio-political world, it has been noted that these techniques are also applied in authoritarian, non-liberal market economies (Jeffreys, 2009: 4), and whilst Foucault downplayed the power of the government in creating discourses, scholars have redirected attention to the role of the state in producing knowledge regimes (Bacchi, 2009:157).

Following the opening up and more market-oriented policies from the late 70s, the Chinese government has been observed to mix techniques of governing, for instance investing much energy into encouraging neoliberal self-regulating behaviors by advocating certain values to improve the competitiveness and skills of citizens, in order to fulfill the goals of economic development (Jeffreys et al., 2009). Two knowledge regimes in particular have been promoted. 'Suzhi" (quality) and "wenming" (civilized behavior) emerged during the 1990's and aimed to produce physically strong, modern and healthy citizens through emphasizing self-regulation (Anagnost, 2008: 61; Wallis, 2013).

The government has also become less directly invasive in social matters but orchestrated new techniques of governing involving the public sector in what has been termed social management – *shehui guanli* (Yu, 2011). By social management, social order, social stability and organization of social life is achieved through the help of institutions, enterprises, civil society actors, and grass root communities. In social management, self-governing groups or institutions safeguard the interests of the nation (Pieke, 2012). This type of governing technique has also led to discussions of a reconfiguration of state-society relationship, in which the state no longer has the monopoly of managing social development and welfare. At the same time, it has been debated how much liberty institutions have and how much influence the government has over this governing structure (Hasmath et al., 2009). In general, a corporate state structure means that institutions are primarily in the service of government agendas, where the state coordinates the affairs rather than to manage directly (Hasmath et al., 2013). But, it does not have to preclude institutions from influencing the course of events through negotiation. Yet, in China, some argue that the indirect result of social management is the strengthened role of the communist party (Pieke, 2012).

Social management shares affinities with a Foucauldian outline of governmentality where governing is practiced by the state, institutions and self-governed individuals, moving beyond a

state-society dichotomy. At the same time, the role of the state in "social management" is proposed to be stronger as it is actively reasserting itself through institutions.

The social management/governmentality framework helps me to analyze what type of governing technique the policy envisions for the targeted population and what implications this has for social order and/or social equity.

2.3 Migrants as "risks" – a mode of governing

The concept of risk is central in the reflexive modernity thesis developed by Beck. In a risk society, risks become a political mobilizing force (Beck, 1999:4). But whereas Beck approaches risks from a realist perspective, Bacchi inserts a reflection on risks as constructed, emphasized for the purpose of governing. A "risk" mode of governing usually follows neoliberal techniques of self-governing, where adherence to values and knowledge is constitutive of a self-governed citizen. As such, passive populations which do not adhere to norms constitute a risk group and need directions to follow order (Bacchi, 2009). One field of risk is health. The centrality of risk in health discourses can for instance be seen in the emphasis on behavior and life style, which tends to recast a political question to become an issue of individual behavior (Bacchi, 2009: 130). As such, "risk" targets inappropriate values of self-governing.

In China, rural migrants have been emphasized as a risk group in terms of health and their behavior. One field concerns risks linked to the process of migration such as the unsanitary living conditions and a harsh working environment (Gransow, 2010; Holdayway, 2014). Another field focuses on the risks of rural migrants as a group: migrant workers are often depicted as "failing" in terms of self-governing – they lack quality, they lack the healthy behavior and knowledge which is required in cities, and are prone to illness, especially STDs (Wang, 2007; Li, 2013; Liu, 2009). Yet, in terms of STDs, comparative studies show that there are no significant differences between urban and rural populations regarding STD infections (Hesketh et al., 2008). The latter negative depiction of migrant workers also intersects with other representations of peasants and migrants, such as: poorly educated, backward, non-cultured, unreasonable, dirty, ugly, impolite, prone to criminality, and flooding the cities (Lin X, 2013; Greenhalgh et al., 2005; Jiang, 2007; Li, 2013).

It has been argued that knowledge regimes in relation to self-governing in China have been aimed indirectly at the middle-class, since a consumerist culture with certain levels of income and education is a prerequisite to the conditions and behaviors promoted (Hai, 2013). Thus, one may ask how migrant workers possibly *can* follow prescribed behavior if economic realities form the core of the discourse? This is the point where government-initiated policies targeting migrants become

interesting, as policies targeting certain "risk groups" are often a way to control groups which do not follow prescribed behavior (Bacchi, 2009:xx).

With these insights, it is relevant to ask how the new policy will enact its visions: will structural impediments be removed so that migrant workers have access to basic health services, or is the focus on improving individual behavior? What does it imply in relation to the government's view of migrant workers? And what do migrant workers themselves say about health issues?

3. Methodology

The ontological and epistemological stance of this thesis is constructivist; I analyze how actors view health and equity, how it is thought about and approached by different actors in society, and the implications and consequences of such views (Moses et al., 2007). Thus, the emphasis is laid on interpretation, with the focus on understanding human action. Following a constructivist view, objective data cannot be gathered, because the researcher's personal characteristics will influence the research; the theoretical outcome should therefore be seen as an interpretation and not an objective truth (Charmaz, 2006).

I define my research as a case study which adopts grounded theory; I "investigate a phenomenon (the equalization of health care) in its real life context (Beijing, China)" (Yin, 2003:13). Another feature of case study is the emphasis on theory guiding the sampling choice (Silverman, 2010) – I engaged in theoretical purposive sampling.

3.1 Discourse analysis

I will use Bacchi's "What is the problem represented to be (WPR)" approach to analyze the health policy documents. The method focuses on understanding the knowledge which polices are built upon and the possible impact of these knowledges. The method follows closely Foucault's definition of discourse as a meaning system; a set of propositions with underlying assumptions. It does not focus on purely linguistic terms as do other discourse methods. What type of knowledge is involved in constructing a policy can be understood by reading off the actions proposed to fix a problem and by applying contextual background knowledge (Bacchi, 2009).

Bacchi stresses that her approach does not concern itself with finding the "real problem", rather, it is concerned with how a policy is framed, since the representation carries implications for the lived reality, which follows a constructivist way of approaching the world. The positioning of policy as only a constructed problem also implies a denial of actual, lived problems. However, Bacchi stresses that she does "not deny that there are troubling conditions that require redress" (Bacchi, 2009:31), but the purpose of the method is to highlight the conditions around the problematization and create room for greater discussion around the issues, which is also the intention of this thesis. The difficulties in accessing health care facilities for migrant workers constitute a "troubling condition" which is not "constructed"—yet, there are many such troubling conditions for many different groups and the question concerns why this group in particular is

emphasized, how the proposed actions are framed, what type of knowledge has produced this representation and what it tells us in relation to citizenship and governmentality.

The analysis consists of six guiding questions which help the practitioner to decipher the texts (Bacchi, 2009:xii). These questions are:

- What is the problem represented to be in the policy?
- What assumptions underlie the representation of the specific problem?
- How has this representation of the problem come about?
- What is left unproblematic in this representation?
- What effects are produced by this presentation of the problem?
- How has this representation of the problem been produced, disseminated and defended?

In this thesis, chapter four is the outcome of the use of the questions, which are not openly stated in the text but integrated in the analysis.

3.2 Grounded Theory

Grounded theory emphasizes that the researcher should remain open to issues introduced in the field, as theory should be constructed based on data and concepts emerging in the field (Charmaz, 2006:2). Thus, the research process is guided by constant analysis of obtained data and questioning of initial questions, filling in gaps and pursuing new concepts, if they are introduced in the field, in opposition to post-fieldwork analysis (ibid). This approach goes well together with Bacchi's WPRapproach, as the questions guiding the analysis suggest new issues, which might not have been considered prior to research. Nor does grounded theory stand in opposition to a case study with its emphasis on theoretical sampling, since it does not presuppose that flexibility cannot be exercised during a case-study; new factors may unfold which lead the researcher to sample new groups or other issues, of relevance for further theory construction (Silverman, 2010). In my case, the original focus on interviews with only migrant workers changed when I analyzed the health institutions which were supposed to be equalized – the Community Basic Health Service Centers. Migrant workers were reportedly the only group that did not visit these centers. Instead, I found that other groups were also "missing" from such institutions, for instance young professionals from other provinces with a *hukou* from another city. In Beijing this group could theoretically be defined as belonging to the "floating population" (Li Q, 2004) due to their lack of a Beijing hukou. At the same time, they were not the target of the policies, which made this group interesting for comparative reasons – why was just one category of people targeted by the policies and not another? Thus, additional interviews with a control group were done, which further shed light on the possible reason for the exclusive focus on migrant workers in the policies. It further suggested how different groups in society are governed, which turned out to be intrinsically linked to the issue of equality and the health policy.

The WPR-approach also led me to interviews with professors, health institutions and civil society organizations (CSO) – the questions brought to light inconsistencies in the policy which could possibly be explained by these actors.

Thus, I see grounded theory and WPR approach as intrinsically linked, both being exploratory and open in nature, which has had a profound effect upon my study.

