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The Spectre of Illness

Experiences and Perspectives of Rural Migrant Women in China's Urban Centres

by

Ellen R. Judd[*]

Abstract: China's contemporary economic dynamism is driven by the movement of as many as 200,000,000 women and men from China's countryside to work in its urban and coastal areas. Their labour provides the basis for China's wealth, while they continue to remain substantively and structurally excluded from enjoying the prosperity they generate. Since 2003, China has begun to address this and other profound social disparities by initiating a series of social programs, including a national initiative since 2008 (with earlier precursors) to build a health system designed to provide basic, accessible health care for all by 2020. This paper explores how rural-urban migrants, who largely fall between urban and emergent rural health care systems, are working to care for the health and wellbeing of themselves and their translocal families on the eve and in the early days of these initiatives. The research reported here derives from initial results in a multi-year field research project in the political economy of care. In-depth interviews were conducted with members of fifty migrant families in a major coastal urban centre in late 2009 and with members of twenty migrant families in a major west China urban centre in the summer of 2010, systematically exploring their experiences with and narratives of familial health care needs and practices since 2007. This research attends to the emergent policy framework but departs primarily from the perspectives and words of women and men migrants addressing the health care needs of themselves and their families in circumstances of social dislocation and high mobility. The present paper focuses specifically on selected clusters of mature women caregivers addressing long-term challenges of familial health care through a gendered perspective that renders caregiving visible and central to the human condition. Understanding the health and health care realities for China's migrant workers cannot be directly or only read from policy but is better seen from the perspective and experiences of migrants facing concrete health issues and working to use all available resources to respond to them through the course of each illness.

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"I am afraid of nothing, except getting ill". This phrase was spoken often by migrant women and men telling of their lives in urban China in 2009 and 2010. It may be heard both as a statement of strength and courage in facing the rigours of migrant labour, and as the identification of a pivotal danger in their lives.

China's dramatic economic growth of recent years has been driven by the work of tens of millions of rural workers such as these, who have migrated to urban and coastal areas to create China's new wealth, and who remain structurally excluded from its benefits. The often extreme disparities and disadvantages suffered by vast numbers of rural residents and a large proportion of those who migrate have generated widespread concern and social unrest. These have led to new policies in this century intended to provide increased security and social stability as part of a project of creating a scientifically designed harmonious society (*hexie shehui*). Addressing the life and death matter of health care has appeared prominently in this agenda.

In these pages, I will trace the background of contemporary migrant labour from China's countryside to its cities and coastal regions, and the social and political configurations that underlie access to health and health care for migrants and their translocal families. Emergent policies and practices of health care provision and access for rural and migrant people will be reviewed, drawing on the experiences and perspectives of rural women migrants in a coastal and an inland city. The focus will be on an overlooked and largely invisible segment of this workforce – the middle-aged women in the formal and informal service sectors who provide essential care for their own families and the families of more privileged urban others.

Migration

Contemporary China is dramatically marked by the magnitude and by the structure of its population of rural-urban migrant workers (*nongmingong*). While human mobility and labour migration may be seen as typical of human vitality and current economic opportunity, the present formulation in China is distinctive as the product of a policy change in 1992, marked by Deng Xiaoping's Tour of the South. Prior to that time, China had since 1949 had policies and programs for development and social transformation that affected both rural and urban China but that retained the overwhelming majority of the rural population in the countryside. Rural China generated disproportionate amounts of capital accumulation for the cities and for the country as a whole, but most of the rural population worked in the countryside. This was so even after 1975 when increased diversification of the rural economy and the mushrooming of rural township and village enterprises created impressive economic growth in the countryside and the nation. The subsequent national collapse of these enterprises, with as many as one million closing in 1990, and the redirection of economic development toward cities and coastal areas created a base for drawing rural workers away from their homes to often distant workplaces (Judd 2010).

The relation between countryside and city had since 1958 been structured by a bifurcated household registration system (*hukou*) that identified everyone as a member of a household that was either agricultural or non-agricultural and that was tied to a specific locality. Agricultural households were grouped into localized corporate collectives (production teams or brigades within communes) with limited entitlements to land, to work on land and to the product of this work. The non-agricultural households were similarly linked with specific towns or cities, where their members had rights to urban employment and to a wide range of entitlements including subsidized housing, education, and food. It was unquestionably more beneficial to hold non-agricultural registration and the barrier between the two statuses was maintained in both policy and practice. This remained the case even after reform-era dissolution of rural collectives and the restructuring of state-owned enterprises. Household registration was not only a difference carried over from a two-tier socialist past, but was also intentionally maintained into the post-1992 era as a mechanism for controlling rural-urban population movement and for managing the human dimension of economic development. Rural people were needed and recruited for work in the cities – but could be largely excluded from urban status and entitlements through the mechanism of household registration. The bifurcate household registration system generates an exceptionally dramatic barrier restricting the rural migrant workers who create enormous wealth for China from access to the status and entitlements that many (but not all) designated urban people can enjoy.

Despite this barrier, rural people have left their homes in massive numbers since 1992. By the turn of the millennium estimates of the size of the migrant population – difficult both to define and to count – were in the vicinity of 150,000,000 (Zhang 2006, pp. 37-38) persons at any given time, and may now approach 200,000,000[1]. Considering the circular and seasonal nature of the work and patterns of rotation of migration among household members, the actual number of people engaged in migrant labour at some point during any one year is much higher. The number involved within a few years or closely affected by migrant labour within their own household is larger still. Indeed, in the three west China communities I studied from 2002 to 2005 nearly every household was directly or indirectly affected by migration (Judd 2010). In these almost wholly agricultural communities with at most 1 *mu* (=1/6 acre) of arable land per person, migration was a pressing necessity and a household commonly required substantial remittances (roughly RMB 6,000 per year) from at least one migrant worker to meet its cash expenses. In these circumstances, people were leaving out of economic necessity and taking whatever work could be found. A rural mother and her migrant daughter might readily be in tears together on a long-distance telephone call over the daughter's hard work and misery. Limited education and skill meant that very many of these migrants were selling fruit and newspapers on the street, working in shoe factories, or labouring as cleaners and other service staff. A much smaller number had the education or skill to be economically more successful and even to cross over to non-agricultural status through higher education or through the ability to purchase an urban home at

[1] On the complexities of defining and enumerating the migrant population see Chan (2009)

a price that created eligibility for non-agricultural registration. While it is important to recognize that migration has provided a minority with opportunities for upward mobility and perhaps more with opportunities to broaden horizons and explore the world, the migration experience for the majority of rural migrant workers has been triggered by pressing need and experienced as hard work on the far side of a wall of exclusion. In addition to the economic disadvantages entailed in their work and incomes, as this barrier presently operates much of its salience and force derives from differential entitlement to education, health and pensions.

The Study

The research reported here consists of initial results in a multi-year field research project in the political economy of care, exploring how rural-urban migrants care for the health of themselves and their translocal kin in circumstances of social dislocation and high mobility. The study explores how migrants use diverse resources from family and wider kin, available market channels and especially newly emergent (as well as residual and continuing) public health care systems. The study is collecting narrative accounts of recent instances of significant health care needs (primarily since 2007) and of how each instance is addressed by migrants, in order to care for themselves and for family members either with them in their migrant location or remaining in the countryside. In November and December 2009, members of fifty migrant families in a major coastal urban centre were interviewed and in June and July of 2010 members of twenty migrant families in a major west China urban centre were interviewed. In both locations those interviewed were rural-urban migrants holding agricultural household registration in the two west China provinces where field investigation in rural sending communities had been conducted from 2002 to 2005, Sichuan and Chongqing.