3.3 Definition of migrant workers

"Liudong renkou", the floating population, is seemingly as floating in definition as the phenomenon it describes. In broad terms, a floater is a person who does not hold a household resident permit (hukou) from the place in which he or she works or resides (Hesketh et al., 2008). The floating population is generally used to define migrant workers, but can strictly speaking be divided into three groups: migrant workers with rural hukou, professionals with another city hukou, and other nationals residing and working in China (Li Q, 2004). However, rural migrant workers are also divided into three different categories: urbanized migrants with a rather high salary, stable job and property in the city; seasonal migrants who work as farmers during the summer and autumn but go to cities to increase their income during winter and spring; and floating migrants whose jobs are unstable, and who primarily come to cities to work. The last group is the largest (Lin N, 2013).

Not only class and employment but also age and gender shape the migrant experience. In China, most migrant workers (about two thirds) are males (Li, 2008). The average age is 28 years, and the majority are under 40 years of age (Lin, L 2013). The average migrant worker has finished the lower middle school (Xinhuanet, 2013). Professions migrant workers generally engage in are construction work, manufacturing, service sector employments, cleaning, employed household work and small scale commerce (Li, 2008).

The new policy (NHFPC, 2013a/2013b) uses the vague term *liudong renkou* invariably throughout the documents. However, attributes such as young age, length of stay in the cities over 6 months, poor housing and working conditions, and the fact that the policy is an effort to equalize

the gap between rural and urban citizen and urbanize rural people (NHFPC, 2013a), suggest that the target group is "floating migrant workers", which this research also takes as the working definition.

The policy does not openly specify a targeted gender, but certain action plans are directed at women, such as pregnancy and maternal care (NHFPC, 2013b), whereas others can be applied to both genders. Therefore, I have interviewed eight women and eight men with rural *hukou* from different parts in China, aged from 19 to 40, who engaged in different "migrant" jobs¹. The average education level was lower middle school, and they had all been in Beijing for more than 6 months. The time of stay ranged from one to ten years. Some had children and/or spouses left in rural areas, others had the whole family in Beijing. Eight of the interviewees had children.

3.4 Definition of comparative group – professional migrants

For the purpose of comparison, I interviewed a second group that falls into the sphere of the outlined "professional" floating population with city *hukou* (Li Q, 2004), in the sense that they did not have a Beijing *hukou* but resided and worked in Beijing. At the same time, they were clearly not the target of the policies, despite being "outsiders" and not attending the community basic health service centers, which made this group a great object for comparison.

They differed from migrant workers in their educational level, their profession and their *hukou*. Whereas the migrant workers interviewed had a rural *hukou*, this group came from cities in other regions. All had at least a four years of BA education from different universities in Beijing and got employment primarily in private companies in Beijing involving IT, publishing, editing, media, private banking, and digital design. The income varied between the informants, from 4000 to 10,000 RMB a month. I interviewed nine professionals: five women and four men. Three were married, and two had children. All of them rented apartments in Beijing.

In some ways, the characteristics of this group overlap with definitions of white collar workers, *bailing*. My point of departure was Sun's definition of a *bailing*: higher education, at least a college degree, non-physical work, salary on a middle class level, and not having an own company (Sun, 2006:5). However, other articles add even more criteria: having a private car and owning an apartment, and a powerful position at work, such as a manager (ifeng, 2009; Dai, 2013).

¹ Cleaners, waitresses, self-employed construction workers, employed and self-employed carpenters, a bread vendor, a part-time jewelery vendor/part-time tailor, one on unpaid maternity leave.

I loosely define the group I have studied as "professional migrants" with certain affinities with *bailing*, especially in terms of salary and education.

3.5 Fieldwork

Since the focus of my thesis is not only to look at intentions in the policy but also to analyze the responses among migrants, the second part of my research consists of fieldwork. The field of my study is Beijing, with a particular focus on Chaoyang and Fengtai districts. The reason for choosing Beijing as a field site is related to the health policy, which lists Beijing as one of 40 cities in China that will conduct pilot projects targeting migrant health to be initiated in spring 2014.

The situation of migrant workers is different in different areas in China, which may contribute to local variation. Beijing is interesting since Beijing's *hukou* policies have been more restrictive than in other areas (Wallis, 2013:39). The composition of migrant workers in Beijing and the type of professions they engage in are also different from other areas. The main employment for female migrant workers in northern areas is generally domestic work and low-paid service sector (Wallis, 2013:190). Finally, Beijing is usually pressured to implement central-level policies and set a good example for other areas (IP2, 26th Feb, 2014), which makes Beijing a site in which the policies are very likely to have some effect. Other reasons for choosing Beijing include the reportedly increasing number of migrant workers residing in Beijing – 7 million, or 35% of the total population (Lin L, 2013)².

I have conducted semi-structured interviews with different actors, including three CSO's working with migrant workers' issues; two Community Health Service Centers in the designated pilot project areas; three professors specializing in migrant workers and / or health; 9 professional migrants, and 16 migrant workers.

Since a semi-structured way of interviewing includes informality, i.e. using non-standardized questions, it has been criticized for potentially affecting the answer (Bryman, 2008: 210). However, if you are interested in how informants themselves define problems, a standardized set of questions runs the danger of missing emic views, which was of great importance in my research.

² In 2012, it was estimated that 236 million Chinese rural residents were migrants – 17% of China's entire population.

The sampling of professional migrants was initiated through a snowball process, a method where the researcher is introduced to new informants who fit the designated group by previously encountered informants (Bryman, 2008: 48). This has also had implications for my study. For example, the professional background and age tend to be similar, since introduction to closer friends is common. The age span of the group is 22-35; four informants work in web design related professions.

Eight migrant workers were sampled by a snowball process, and other sampling methods mainly consisted of "active legwork", resembling Wallis' (2013) fieldwork practices: the researcher visits places where potential informants dwell or work. I have visited restaurants, hotels, shops – venues that commonly employ migrant workers (Wallis, 2013). In addition, I walked around in poor-quality housing areas, where low-income residents and migrant workers generally live (Wang, 2004: 66). I also had the opportunity to attend a female migrant worker performance, where I met some informants.

The usage of such methods also had implications for my study; in many cases the interviews were rather short, since this direct approach also meant that people who agreed to be interviewed took some time off from their work and did not have a lot of time to spare. In addition, the direct approach violates cultural norms of "guanxi", networking (Yang, 1994), which indirectly affects the level of trust that can be established between the researcher and the interviewee. On the other hand, using the direct approach, I was able to observe the conditions and environment in which the informants dwell, which gave me a greater understanding of how the environment may contribute to preferences and answers of the informants.

Most interviews occurred once, but with some informants I had the opportunity to conduct follow-up interviews. My background as a foreign researcher put me outside native cultural boundaries, which was both and advantage and a hindrance. On the one hand, cultural codes and implied meanings might have passed me by. On the other hand, being an outsider may have given me access to information which informants could not disclose to someone they have regular encounters with. In addition, an outsider is to a greater extent allowed to ask "stupid questions", to shed light on issues which are taken for granted and can therefore be hard for a native researcher to ask about. Being an intermediate Mandarin speaker and conducting all interviews but three in Mandarin may also have affected the study. The same applies to my gender: it was more "natural" for a female researcher to touch upon subjects of reproductive health issues with female informants rather than with men.

3.6 Ethics

I clearly explained my research to my informants and did not work undercover, meaning they all were aware that they participated in a study. Furthermore, not all informants wanted to be recorded, which I respected. Sometimes recording was not possible or suitable, in which case I took notes instead. Based on the private issue of health and its intersection with politics, I ensured the participants' anonymity, and I do not publish any names.

4. Equalization of health care in China: Policies and history

4.1 History of the Chinese health-care system and health equity

Under Mao Zedong, the health of the population became a priority concern for the government. Public health care developed and the ministry of health was established in 1949 (Huang, 2013:24). Large efforts were put into leveling out the existing differences between urban and rural areas, through establishment of health care facilities in rural areas and prevention campaigns, such as vaccination and sanitation. Health care was provided by the urban *danwei*, workplace, or rural cooperative, thus tied to employment and *hukou*. It could be said that the health policies during Mao reflected the Maoist ideology of equality and a utopian vision of change in Chinese society (Huang, 2013:38). However, the Maoist system also hid inequalities and provided the urban areas with better quality health services (Cook, 2011:215).

In the 1980's, the central government withdrew as the main financier of healthcare and market based health care reforms were introduced. Local variation became more prominent due to a decentralized system where local governments are responsible for welfare and healthcare (Cook, 2011). The economic reforms, the collapse of rural cooperatives and to a large extent the urban *danwei* left a large part of the population, especially the rural population, without any health insurance and with scarce health facilities (Huang, 2013). A new health insurance scheme, the urban employee insurance, emerged in the 1990s to replace the danwei system and became legally mandatory for all urban employed workers in 1998 (Xu et al., 2011). At the same time, a strong emphasis on greater individual responsibility in the health sphere emerged and deepened during the 1990s. In general, post-Mao reforms put economy as the most important goal to pursue (Huang, 2013).