Initial recruitment was sought through the networks of local contacts and each participant was asked to recommend further participants, which many did. The resulting sample has both wide diversity and clusters of connected households. The diversity provides the sample with a range of coverage (of economic level, occupation, family ties, access to health care resources and health care needs) and each cluster is a nexus of depth providing multiple positioning on shared experiences around a particular theme (of bereavement, elder care, health care access, and health insurance claims). Participants were prescreened for recent individual or familial experience of health care needs and the sample intentionally excluded younger workers (except as additional family members) and focused on the middle-aged persons who commonly carry primary responsibility for family health care. Young migrant workers often provide significant economic resources to provide care, but it is more commonly their parents who are actively managing the health care of themselves and their families. A focus on this middle generation has proved highly fruitful for adding attention to critical portions of the migrant population outside the more visible milieux of factory workers and entrepreneurs.

All available adults were interviewed in each family and the interviews were conducted in their homes, if possible, or occasionally in or near workplaces. For

each family two kinds of data were collected. The first consisted of systematic data on family membership, relationships and locations of work and residence, and on the access of each member to public and private health and related insurance or benefit programs (worker's compensation, pension, life insurance) and whether these had been used. The second consisted of narratives of major instances of family need for health care. The narratives were collected in a semi-structured manner, and often allowed for additional exploration of specific issues. Efforts were made to ensure that in each case the interviews elicited specifics about the health care need; its process of identification and the history of steps taken to address it, including medical care, hospitalization, medication, personal care and other health-related measures; the human, material, financial and knowledge resources mobilized; financial and familial implications of the health care issue and its resolution; and the outcome and assessments of the outcome.

An Emergent Health Care Regime

As labour migration mushroomed in China after 1992, rural people embarked on their near and distant travels with little remaining of the socialist era collective social programs, and with none that were portable. Cooperative health care, which had been brought to the countryside as the collective era proceeded, had been lost when the collectives were dismantled in the rural economic reform of the 1980s (Wang 2009). There were some residual elements remaining in the form of basic public health provisions and in the form of paramedics ("barefoot doctors"; *chijiao yisheng*) who had been trained earlier to provide basic medical care and midwifery services. These were no longer provided with any public support when the collective channel for that disappeared, but the trained personnel remained and some continued to work on a fee-for-service basis, as did some traditional healers in various forms of Chinese and herbal medicine.

In response to a widespread and urgent sense of social injustice as the disparities between growing affluence and remaining absolute poverty became increasingly jarring by 2003 (O'Brien and Li 2006, Lee 2007), there was a series of steps taken to reduce the disadvantages faced by the rural population, including abolition of rural taxes and levies and some income transfers, most notably a "grain subsidy" (*liangshi butie*) that provided an incentive and income support for agricultural land holders. Health was a major concern, especially as market provision of health care made it unaffordable for the poorer rural residents, resulting in households being forced into poverty by a serious illness of any member, and in people suffering disability, ill health and premature death when unable to meet health care costs (Li 2008). National policy moved toward a plan to provide basic and affordable health care throughout the country by 2020 (Chen 2008), with gradual work toward this goal in test sites from 2005 and wider application shortly thereafter. These programs share a broad national vision and framework of state subsidy, but are locally based and tied to local financing, with the key level located at the county. This results in a program designed to promote health care provision at the local level throughout rural China, reaching down to the level of town and township health hospitals (the level below the county).

Migrants remain predominantly and problematically within the realm of the rural health care system in their officially registered localities – no matter how far away they may be – with two exceptions. The minority of migrants who cross over to non-agricultural registration lose access to the rural system and potentially gain access to urban health care as they are incorporated into the urban population. There have also begun to be programs specifically for migrants who are in relatively stable long-term employment with larger and more established employers, although these programs so far reach relatively few.

Consequently the key for access to health care for the overwhelming majority of migrants, and especially for those with marginal and poorly remunerated work, is the emerging program for rural health care. The New Rural Cooperative Medical System (*xin nongcun hezuo yiliao zhidu,* commonly shortened to *xinnonghe*), as it is known nationally, is a highly ambitious and important social program that is critical to the national goal of basic health care for all by 2020. Within shared national parameters, it is a set of locally based systems that enroll rural residents on a voluntary but actively encouraged and subsidized basis. Each officially registered rural resident (including migrants) is eligible to join, but households must join as a unit, in that all household members who hold agricultural residence at a given place join together. Joining initially required payment of RMB10/person/year (RMB1=USD.15=€.11), and now generally RMB20/person/year, which is collected for the household around the time of spring festival when some members may return home, although registration and payment may be done on their behalf by relatives in their home rural community. This charge is low enough that there is now a high rate of registration and payment (exceeding 90%), although the amount in the fund is so small that it does not provide for a high level of coverage. Those who make no claims in a year may be provided (depending on local regulations) with a yearly amount of RMB40, which can be used toward medicine or health costs not otherwise covered. However, the main purpose is to provide partial economic relief for more serious illnesses that typically (but again, this varies) require at least three days stay at the township hospital. The coverage then will still only be for a proportion of the cost and will be subject to a ceiling. In general, this may facilitate greater use of local health care facilities, although there is widespread preference for avoiding medical care and for self-medicating, practices which are encouraged by the deductibles that must be paid prior to receiving almost any coverage through this system.

Each county has its own specific plans, regulations and rates of reimbursement for *xinnonghe*, but one instance from rural Chongqing may serve as a useful illustration, especially as its regulations are readily available online (Chongqingshi shuangqiaoqu renmin zhengfu bangongshi 2008). While the regulations specify financial sustainability and limitations, they also present a positive picture in some important respects. For instance, combined financial resources per person were set as RMB10 from household enrolment fees, RMB40 from the central government, RMB30 from Chongqing City (provincial level) and RMB10 from the district (county level). The major anticipated expense of hospitalization at an approved (*dingdian*) hospital was to be reimbursed at a rate of 65% for a town(ship) level hospital (with a RMB50 deductible), 50% at the county level hospital (with a

RMB200 deductible) and 25% at a city level hospital (with a RMB1,000 deductible), with a total maximum across all categories of hospital of RMB30,000. Care for nine chronic illnesses was also specified as eligible for reimbursement at a level of 50% up to RMB500/year, provided there was pre-authorization and treatment at an approved hospital (hospitals in China provide outpatient as well as inpatient services).

Each county level system varies, but all share the feature that the highest rate of reimbursement is within the township level and where the care involves inpatient care in the township hospital, with lower rates of reimbursement at the county level hospital and lower still at the prefectural level or city level hospital. There is commonly no provision for reimbursement of expenses incurred elsewhere, although in some cases receipts may be taken to the migrants' official rural home for a low level of reimbursement, contingent upon local approval. In addition, there is beginning to be a system of designated hospitals that can serve migrants within the limited framework of the *xinnonghe* in locations where there are concentrations of migrants from a given province. There is very limited provision for medicine costs. There is no provision for home care, which is a major issue for the many migrants who are contributing to the support and care of aging parents, even when these are in the countryside.

This is a fluid system and one which is rapidly being extended and receiving steadily increasing financial support, with resulting increases in reimbursements provided for health care expenses, although these remain very limited (Han and Luo 2007, Weishengbu 2007). This system is especially difficult to access on the part of rural-urban migrants, who are located outside the better-funded provisions of urban workers (where those are covered). The experiences of the seventy families in the present study to date show widespread attempts to use the *xinnonghe,* albeit with limited success, and very considerable failure to access care effectively in urban work locations, primarily due to barriers of cost.