In the 2000s, media reports of health care failures and insurgence of infectious diseases such as SARS pushed the central government to acknowledge that the marketization of health care and the rise of individual costs had gone too far, and health insurance schemes were enacted for rural inhabitants, NRCMS, as well as unemployed urban inhabitants, URBMI (Cook, 2007). The SARS epidemic could also be said to put migrants as a group to the forefront as immigration patterns have implications for disease transmission (Holdaway, 2014).

Health care became a top priority in 2006, when Hu Jintao declared that every Chinese citizen should be able to enjoy basic health care continuously (Hsiao, 2008). Rural migrants were noted to face particular difficulties in the health sphere since they were frequently prevented from

participating in the UEBMI and their rural insurance only covered the health institutions in their registered county (Barber et al., 2010; Liang et al., 2013). From a larger point of view, the Hu-Wen leadership took efforts to extend distributive citizenship rights to rural inhabitants by improving social welfare (Guo, 2013:24); for instance, medical equality was promoted as the goal of the medical insurance reform (Hood, 2013). As such, citizenship became a core question within the reforms.

Yet, it is questionable whether the previous policies effectively combat health inequality in China. There are five basic health insurance schemes in China: the Urban Employee Basic Medical Insurance program (UEBMI), the New Rural Cooperate Medicine Scheme (NRCMS), Urban Resident Basic medical Insurance (URBMI), the Urban and Rural Medic Aid (URMA) aimed at the very poor (Lu et al., 2012), and the Government Employee Insurance (GEI) (Liang et al., 2013: 6). These schemes are funded differently and have different average reimbursement rates. The UEBMI is paid by the employer and the employee; the NRCMS and URBMI are funded by local governments and individuals, and URMA is funded by the central government (Malet, 2010:15).³ Although the funding of NRCMS differs between different localities, the funding pools are on average much lower and insufficient in the NRCMS, which means that actual rural reimbursement rates are also lower for rural inhabitants, whereas people participating in the UEBMI and URBMI get higher reimbursement. Examples from Beijing municipality show that the reimbursement rates for inpatient services in NRCMS, UEBMI and URBMI are 50%, 90%, and 70% respectively (Lin, 2013; Barber et al. 2010), which means that people participating in the NRCMS insurance will on average pay more out of pocket than the other two groups. According to Liang et al (2013), the national average out of pocket expense by inhabitants adhering to NRCMS is 56% whereas URBMI-insured spend 38,2%.

An ethnographic study in a rural village in Sichuan demonstrated that rural dwellers, despite the rural health insurance, still prefer not to visit the doctor in order to save money (Lora-Wainwright, 2011).

Thus, the different insurances are not equal but perpetuate the inequality which is institutionalized in the household registration system.

³ See appendix 4 for an outline of health insurance system.

The urban bias is further exemplified in the distribution and the quality of health care. Hospitals in urban centers are better equipped than their rural counterparts; sometimes health facilities are completely lacking or very poorly equipped in rural areas (Huang, 2013:67).

Furthermore, China's health institutions differ in quality and ranking. There are public hospitals, ranking from first to third level hospitals, private hospitals and primary community health service centers. The higher the rank of the hospital, the better equipped it is, with better doctors and better resources; and vice versa. In general, there are lower insurance reimbursement rates at highend hospitals, and higher reimbursement rates at the grass-root, basic service levels. In addition, reimbursement rates differ between inpatient and outpatient services and between different localities (Eggleston, 2012). In practice, utilization of basic care is encouraged and economic conditions influence the usage of high-end hospitals.

Therefore, as manifested by the different insurances, health policies up to present, despite their professed goal of equality, could be seen to perpetuate class inequalities based on household registration and urban nepotism.⁴

4.2 Equalization of Basic Health and Family Planning Services – what is the problem represented to be?

Similarly to the urban bias in the outline of health care, it is questionable whether the policy regarding Equalization of Basic Health and Family Planning services challenges rural/urban inequality. Although, in line with earlier representations of difficulties that migrant workers encounter in the health sphere, the policy initially presents the problem as distributive disparity between rural/urban inhabitants, later in the text the problem is recast as an issue of failure of migrant workers themselves to attend the services, which specifically poses a problem for health and family planning services:

"Related research shows that the usage of health and family planning basic services is *not ideal* among the floating population, which has become a weakness and a problem for health and family planning basic public services⁵"(NHFPC, 2013a).

Undoubtedly, the increased coverage of insurances is a good step forward compared to the conditions in the 1990s. But the efforts seem misdirected if inequality is perpetuated in the insurance schemes and in the different quality of health care.

The reason for migrant workers' failure to visit health care facilities is furthermore framed as an issue of education since migrant workers' "health awareness and knowledge is rather low⁶" (NHFPC, 2013a). What type of awareness and understanding is desired is not directly specified in the document. However, by looking at the actions suggested in the policy – vaccinations, pregnancy health check-ups, health education, family planning services, and contagious disease prevention – the health knowledge required is primarily linked to biomedical definitions of prevention. Biomedical views of health also intersect with the government's stress on development according to scientific principles, which have been part of China's modernization project since the 1980s (Greenhalgh etal, 2005).

In addition, the policy stresses that one must initiate health education *to raise migrants' self cultivation*⁷ in health matters (NHFPC, 2013b).

The presentation of the problem as an issue of prevention and migrant workers' lack of knowledge is not only confined to the policy; it is disseminated in the work of civil society organizations (CSO). One CSO I interviewed started to provide annual health check-ups for migrant children in suburban areas because the parents of these children have low health awareness and do not often bring their children for preventive health check-ups (IN1 24th Mar. 2014). Likewise, another CSO emphasized low awareness as a reason for female health activities:

"(...) They might think, because they are from the countryside, that they do not need any check-ups before they give birth. They will not find it very important, either. We felt that they needed some knowledge and awareness in this sphere" (IN2 19th Mar. 2014).

6健康意识薄弱 (NHFPC, 2013a)

⁵ 相关调查研究表明,流动人口利用卫生和计生基本公共服务状况并不理想,成为卫生和计划生育基本公共服务的难点和薄弱环节

The lack of knowledge is further emphasized by one of the professors:

"There are several reasons why [community health service centers] are not used. But one reason is because migrant workers' health awareness and knowledge is very low. They think that [the services of community health centers] are useless" (IP1, 14th Mar. 2014).

The emphasis on individual shortcomings and education to improve self-cultivation indicates that migrants are thought to lack the skills needed for self-cultivation. Thus intervention is needed in order to adjust and enforce migrant workers' ability to rule themselves, improving their "self-governing". In this pursuit, the government is also joined by civil society actors, which resembles the premises of social management, where social groups or institutions are enlisted to govern themselves and others in line with the interests of the state (Pieke, 2012).

Secondly, inequality in the health sphere is assumed to particularly reside in preventive health. The view of prevention is limited to bio-medicine; vaccination, contagious disease prevention, health education, and maternal health check-ups (NHFPC, 2013b). There are a number of services that specifically or indirectly target women – indirectly, since women are seen to bear the responsibility for child care in Chinese society and have been the primary targets during family planning campaigns (Greenhalgh et al., 2005). However, contagious disease prevention and health education could also be applied to men.

Other ways to look at prevention, such as social environment and working conditions, are not addressed. Nor is medical curative health care part of the equalization efforts, which is noteworthy, since among my migrant worker informants, it was clear that most chose not to go to the doctor because of price issues, lack of urban insurance, or problems with getting any kind of reimbursement with their NRCMS. For more serious illnesses or giving birth, they preferred to go home because of the NRCMS insurance coverage and economic considerations (All IM Feb-April, 2014).

One reason for not addressing the problem of curative care in the policy could be the fact that migrant workers leave the cities when they get seriously ill. In a sense, the problem is then thought of as no longer the "problem of the cities", as a professor explained:

"(...) If they do get sick for a long time, they go home, they will not stay in the cities – they are supposed to earn money, not spend it on health care. So the people who stay here are very healthy. Our research in 2003 showed that migrant workers in the cities fall into the category of selectively healthy, which means that if I am healthy, I stay, if I am unhealthy, I go" (IP1, 14th Mar. 2014).

This mode of thinking also suggests that improving the long term welfare conditions in terms of health for migrant workers in urban areas is not prioritized.

4.3 An equalized institution? Community Basic Health Service centers

Equalization of basic health services also begs the question of which health institution is supposed to be equalized, which the policy does not mention. Yet, a professor who was part of a designated team investigating the policy confirmed that Community Basic Health Service centers are the targeted institution (IP1, 14th March, 2014). The services which are provided at Community Basic Health Service centers also fall in line with the services emphasized in the policy. A Community Basic Health Service Center has two major functions: health information and medical check-ups as well as basic cure for minor ailments. Health information and check-ups include family planning, maternal care, and contagious and chronic disease prevention. The centers also set up health archives. Both urban and rural residents are welcome to use these facilities (Beijing Community Services Network, 2011) and some types of preventive facilities are free, such as vaccination (IP1, 14th March, 2014).

The assumption is therefore that there is a particular kind of inequality between urbanites and rural migrants in their access to, and usage of, these services. But is this really a question of equality?