The limited access of rural-urban migrants to health care while working in cities where designated urban residents may have access to superior health care plans has resulted in more recent measures to introduce plans for health care for migrant workers[2]. These plans are mandated and regulated by local governments where the migrants work and implemented through their workplaces. They are relatively comprehensive programs for regular health care coverage and for catastrophic health care coverage. They may be part of a package that also includes a pension provision. Workplaces that provide such coverage will also have coverage for work-related injury, as do some workplaces that do not offer health or health and pension packages. This initiative is an important step in reducing disparities between urban workers and rural migrant workers, but is not yet widely available and, where offered, migrant workers quite commonly opt out or cash out their benefits where and when this is possible. Both published reports and the interview data in this study show considerable reluctance to enroll in these programs (Shi and Zhang 2007, Hesketh et al. 2008). The chief reasons appear to be related to the relatively high deductions from wages that are required to fund these, together with

[2] For example, see the leading case of Guangzhou (Fei Guangzhoushi 2009).

widespread lack of clarity about what is being provided in return for these deductions and restrictions on portability. This potentially positive initiative is neither widely available or, where available, fully utilized.

The consequences of this overall picture are complex and uneven, as each health care situation has its own unique features and each family has its particular situation of eligibility or enrolment in specific local programs. In addition, health status and health care access are both fluid and only partly known at each stage of a care process. Understanding the emergent health and health care realities for China's migrant workers cannot be directly or only read from policy, constantly improving as it is, but is better seen from the perspective and experiences of migrants facing health issues and attempting to use available resources to respond to them through the course of each illness.

"We Are All Relatives"/"I Look After Everything Myself"

One of the clusters of migrants interviewed in this project consisted of a set of related women making livelihoods for themselves and their families through a patchwork of hourly domestic work (mostly cooking and cleaning) for professional and middle-class households in a coastal metropolis. The typical hourly wage was RMB8-10/hour, but could be as low as RMB7.1/hour and employers might try to reduce the wage further by asking for "2 1/2 hours" (rather than 3 hours) to save themselves a small amount. Hourly workers such as these would work for several households and could make around RMB1,000/month, below the level of most factory workers or even regularly employed cleaners, but enough to support a very basic level of accommodation and food.

As Liu Dajie, the first woman encountered in this set, quickly emphasized – "we are all relatives" – she was part of a network of relatives. This network was her small immediate community, consisting of a number of women tied through marriage to related men, and so coming from a common marital village through patrilocal residence (Judd 2008). The women key to the present discussion are the widows of two brothers, living a short walk from each other and each renting small shared rooms together or contiguous with their own adult children (and their families) and the wives of their husbands' nephews. The older women had come to work here through a chain of introductions, as common for migrants, and had later brought their adult children here to work, although some of these had gone to other urban centres in search of better opportunities.

Liu Dajie was in her forties when we met and had already worked as an hourly domestic worker for over ten years, since 1999. Unlike the usual model of young school-leavers migrating to the city as rural surplus labour working in urban factories, Liu Dajie had followed her sister-in-law to the city as soon as her two children were old enough to manage without her in the countryside. This was not an easy choice, in the absence of grandparents to provide care, but was an economic necessity for the family. Shortly after she was established, her husband joined her to work in the city as a guard and then as a construction worker, for wages approximating her own.

In 2007, Liu Dajie's husband was pressed by his daughter and wife to get medical attention for his ill health, a step migrants are loath to take in light of both cost and the prospect of devastating diagnosis. He was diagnosed in a coastal hospital as having liver cancer and he and his wife went to the leading hospital in their home province for a second opinion. He spent some days in this hospital for further tests, with the result that the cancer diagnosis was confirmed. The doctors there declined to treat him, as his cancer was already terminal (a much too common story heard from migrants in this study) and the family could not afford treatment that would not save his life. The family returned with him to his rural home. His wife and daughter left their jobs and cared for him there, with some support from the township hospital, and he died three months later. The family spent all their savings, sold possessions and went into debt for his care during his final illness. The family had been enrolled in the *xinnonghe* since it began in their locality in 2006, but they were not reimbursed for care in the city hospitals or for home care, but only for a portion of the township hospital costs. At the time of the interview in late 2009, his widow was still working to repay money she had borrowed from relatives, and the *xinnonghe* was not viewed in this family as having been useful, although they continued to be enrolled in it.