I was informed during a visit to two different Community Health Service centers in the designated pilot project areas, Chaoyang and Fengtai, that local *hukou* residents, primarily old people, outnumber migrant workers and other groups among their visitors (IC1,4th Mar. 2014; IC,5th Mar. 2014). A scholar investigating these issues confirmed this fact (IP1,14th Mar. 2014). However, the specified age category of migrant workers that the policy targets is "young", which is based on the argument that this is the average age of rural migrants in cities (NHFPC, 2013a). The fact that only old, predominantly Beijing *hukou* holders have used these services up to present begs the question of why "young" rural migrants belong to the targeted group and not other age-groups of Beijing *hukou* holders or other city *hukou* holders residing in Beijing, who are also distinctly missing from the services. This is another issue which is left unproblematic in the policy, as their absence, in the line of reasoning in the policy, would mean that these groups also have "low health awareness". Why are they not targeted? This is a question I will bring up in chapter five.

⁸ I visited clinics that were mentioned in relation to the policy in news articles, see (Li 2013; Hu, 2013).

4.4 Managing migrants through health institutions?

The second issue which is addressed in the policy concerns migrant workers as a problem of governance:

"While the big movement of people promotes economic growth, minimizes disparities between areas, and changes the population distribution pattern, it has also put severe pressure on public services and created a challenge for the government in terms of social management" (NHFPC 2013a)⁹.

The actions suggested in the policy to solve the specific problem of social management include the exploration of a new migrant service management system and the establishment of health archives of the migrant worker population (NHFPC, 2013a).

Health archives can be seen as a type of disease prevention on a large scale – from the perspective of society – as it is explained on the homepage of Beijing Community Health Service centers. Through health archives, one can better analyze risk factors and risk populations in terms of infectious or chronic diseases (2011). However, health archives could also lend themselves to population control.

China has already an established medical record system (*bingli*), but until recently these records covered only specific diseases and did not include personal medical records with a complete case history. Hospitals and clinics maintain these medical records, and the records have only recently been digitized (Zhong et al., 2010). Yet, the new health archives are complementary and more extensive than the medical records. They contain medical information about a person's family, about received health education, chronic diseases, family planning and the number of times a person received a public health service. At present the only health institution that has set up this type of new health archive is Community Health Service centers (Zhong et al., 2010), and they are presently kept only for urban residents and are initiated on a voluntary basis (Beijing Community Services Network, 2011). However, the policy emphasizes that these records should be set up especially for migrant workers (NHFPC, 2013a), undermining the voluntary basis. This can be seen as an effort to initiate disease prevention on a larger, societal scale. In addition, the archives could lend themselves effectively to population management and control.

⁹ 大规模的人口迁移在推动经济增长、缩小地区差距、改变人口分布格局的同时,对政府公共服务和社会管理带来了巨大压力和严峻挑战

The enforcement of health records in line with the call for better social management indicates that the Community Health Service centers are possibly envisioned as an institution for both population control and welfare and exemplifies Feng's (2011) statement that social management in China is increasingly envisioned as improved service delivery.

4.5 Discussion

The strong focus on migrant workers' lack of knowledge and awareness makes this group appear to be unable to take care of themselves and their health, thereby posing a threat to the urban society. Biomedical knowledge is the preferred knowledge promoted in the policy. This understanding of health is in line with the government's developmental efforts, which are based on science.

This presentation of migrant workers promotes the view of this group as irresponsible and in need of guidance; it legitimizes intervention. These types of representations portray the group as a risk and may be a way to instill order and to control groups which do not follow prescribed behavior (Bacchi, 2009:xx). The intention of the policy is also to make things happen – a call for other actors to join in instilling normative values among migrant workers. The professed discontent of low visiting rates at basic health care institutions and the framing of the question as a lack of sufficient knowledge indicate that institutions are assumed to play a vital role in correcting faulty behavior, instilling adherence to norms and improving self-governing. This type of technique is in line with social management, where groups or institutions safeguard the interests of the state, and seem to already have been adopted by the civil society organizations I interviewed.

In line with Kelly (2013), both social order and social justice discourses seem to inform the policy, as indicated by the calls for both equalization and social management. In terms of equalization, the policy could be interpreted as an effort to promote predictable behavior through education and self-governing which at the same time strengthens the institutional control over migrant workers. As such, the policy should maybe not be taken as a sign that migrant workers receive the same treatment and rights as the local population; instead, they constitute a targeted risk group which needs more efficient control to instill social order.

In terms of citizenship, distributive rights in the health sphere are not extended; to stress knowledge as a means of prevention lays the responsibility for accessing this health institution on migrant workers themselves. The policy does not consider other structural inequalities linked to migration that might impede this group's access to preventive care units. Instead, the policy focuses on social membership values of citizenship which, again, seems to be integrated with the goal of

social order, enhancing self-governing and thereby predictable ways of behavior. Therefore, goals of social stability are seemingly prioritized, despite the professed goals of equalization.

5. Migrant workers and professional migrants' perception of prevention

The policy stresses the lack of awareness and knowledge about biomedical preventive health behavior among the migrant population. However, there are also other possible ways to view the question; for instance, lack of awareness could relate to a different definition of what constitutes "prevention". Do migrant workers define prevention differently from a biomedical outline? Behavior may also be related to environmental influences and working conditions. Is the policy too detached from real life concerns to generate sanctioned responses from the intended group? Or is this type of services simply not in migrant workers' interests?

This section explores migrant workers' attitudes to prevention. I also look at whether migrant workers' knowledge in these matters is different from that of professional migrants, who reportedly show low attendance at the designated health institutions but are not targeted by the policies. Are there any reasons for this?

The previous chapter displayed the focus on vaccinations, mother-and-child preventive care and prevention of contagious diseases; services which are available at Community Basic Health Service Centers consisting of preventive medical check-ups, education and information. Likewise, I focus on these spheres. In addition, I discuss alternative definitions of prevention suggested by informants themselves.

5.1 Vaccination, maternal and prenatal care

In terms of awareness of child vaccination, female migrant workers professed knowledge of vaccinations and vaccinated their children. Despite having given birth in rural areas, the women with children in Beijing actively sought clinics where vaccinations could be provided (IM4 8th Mar. 2014; IM3 5th March, second interview, 2014; IM6 4th April, 2014). Thus, in terms of vaccination, there seems to be no particular "lack of awareness".

Other actors in society, such as Community Basic Health Centers, further emphasize that vaccinations are already the most popular service among migrant workers (IC1 5th Mar 2014; IC2 4th Mar 2014). Likewise, a professor who conducted investigative work to inform the policy also confirmed the popularity of vaccinations among migrant workers (IP1 14th Mar. 2014).

In terms of prenatal care, such as pregnancy check-ups, there were more diverse answers in terms of whether these services had been used. Some had used such services, others had not. Price issues seemed to be a major reason for not using pregnancy check-ups:

"But we picked something that was relatively cheap, you know. We didn't pick the ones that were more expensive, like the ones including pre-natal health check-ups. But I have heard that some really can cost a lot" (IM6, 4th April 2014).

I was informed by migrant workers, professional migrants and representatives from CSOs alike that giving birth in Beijing is an expensive business. The total cost includes prenatal check-ups and could reach 10.000 to 20.000 yuan (IM6 4th April 2014; IN2, 19th Mar, 2014; IB5 3rd Apr, 2014). However, one CSO representative claimed that the problem of high birth costs is essentially solved due to the new birth insurance (IN2 19th Mar, 2014).

The birth insurance was expanded in 2012 to include all employed people, regardless of *hukou*. It was previously only given to employees of urban enterprises and to urban state employees (Ministry of Human resources and Social security, 2012). Yet, not one of my female migrant worker informants had heard of such insurance or heard of their friends using it. Instead, birth costs had been paid out of the pocket. In comparison, professional migrants and friends of theirs who had given birth recently had this insurance. This could be explained by the fact that it is provided by the employer and therefore depends on the type of employer you have.

Using a Beijing hospital during pregnancy also has other benefits, such as maternal and prenatal education. Whereas professional migrants have heard about these services, migrant workers did not know about these services. Female migrant workers were more likely to say that they had received information from peers or family or read things themselves.

Thus, in a sense, awareness of prenatal and maternal issues is instilled at health institutions, and to enter these, to receive not only treatment but "education", economic resources are needed.

5.2 Preventive medical check-ups

Most migrant workers, female and male alike, with a few exceptions, have never had a medical health check-up for preventive reasons, to check for contagious or chronic diseases. In the interviews, two reasons for this emerge: one is related to the fact that informants only go for check-ups when they feel bad. The following example is a very typical example of the answers I received:

X: I have not gone specifically just for a health check-up. I only go if I feel bad or if I feel that something is not normal. Then, if I have a health check-up and they notice something is wrong, I will go to a hospital. There will not be any specific health check-ups arranged by the company.

C: How about other companies?

X: Well, yes, bigger companies might have something. But I work for such a small company, not more than 10 people, so they will not pay attention to those things, the company will not invite any specialist to come and talk about these things

C: Do you think it is important with health check-ups?