After her husband's death, Liu Dajie returned to work in the city, as this was necessary for her economic support. She intends to remain there as long as she can work and then to return to her rural marital home. Although she does not know who is working her household's small amount of land and has no knowledge of the grain subsidy to which it entitles her family, she assumes that she will be able to return and support herself from the land. Despite her confidence on this point, indications that widows are not always able to retain land in their marital communities give grounds for concern (Judd 2007). It is certain, however, that she will not be remaining in the coastal city past her working years as the cost of living in the cities is too high to permit migrants to remain there unless employed. Employability for domestic workers disappears not long after a woman reaches fifty years of age.

Liu Dajie's sister-in-law (*saozi*), Lin Dajie, had a somewhat similar but more unusual history of care for her husband, who passed away in 2008. She was the relative who had introduced Liu Dajie to work in the coastal city, having herself come there two years earlier, in 1997, similarly bringing her husband slightly later and leaving her three young teen and preteen children to care for themselves. Her husband initially became ill in 2003, diagnosed with high blood pressure in the coastal city. On a visit to his rural family in 2004, he had a stroke and became paralyzed. After one month of care in the countryside, his wife concluded that it was economically necessary for her to take him to the city where she would be able both to work and to care for him. This was an unusual decision, as ill family members are more commonly cared for in the countryside, but this requires that someone be available there to provide care. Lin Dajie had an exceptionally demanding and painful period of caring for her husband under these difficult conditions. She received some help from relatives, although the time demands meant that help from her nephew's wife had to be reimbursed, even though there was no source of public support to cover this cost. His three brief hospitalizations

in the coastal city were also not covered. Even with his wife's continued work this resulted in heavy expenses and family debt. When his condition worsened in 2008, she took him to their rural home for his final illness and he passed away a few months later. The *xinnonghe,* in which his family was enrolled from 2006, covered a portion of this final care only. Lin Dajie was herself ill throughout this period with an intestinal ailment she declined to have treated during her husband's illness and for which she sought affordable township treatment and inexpensive medication only later. Lin Dajie spoke powerfully and emotionally of these years, with repeated emphasis – "I look after everything myself" – that she was the source of her husband's care through these years. The toll on her had been heavy and she had been left still hard-working and strong, but fearful of illness and the prospect of death it carries.

The world of rural migrants in urban China is directly dependent on the immediate labour of the migrants, both for income and for essential care. This is especially so for those at the lower end of the socioeconomic scale, who lack significant property or savings. In such a situation, every family member's contribution is critical, and the loss of each contributor places a severe strain on the wellbeing of the family. In this case, multiple illnesses (another cancer death, two children with disabilities and a minor illness) in this moderately sized network of relatives added demands on all and reduced the extent of assistance available in each instance. Even migrants with relatives close at hand and helping could feel as if they were dealing with the situation on their own.

It is widely observed in rural China that middle-aged and older women provide essential care for children, the elderly, the ill and the disabled, as well as domestic labour for their households, usually in combination with income-generating agricultural or animal husbandry work on small plots and courtyard space. When a middle-aged woman is called upon to migrate to the city to provide cash income, her household and often closely related households (of parents, parents-in-law and also of siblings who share in elder care) face a major loss of essential care. This is so even without serious illness, but that circumstance is virtually certain to occur within a family at various times. The care demands are accentuated by the lack of public home care and by requirements for familial personal care on a full-time basis for anyone hospitalized (unless able to care for him/herself). Extraordinary pressures are placed on those middle-aged women who leave the countryside to work in the cities — where they are very commonly underpaid providers of care that lightens the burden on more privileged urban dwellers.

When migrants face illness in the cities, they may readily purchase medicines or consult health care providers working in the pharmacies that dot migrant neighbourhoods, but are unlikely to attend clinics in urban hospitals unless they are very ill and often then only if pressed to do so by a family member. The high costs produced by the fee-for-service funding basis of hospitals and the spatially limited *xinnonghe* coverage for such visits in the cities (and only partial coverage in the countryside) result in delays and avoidance of diagnosis, as evident in these cases, that make successful medical treatment difficult or impossible.