X: Well, it depends how you feel. If you feel bad, then it is important of course. (IM7, 4th Apr.2014)

The emphasis on feeling and personal judgment as a prerequisite for check-ups was also something that was emphasized:

"(...) But most people, they just follow their instinct and feeling about their health. If they feel queasy, don't want to eat this, can't eat that, that is when they go to the hospital and have some examination. But I, since I have never had any problems with food and can eat whatever, I have understood I am very healthy. I have never had any problems with my heart, or such. So, if I feel ill, then I will go. (...) So, through this easy thing, by following the feeling, you can just understand how you are, if you are ill or not. You don't need health check-ups to know this" (IM5, 4th April, 2014).

Thus, as the interviews indicate, medical check-ups are not thought of as prevention because they are used in relation to curative care, when you already feel sick.

Migrant workers also stressed the fact that they were healthy and did not really have to consider health matters (IM5, 4th April 2014; IM10, 8th Mar, 2014; IM3, 19th March, 2014; IM9, 4th Apr, 2014). Given their age, this answer is statistically not very surprising. Some of the professional migrants interviewed also stressed that prevention was not really so important to them: "(...) You have asked two people who have not the slightest interest in health matters at any level, ha ha" (IB3, 27th Feb 2014).

The second reason which emerged as important was the role of the employer in relation to preventive health check-ups and contagious disease prevention. In the Occupational Disease Prevention and Control Act, employers are required to provide employees whose work exposes them to health hazards with health check-ups and health information (M.o.H, 2011). Likewise, a policy concerning occupational health surveillance stipulates that the employer has the responsibility to safeguard workers from hazardous factors, giving them annual health check-ups. Health check-ups before entering an employment where the worker is subjected to hazardous working environment is also a prerequisite (M.o.H, 2007). The Labor Law stipulates that employers are only required to provide underage workers and people having hazardous jobs with regular physical check-ups (Ministry of Commerce, 1994). Because these laws primarily concern potentially hazardous industries, migrant workers are indirectly targeted, since they often engage in such work.

For most migrant workers I interviewed in Beijing, the employer had never provided any health check-ups. In comparison, most professional migrants went on annual or regular examinations provided by the employer, and it was common that every time they switched a job, they had to provide a health certificate upon entering the company. The regular check-ups provided by the employer were said to be free, whereas the health examination needed upon entering employment was paid out of the pocket (IB4, 22nd Mar. 2014; IB3, second interview 4th Mar. 2014).

At the same time, none of the laws require the employer to provide check-ups. However, article 76 in the Labor Law stipulates that the employer is required to provide the laborer with "better welfare treatment" (Ministry of Commerce, 1994). Likewise, some professional migrants thought of the practices as welfare and something to value:

"(...) It is a type of welfare. But not all employers provide this. In China, what I do for living, this type of profession, is really good and developed, so the welfare may be better where I work than in other places" (IB4, 22nd Mar. 2014).

This group of professional migrants generally spoke of health and prevention as very important and emphasized the importance of taking responsibility for their health themselves in other ways, such as through regular exercise, and monitoring their nutritional intake. In fact, in contrast to migrant workers, many professed that medical check-ups could be seen as a type of prevention:

"(...) I have changed work 3 times and every time you start a new company you have to provide a health examination paper. But also when you work, there is a yearly examination so I have also had that. I think it is good, you can make sure you will not get sick. That is what I think" (IB5, 3rd Apr. 2014).

No one questioned this employment practice, but simply accepted it.

Five of the professional migrants were in general not interested in health prevention issues. They said they would never have such check-ups by themselves, unless they felt bad.

C: "Would you have used it [medical preventive health check-ups] yourself [if the employer had not provided it]?"

X: "No, I would not go if the employer had not provided it. I only go if I feel sick" (IB3, second interview, 4th Mar. 2014)

In this respect, half of the professional migrants and migrant workers similarly viewed medical check-ups as a practice you engage in when you feel bad. The other group of professional migrants already saw medical check-ups as a natural part of life, something that you do because it is beneficial in the long run, a type of prevention and welfare provided by the employer.

The professional migrants that thought medical prevention was beneficial were more likely to talk about prevention from the perspective of bio-medicine and science. Biomedical knowledge is also the preferred definition in the policy. The way this group spoke about health facilities and health in general was more detailed, which could also be thought to manifest a more active and "responsible" approach related to health matters. In fact, individual responsibility for one's own health was also stressed in this group (IB6, 22nd Mar, 2014; IB2, 25th Mar 2014; IB4, 22nd March, 2014; IB5, 3rd Apr. 2014). This fact is underlined by the detailed descriptions of how to prevent illness:

"I wash my hands with alcohol to get rid of germs and I take vitamins every day, but I don't know if it is useful or not, and I also take the thing for the bone, like calcium, I think it is important to prevent illness from an early state. And I drink a lot of water every day because it lowers the chances of kidney stones. I also do a bit of exercise, but I don't know if that is so useful now with the pollution. I go to the gym once a week, it is good for the blood circulation, and I do health check-ups once a year" (IB2, 25th Mar. 2014).

The detailed knowledge in these matters could of course be thought to derive from school education. However, even if professional and migrant workers alike stressed that they had received some type of health education in school, most could not really specify the exact content – it ranged from washing hands to how to prevent influenza. In general, they stated that they must have been very brief courses, since many could not remember much. The different regions and levels of education did not make a difference, since many professional migrants claimed to have had no health education in high school or university. Instead, several professional migrants professed to be active themselves in terms of knowledge intake in these matters.

Migrant workers and professional migrants alike were not aware of the policy or the pilot projects. Below follows a typical answer:

C: "Have you heard about the equalization of basic health care services, a pilot project which is starting in Chaoyang district?"

AY: "What? No" (IM1, 27th Feb.2014).

Not knowing about the policy also suggests that migrant workers cannot be aware of their public image of having low health awareness. Therefore, one might ask how migrant workers can internalize norms of biomedical prevention and follow prescribed behavior if they do not know about them?

On the other hand, the policy has already established that migrant workers by themselves have not acquired the knowledge and behavior required for life in the cities and have failed in self-governing and self-cultivation. Therefore, intervention by other actors is necessary. Interviews with professional migrants suggest that by regular health examinations the employer might instill norms

for this group, whereas migrant workers fall outside this form of control. Therefore other institutions are enlisted to correct their behavior.

5.3 Alternative ways of looking at prevention

There were other preventive strategies that migrant workers thought of as more beneficial for preserving health and preventing illness. Food was one of such strategies:

"(...) The only thing you have to think about is what you eat and that it is nutritious (...)" (IM5, 4th April, 2014).

"I like to read books, to know which fruit to eat, what veggies and so on, so I check books very often and do not really go for health check-ups. I just check what to eat for what illness and then I eat that" (IM6, 4th April, 2014).

The healing properties of food were further exemplified when I had been sick for a week and visited one of my informants for a second time. Here is a quote from my diary:

"I have been sick, and when I visit the restaurant, XY hears that I sound sick. She tells me to start eating meat; it is not good to be a vegetarian. And she tells me to drink more hot water. I should not eat "hot" food now. 10 Like oranges, then I will get worse. She asks what I eat for breakfast and is not happy when she hears I eat bread and coffee. I need to drink porridge and eat a boiled egg. To eat a lot for breakfast is the best way to preserve health – I should know, isn't my topic about health, she asks." (IM2, 18th Mar. 2014, second interview).

Intake of food as a preventive health measure has a long history in China. Eating and medicine are not radically distinct concepts, and dietary regimes have long been used to achieve a healthy body and soul (Farquar, 2002: 47). The informants' knowledge and use of such measures instead of biomedical preventive measures resonates with a cultural understanding of health. Food and health programs are also frequently broadcast on TV, but they include both cultural health/food knowledge and biomedical definitions of healthy food (CCTV2, Jiankang zaobanche; CCTV 10 Jiankang zhilu).

Furthermore, the environment was mentioned as crucial for a person's general health status. Fresh air, a quiet pace of life and fresh food were emphasized as beneficial, although it was

The traditional Chinese medical system classifies food according to its different properties and effect on the body; hot food heats the body, cold food has cooling effects. Hot/cold do not refer to the actual temperature of the food but to properties associated with the food (Chen, 2013:23).

acknowledged that none of these factors could be found in cities, only in rural areas (IM2, first interview, 3rd Mar, 2014). Environmental constraints on the kind of prevention you could engage in were also acknowledged. One informant stressed that given the living conditions, it was just not realistic to shower every day – the public showers in the area were located in the streets and only provided cold water (IM5, 4th Apr, 2014). In addition, other informants stressed that exercise was not realistic either due to their type of work, such as manual labor (IM8, IM9, 4thApr, 2014). Thus, many felt that what they could realistically do was to pay attention to food. Therefore, it could be argued that food as a matter of prevention is valued because it does not involve as many other economic and environmental constraints. In addition, it is already a valued traditional cultural practice.

In terms of how people acquired knowledge about health prevention, migrant workers stated that they read books, watched TV, checked things online, or learned from people around them. However, many professed that knowledge was usually related to illness; once ill, you start to look for information to cure it and also learn something in the process (IM7, 4th Apr, 2014; IM8, IM9, 4th Apr, 2014). Similarly, watching health programs on TV was not intentional but something my informants said they might stumble upon.

5.4 Summary and discussion

It was more common that migrant workers preferred curative services to preventive check-ups if they were to go to a medical institution. Prevention was instead thought of as something that takes place outside medical institutions, such as paying attention to what you eat, the environment, and your living conditions. Exceptions to this rule include the use of vaccinations by migrant children and the acknowledged utility of pregnancy check-ups. However, it is also very likely that price issues influence the usage of these services. It does not mean, however, that migrant workers are not aware of the risks, but rather that constraints cause them to abstain from using these services.

Migrant workers take into account economic considerations, environmental constraints such as poor facilities, age, and cultural understandings of health when acting on potential health risks. This also leads to behaviors that might not follow governmental definitions of health and causes this group to be portrayed as a "risk-group" in health matters. Values informing self-governing are defined by the policy as linked to biomedical values of prevention, whereas migrant workers, apart from vaccination, look at prevention from the nutritional and environmental perspectives. Thus, the values of what constitutes preventive "self-cultivation" are not shared, and in a sense, it would be hard to share such values as the environment puts constraints on what can possibly be valued.

The rhetoric surrounding self-cultivation centers on the potential for social mobility for all groups, where migrant workers are not victims but need to cultivate themselves (Sun et al., 2013). But, as my research shows, conditions also need to be conducive to the promoted type of self-cultivation. As Hood points out, medical equality will never be reached if one does not address social, political and economic factors of illness and health (Hood, 2013).

In addition, my research shows that certain groups may be helped by other institutions in society to inculcate the "right values." For instance, professional migrants have their annual health check-up provided by the employer, which could potentially induce this group to become more active in terms of health matters since it serves as a reminder of risks. Interestingly, an annual health check-up could also be thought to mitigate health risks and render the subjects less active. My results show both these outcomes. Yet, what I would like to emphasis is the unequal amount of "initial support" that is provided to these groups, which affects their ability to develop desired preventive behaviors. Thus, the institutional regularity of health check-ups provided by the employer already displays the unequal starting points for different sectors of the Chinese society. In a sense, it could be argued that migrant workers face a double punishment, since they are targeted by the policy because they are perceived to have low awareness of health, constitute a risk and therefore need directions. At the same time, it is virtually impossible to live up to these norms due to structural inequalities in society.

Furthermore, citizenship theories discuss the undermined role of the state and the increasing prominence of the market and international actors in the redefinition of citizenship and distribution of social rights and social membership dimensions of citizenship. In China, my research indicates that this can be true for groups with urban *hukou* coming to Beijing from other parts of the country, as their affiliation to good employers determines their access to health care. Beijing urban citizenship is in a sense distributed by private employers to groups which have market potentiality, and the values of health prevention, which partly define social membership, are nurtured through employment mechanisms. However, professional migrants could be seen as already privileged in comparison to migrant workers, since they have an urban *hukou* and thereby better access to education and means to upward mobility. Thus, market forces may obviate the necessity of having a Beijing *hukou* to be able to obtain distributive and social benefits in Beijing, but the role of the state is still more important, since the *hukou* division sets the preconditions for the market to serve as a distributor of goods and social membership.

6. Conclusion

In the policy, the equalization of basic health services refers mainly to preventive measures within one specific medical institution and to the provision of medical education. Preventive medical services, such as contagious disease check-ups and pregnancy check-ups, require money, time and a disposition which values preventive care. In the policy, it is the disposition which is mainly targeted; values are nurtured through education. The emphasis on education and values also encourages self-cultivation, which places a lot of responsibility on the individual. It is taken for granted that people act on their knowledge, whereas other constraints are largely not discussed. Thus, even if education is useful, it is questionable whether migrant workers will be able to act on the knowledge acquired due to other structural impediments.

The shortcoming of this particular outline is that it focuses on *migrants as a group* and disregards *migration as a process* (Holdaway, 2014). As my interviews demonstrate, the "problem" at present is structural impediments primarily caused by migration and not inherent in migrant workers personally. They have poor sanitation, bad housing, lower salaries, different working conditions from other groups, limited access to health care – in other words, the environment influences their priorities regarding prevention. The "equalization" of basic health care, as it is envisioned by the policy, could be seen as a way to maintain urban exclusiveness, not the opposite. Far from improving the urban environment in which migrant workers dwell, the policy emphasizes the migrant workers' own shortcomings.

This approach to equalization of basic health care in the policy also has implications for how citizenship is viewed. Distributive rights are thought to depend on the *agents themselves*, in that knowledge is primarily required to access these medical institutions. The relationship promoted between polity and citizen is consistent with the neoliberal project (Ong, 2006), where the citizen makes his or her own destiny under the framework provided by the state.

At the same time, the social membership dimension of citizenship – membership through values – is emphasized in the policy. The objective is for migrant workers to conform to standards of conduct and values of prevention, which other groups in the cities are thought to have already. As such, tools for the attainment of social membership are promoted in the policy. However, the definition of citizenship is not changed, as it preserves an urban-biased definition of citizenship, as previously noticed by Solinger (1999).

Therefore, much wider improvements need to be considered before one can call this project "equalization". Instead, the value of such welfare reforms could be what Kelly (2013) describes as a social order discourse in policy documents, where stability is in fact prioritized over equality.

Health issues intersect with 'social management', where public health institutions and civil society actors are enlisted in the practice of governing to control migrant workers. Welfare policies then become a way to enhance social stability and social order, not in the conventional meaning of appearing public discontent but as a way to manage the floating population of migrant workers.

The social-order discourse can also explain why other "floaters", such as non-Beijing professionals, are not targeted by the policy. Using insights from governmentality theory, we can see that there is a great difference in how these different groups are governed in Beijing, which can partly explain the emphasis on migrant workers in the policy.

In general, in Beijing, governing in health matters is enacted through employers, medical institutions, media, self-governing, policies and civil society organizations. Whereas well educated non-Beijing professionals are provided with annual preventive health check-ups by their employers, the employment of migrant workers is more precarious and in most cases lacks these functions. Thus, in a sense, migrant workers partly fall outside the sphere of institutional governing since employers do not enforce certain regulations, and medical institutions are not visited.

In addition, migrant workers may not share the specified types of health values required for self-governing. In comparisons, professionals constantly encounter values and norms of prevention through institutions and particularly at their work place, and they may be more likely to comply with such norms, even if some at the outset might be as uninterested in biomedical prevention as migrant workers. Thus, professional migrants are in fact *governed more tightly* than migrant workers. On the contrary, in matters of governing, or the lack of such, migrant workers could be perceived as a *social risk*.

The importance of institutions for instilling values further raises the question of self-governing. It has been argued that behaviors and values involved in neoliberal self-governing in China have largely been directed towards the middle class due to its economic position in society, thereby emphasizing an economic prerequisite for developing such values (Hai, 2013). However, my example also sheds light on the importance of affiliations to institutions for the development of values related to self-governing; the economic prerequisite in terms of salary is seemingly not enough for the development of preventive awareness among professional migrants, it is enforced through private and public institutions.

This research further raises issues concerning the role of social management as a governing technique for a state-society relationship. With respect to health care in Beijing, my research tentatively suggests that the liberty which institutions and CSOs can pursue to follow their own

agendas are limited. Instead, they act as distributors and facilitators of state affairs. The relationship between the state and society therefore seems to follow the outline of a corporatist state, and in line with Pieke's suggestion, the government seems to reassert itself through institutions.

Furthermore, the role of the employer as a welfare provider participating in "social management" and instilling normative ways of conduct in Chinese society is another interesting point for future research. What does it say about state-society relationship? It is further of interest to explore the employers' attitudes to health check-ups, the implications of health check-ups for job applicants suffering from chronic diseases, and the possible resistance towards this practice among employees.

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Interviews

<u>Interviews with Community Basic Health Service centers</u>

IC1 Nurse, Community Basic Health Service Center, Chaoyang, 5th March 2014. Notes taken during interview

IC2 Administration Office, Community Basic Health Service Center, Fengtai, 4th March 2014. Notes taken during interview

Interviews with migrant workers

IM1 Interview with female migrant worker. Cleaner. 36 years. From Shandong. Married. Two daughters. 27Th Feb. 2014. Notes taken during the interview.

IM2 Interview with female migrant worker. Waitress. 35 years. Two children, 13 and 7. Married. From Sichuan. First interview 3 March, second 18 March. Notes taken during interview.

IM3 Interview with female migrant worker. Tailor/Laundry shop/Jewelry saleswoman. 35 years. A ten year old son. Married. From Henan. First interview, 19th February. Second interview, 5th March. Third Interview, 17th March 2014. Notes taken during interviews.

IM4 Interview with female migrant worker. From Hebei. 9 months year old son, 2 older daughters. 39. Married. On "Maternity leave"/ In between employment. 8Th march 2014, Recorded Interview.

IM5 interview with male migrant worker. From Jilin. 36 years old. No children. Self-employed construction worker. 4Th April, 2014. Recorded Interview.

IM6 Interview with female migrant worker. From Hebei. 34 years old. Cleaner. Married. 2 children. 4 th April 2014. Recorded Interview.

IM7 Interview with male migrant worker. From Hebei. 29 years old. Works for an installation company. 4Th of april 2014. Recorded interview.

IM8 Interview with male migrant worker. From Hebei. 22 years. Single. Works for a small furniture company. 4Th of april 2014. Recorded interview.

IM9 Interview with male migrant worker. Single.26 years From Shandong. Works on and off for a small furniture company. 4Th of april 2014. Recorded interview.

IM10 Interview with male migrant worker. 28 years. From Hebei. Works on and off for a small furniture company. One girlfriend, One son. 8Th march. Recorded Interview.

IM11 Interview with female migrant worker. Sells bread on the street. From rural Chongqing. Married. 2 grown up daughters. 40 years. 4Th March. Notes taken during interview.

Interviews with professional migrants/bailing

IB1 Interview with male professional "migrant" / bailing. 25 years. Single. From Shaanxi. Graphic Designer for a company. March 2nd 2014 Notes taken during interview.

IB2 Interview with female professional "migrant"/bailing. 25 years. Boyfriend. From Inner Mongolia. English teacher but in between jobs. Just finished her studies in international law. March 25th 2014. Recorded Interview.

IB3 Interview with female professional "migrant"/bailing. Graphic designer for a company. Married. From Shaanxi. First interview 27th Feb. second 4th March 2014. Recorded interview 1 and Notes taken during interview 2.

IB4 Interview with female professional "migrant"/bailing. 25 years. Single. Works as a personal economic adviser at a Bank. From Xinjiang. 22Nd of March, 2014. Recorded Interview.

IB5 Interview with female professional "migrant"/bailing. 29 years. Married. One child. Work as web editor for a private company. Interview on the phone. 3rd April, 2014. Recorded interview.

IB6 Interview with male professional "migrant"/bailing. From Xinjiang. Single. 22 years. Works for an IT company. 22Nd of March, 2014. Recorded Interview.

<u>Interviews with CSOs – civil society organizations</u>

IN1 Interview with CSOx executive director. 24Th March 2014. Notes taken during interview.

IN2 Interview with CSOx executive director. 19th March 2014. Recorded interview.

Interviews with Professors

IP1 Interview with professor at Beijing University, Public Health Department, delegate at People's National Congress and part of a designated research team concerning the "Equalization of Basic Health and Family Planning for migrants" policy. Mar. 14th 2014. Recorded interview.

IP2 Interview with professor at Beijing University, Social Science department, focuses on migration studies. Feb 26th 2014. Notes taken during the interview

The equalization of basic health and family planning services for the floating population (2013a) 流动人口卫生和计划生育基本公共服务均等化试点工作方案》解读

中华人民共和国国家卫生和计划生育委员会 2013-12-19

一、开展流动人口卫生计生基本公共服务均等化试点工作的重要意义

十八届三中全会和国家基本公共服务体系"十二五"规划对推进基本公共服务均等化提出了目标和要求,卫生和计划生育基本公共服务均等化是其中的重要组成部分。当前,我国流动人口总量持续增加,到 2012 年流动人口有 2.36 亿人,已达到总人口的 1/6。大规模的人口迁移在推动经济增长、缩小地区差距、改变 人口分布格局的同时,对政府公共服务和社会管理带来了巨大压力和严峻挑战。相关调查研究表明,流动人口利用卫生和计生基本公共服务状况并不理想,成为卫生 和计划生育基本公共服务的难点和薄弱环节。开展流动人口卫生和计划生育基本公共服务均等化试点工作是国家卫生计生委贯彻落实党的十八届三中全会精神的重要 举措。推进流动人口卫生计生基本公共服务均等化,是推进农业转移人口市民化、促进城乡一体化发展的必然要求,是转变政府职能、创新社会治理体制的内在要 求,是加强卫生计生服务管理、提高全民健康水平的应有之义。

二、试点工作的背景

2009年,原卫生部、财政部、原国家人口计生委印发了关于促进基本公共服务逐步均等化的意见,提出了基本公共卫生服务逐步均等化的工作目标和主要任务,要求到2020年基本公共卫生服务逐步均等化的机制基本完善,重大疾病和主要健康危险因素得到有效控制,城乡居民健康水平得到进一步提高。为实现这个目标,近年开展的主要工作有:

2009年新一轮医药卫生体制改革启动以来,原卫生部协调相关部门积极出台措施,实施基本公共卫生服务项目和重大公共卫生服务项目。几年来,项目管理制度和措施逐步完善,经费投入得到保障,服务数量和质量稳步提高,服务效果进一步显现。

2010年10月,原国家人口计生委联合中央综治办、财政部、人力资源社会保障部在全国49个城市 开展创新流动人口服务管理体制、推进流动人口计划生育基本公共服务均等化试点工作。主要任务是建 立健全流动人口工作统筹管理、综合决策体制,完善流动人口计划生育基本公共服务网络和综合服务管 理信息系统,使 流动人口在现居住地获得与户籍人口同等的宣传倡导、计划生育、优生优育、生殖健康、 奖励优待等方面的基本公共服务。经过努力,试点工作也取得积极成效。

2013年国家卫生计生委组建后,提出统筹推进流动人口卫生和计生基本公共服务均等化,明确了相 关工作目标、改革重点和主要任务,开展了一系列流动人口卫生计生基本公共服务专项调查研究工作, 决定在原国家人口计生委等四部门开展计划生育基本公共服务均等化试点工作的基础上,增加基本公共卫生服务内容,在 全国选择流动人口集中的 40 个城市(区)启动新一阶段试点工作。试点工作按照以人为本、保障基本、逐步均等、有序推进的原则,着力探索流动人口卫生和计生 基本公共服务的有效模式,加快提高这一重点人群基本公共服务的可及性和水平,为建立流动人口卫生和计划生育基本公共服务制度积累好的经验。

三、试点工作思路

(一)突出重点

考虑到流动人口群体存在一定特殊性,如年龄结构比较年轻,处于生育旺盛期,整体上比较健康但健康意识薄弱;流动性大,多数居住共工作条件较差等,他们对健康教育、妇女儿童保健、计划免疫、计划生育、传染病防治等公共卫生服务需求较高,而对慢性病、老年保健等服务需求相对较低。因此,试点工作方案对推进流 动人口卫生计生基本公共服务均等化没有要求面面俱到,而是根据流动人口的特点,在国家基本公共卫生服务规范和计划生育服务有关要求的框架下,把健康教育、 妇女儿童保健、计划免疫、计划生育、传染病防治等公共服务作为主要任务,从保障基本服务起步,有步骤、有重点地推进,确保试点工作的针对性。同时,我们在 前期调查研究的基础上,对流动人口健康教育、预防接种、传染病防治、妇幼保健等重点工作提出了具体的要求,确保各项重点工作在基层具体化和可操作。

(二) 整合资源, 发挥优势

目前,省以下卫生计生行政部门和基层卫生计生服务机构正在进行整合,卫生部门的各级卫生服务机构的技术力量比较强,计生部门的基层服务管理网络力量比较强,全员流动人口统计和流动人口动态监测工作基础扎实,流动人口底数掌握比较全面。卫生和计划生育机构整合之后,充分发挥两个部门的优势,既有效扩大基本公共卫生服务的流动人口覆盖面,又提高流动人口计划生育公共服务的技术水平。

(三)由试点到全面推进

在全面分析有关情况的基础上,考虑到各省今年底前后正在进行机构改革和各地工作实际,为更扎实、有效地推动这项工作,经认真研究决定,这项工作分两步走,今年先行启动 40 个城市的试点工作,积极探索流动人口卫生和计划生育基本公共服务的工作模式和有效措施,待各地条件基本具备、工作比较完善时再全面推进均等化工作。

四、试点工作方案的主要内容

试点工作方案主要包括以下三个方面内容:

- 一是明确试点工作的指导思想,并提出试点工作目标:在"十二五"期间,探索流动人口卫生和计划生育基本公共服务的工作模式和有效措施,促进流动人口卫生和计划生育信息共享与应用,提高流动人口卫生和计划生育基本公共服务可及性和水平,为建立流动人口卫生和计划生育基本公共服务制度积累经验。
- 二是结合流动人口的特点确定了七项重点工作:一是建立健全流动人口健康档案,二是开展流动人口健康教育工作,三是加强流动儿童预防接种工作,四是落实流 动人口传染病防控措施,五是加强流动

孕产妇和儿童保健管理,六是落实流动人口计划生育基本公共服务,七是探索流动人口服务管理新机制。

三是对试点工作明确工作要求。包括加强组织领导,落实职责分工;增加经费投入,提供财政保障; 开展调查研究,准确掌握情况;整合信息资源,推动信息共享;强化督导检查,完善考评机制等。

Equalization of basic health and family planning services for the floating population (2013b).

Description of activities.

国家卫生计生委办公厅关于印发流动人口卫生和计划生育基本公共服务均等化试点工作方案的通知

中华人民共和国国家卫生和计划生育委员会 2013-12-19

国卫办流管发(2013;35号

北京市、天津市、河北省、山西省、辽宁省、吉林省、黑龙江省、上海市、江苏省、浙江省、安徽省、福建省、山东省、河南省、湖北省、湖南省、广东省、广西壮族自治区、重庆市、四川省、贵州省、云南省、西藏自治区、陕西省、宁夏回族自治区、青海省、新疆维吾尔自治区卫生厅局、人口计生委(卫生计生委):

《流动人口卫生和计划生育基本公共服务均等化试点工作方案》已经国家卫生计生委第 12 次主任会议讨论通过,现印发给你们,请认真组织实施。

国家卫生计生委办公厅 2013年11月28日

流动人口卫生和计划生育基本公共服务均等化试点工作方案

根据关于加强流动人口卫生计生工作的总体部署,为进一步落实流动人口卫生和计划生育基本公共服务,我委拟在原国家人口计生委等部门开展流动人口计划生育基本公共服务试点工作的基础上,在全国 40 个城市启动流动人口卫生和计划生育基本公共服务均等化试点工作。具体方案如下:

一、指导思想

以卫生计生机构改革为契机,按照国家基本公共卫生服务规范(2011版)和计划生育基本公共服务均等化的要求,坚持以人为本、保障基本、逐步均等、有序推进原则,完善和创新流动人口卫生和计划生

育基本公共服务,大力推进流动人口卫生和计划生育基本公共服务均等化。

二、工作目标

在"十二五"期间,探索流动人口卫生和计划生育基本公共服务的工作模式和有效措施,促进流动人口卫生和计划生育信息共享与应用,提高流动人口卫生和计划生育基本公共服务可及性和水平,为建立流动人口卫生和计划生育基本公共服务制度积累经验。

三、试点范围

在全国 27 个省(区、市)40 个流动人口较集中的城市开展试点工作(名单见附件)。

四、重点工作

- (一)建立健全流动人口健康档案。为在辖区居住6个月以上的流动人口建立统一、规范的健康档案,及时掌握流动人口的健康状况。健康档案主要信息包括流动人口基本信息、主要健康问题及卫生服务记录等内容。流动人口健康档案应当及时更新。
- (二)开展流动人口健康教育工作。在流动人口数量较多的社区、企业、厂矿、单位和学校等主要场所设置健康教育宣传栏和资料发放点,每年定期开展卫生和计划生育基本公共服务政策宣传活动,举办传染病防治等健康知识讲座,组织关爱流动人口健康义诊活动,提高流动人口健康素养,引导流动人口更好地接受服务。
- (三)加强流动儿童预防接种工作。为辖区内居住满3个月的0-6岁流动儿童建立预防接种档案,采取预约、通知单、电话、手机短信、设立临时接种点等适宜方式,为流动适龄儿童及时建卡、接种。每年集中开展"查漏补种"活动,对漏种儿童及时补种。根据传染病防控需要,开展乙肝、麻疹、脊灰等疫苗补充免疫、群体性接种和应急接种工作。对入托入学流动儿童严格执行查验预防接种证等管理措施,不断提高流动适龄儿童疫苗接种率。
- (四)落实流动人口传染病防控措施。对建筑工地、商贸市场、生产加工企业等流动人口密集地区,加强传染病监测工作,及时处置传染病疫情,切实落实流动人口艾滋病、结核病等传染病的免费救治等政策。
- (五)加强流动孕产妇和儿童保健管理。为流动孕产妇、儿童建立统一的保健管理档案。加强妇幼保健知识宣传。强化育龄妇女孕情监测、叶酸补服、流动孕产妇早孕建卡、孕期保健、高危筛查、住院分娩和产后访视等关键环节控制工作,保障母婴安全。完善0-6岁流动儿童家庭访视、定期健康检查、生长发育监测、喂养与营养指导等儿童保健服务。加强流动孕产妇及新生儿预防艾滋病、梅毒、乙肝母婴传播工作。
- (六)落实流动人口计划生育基本公共服务。继续落实流动人口计划生育基本公共服务均等化试点工作的各项要求,全面开展计划生育法规政策宣传倡导、计划生育技术服务、优生优育、生殖健康、奖励优待等服务项目,重点落实国家规定的计划生育免费技术服务,为流动育龄人口提供避孕节育、优生优育科普宣传、免费发放避孕药具及健康指导服务。
- (七)探索流动人口服务管理新机制。依托覆盖城乡的基层卫生服务机 构和计划生育基层服务管理网络,创新工作模式和运行机制,提升服务能力和水平。探索卫生和计划生育基本公共服务覆盖流动人口

的措施和路径,努力实现流动人 口卫生和计划生育基本公共服务均等化工作有新突破。

五、工作要求

- (一)加强组织领导,落实职责分工。试点省份要高度重视试点工作,特别是在机构改革过程中,要注重卫生计生部门协作配合,确保工作任务落实到位。试点城 市要根据试点任务相应调整或成立工作协调小组,明确相关部门职责,建立联席会议制度,并抓紧组织编制试点实施方案,明确工作目标、主要任务、保障措施及进度安排,务求试点工作取得实效。
- (二)增加经费投入,提供财政保障。中央财政继续安排资金支持试点工作。试点省份强化省级财政支出责任,参照当地户籍人口卫生和计划生育基本公共服务经费投入标准,将流动人口卫生和计划生育基本公共服务经费纳入当 地公共财政支出预算范围予以保障。试点城市逐步加大经费投入,按照常住人口规模编制年度预算,使流动人口卫生和计划生育基本公共服务经费与需求相适应。
- (三)开展调查研究,准确掌握情况。我委将于2014年第一季度组织开展试点城市流动人口卫生和计划生育基本公共服务现状调查工作,试点城市要按照统一要求,协助做好本地流动人口数据,特别是流动育龄妇女、孕产妇、0-6岁儿童等重点人群数据的清理核查工作,掌握本地区流动人口卫生和计划生育基本公共服务现状,为做好试点工作提供基础数据支持。
- (四)整合信息资源,推动信息共享。试点城市要依 托区域人口健康信息平台,完善居民电子健康档案,整合流动人口卫生和计划生育公共服务信息资源,普及应用居民健康卡,建立健全相关信息共享机制。完善现有 的公共卫生服务相关信息系统和流动人口计划生育信息系统,逐步实现流动人口卫生和计划生育公共服务信息跨地区、跨部门的互联互通、共享应用。
- (五)强化督导检查,完善考评机制。试点城市要将试点工作纳入基本公共服务绩效考核体系,定期开展监督检查。绩效考评结果要与财政补助挂钩。我委将建立 试点工作通报制度,每年对试点工作组织开展督导评估,并根据检查评估结果动态调整试点地区和中央转移支付经费。各试点省份要在2013年底前完成对试点工作的具体部署和安排,并将相关情况于2014年1月底前报我委流动人口司。

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1. Overview of the three main health insurance programs in China

Source: Barber et al. 2010:14.

Characteristic	New Rural Cooperative Medical Scheme (NCMS) ³²	Urb an Employee-Basic Medical Insurance (UE- BMI) ³³	Urban Residents-Basic Medical Insurance (UR-BMI)
Administration	County level (2176 counties)	Municipal level	Minicipal level
Local	Counties determines the	Wide variations across	Wide variations across
government	deductible, ceiling,	municipalities in eligibility,	munic ipalities in eligibility,
authority	re imbursement ratio, medical savings account	financing, benefits packages	financing, benefits packages
Date started	2003 (Old rural cooperative	1998	2007 (79 pilot cities)
	medical scheme at village in place since 1950s.)		2010 target-all cities
Participation	Voluntary at house hold	Mandatory for individuals	Voluntary at household
Populations	Rural residents	Urban e mployed	Children, students, elderly, disabled, other non-working urban residents
Target	Est. 840 million	Est. 300 million	Est. 200 million
Current	94.2% (2009)	67%	60.4%
coverage		(200 million, end 2008)	(118 million, end 2008)
Revenues	94.435 billion RMB	270.9 billion RMB	15.4 billion RMB
(b illion RMB)	(13.9 billion USD) (2009)	(39.8 billion USD)	(2.3 bill USD)
Expenditures (billion RMB)	92,292 billion RMB (13.6 billion USD) (2009)	201.6 billion RIMB (29.6 billion USD)	6.7 billion RMB (985 mill USD)
Source of revenues	For western areas, the contribution is 40 RMB each from local and central government, and 20 from individuals. The central contribution to eastern provinces tends to be lower, compensated by higher provincial or municipal contributions.	8% of employee wages: "6+2": 6% payroll tax on employers (ranging from 4 to 1 % by municipality) and 2% employee contribution Medical savings accounts generally cover OP expenses, medicines (employer contribution + 30% of employee contribution)	Average 245 RMB for adults, 113 RMB for minors (pilots 2008). In 2008, the government contribution was at least 80 RMB /person, with a central level contribution to west and central areas of 40 RMB/ person. Provincial contributions vary. The poor and disabled receive an additional 60 RMB per year (50% from central).