Such care as is possible may nevertheless be financially catastrophic for the family, even where care is sought in the rural home or home province. As in these

cases, most commonly the only public resources available for migrants are the rural health care system and the *xinnonghe*, both of which are harder to access adequately from a distance. This decreases the level of remuneration and may require family members to leave their work to accompany and care for a gravely ill patient in the more affordable rural location.

The issue of illness is serious for everyone, but looms especially large for migrants in posing exceptional challenges for medical and for financial resolution. The challenges arise in the first instance from the localized spatial structure of health care provision for rural migrants. They also arise from at least partially understandable restrictions on coverage, necessary as they are to ensure sustainability of the present cooperative funding mechanism, and the consequent exclusion of so much of necessary care from eligibility for remuneration.

The situation faced by women such as Liu Dajie and Lin Dajie may be understood more completely by complementing their histories of care with slightly different experiences from additional cases in the sample, and two further clusters emerge as particularly relevant.

Elder Care

In the inland urban field site, this study benefited from the inclusion of a loose cluster of older women (most in their fifties) who were providing live-in elder care in middle-class and professional homes. Their insights can be further augmented by reference to some of the numerous instances of migrants arranging distant care for their own parents and parents-in-law in both the coastal and the inland sites.

The migrant women who were providing live-in elder care were each placing themselves in an anomalous and at least potentially conflicted situation. Each of these women was spatially and in diverse ways socially distanced from her family in order to do this work. At the very least, she would be living separately even if her family were in the same city. All but one reported that their parents and parents-in-law were deceased, so that they could not be construed as leaving their own filial obligations. But there were still complex tensions involving the unavoidable distancing from ties of kinship and care that their work and living arrangements entailed, for women of their generation are often key to care of spouses and both younger and older generations. One of these women's narratives underlined the extent of this in her long-term involvement with the care of her husband's older brother, a man whose frail health had made him unmarriageable. Further decline of his health in the past three years had resulted in near-blindness and multiple hospitalizations. As a destitute man without children he had at this point become a "five-guarantee" household, which meant he was supported through local government at a very basic level, which is a recourse not available to the rural elderly who do have children. Nevertheless, this man's younger brother and sister-in-law visited him, and provided some personal care and supplemental medications.

Care for the elderly is a pervasive issue since it is defined as a responsibility of the children; public supports in the countryside are presently very limited and rarely extend beyond the modest provisions of the *xinnonghe*. Of the 132 cases of

recent family illness elicited in this study to date, 59 involved illnesses of elderly family members. Migrants remain members of translocal families defined primarily as rural and strive to care for elderly family members in the countryside, especially when ill, at the same time as working elsewhere to support themselves and provide for their children. Members of the senior generation lighten the load by working until advanced ages, looking after themselves and very commonly declining medical care, especially when it seems non-essential, unlikely to be definitively helpful, or expensive.

The gamut of elder care the migrants report giving is very broad. It extends from the extreme of a migrant woman leaving her family in the city while she returned to the countryside to care for her mother who was living with paralysis and dementia through her final five years, to the other extreme of people reporting that they give very little care or support. Between these extremes, there are commonly cases of migrants returning at times of serious illness to provide personal care and emotional support. Where a specific intervention might be useful, there are cases of hospitalization and surgery, such as removal of a kidney or resolving a gastric obstruction, and the *xinnonghe* is now available to help with these costs. There is commonly also some attention to medication for chronic illnesses such diabetes and high blood pressure. However, ailments considered part of aging may not be actively treated, including loss of sight, hearing or mobility. Major interventions, as for cancer, are rarely reported for elderly rural people. Much of the practical concern is for devising ways to provide the personal care required by long-term frailty and untreated or undertreated infirmities.

Apart from the direct problem of illness and limited personal and public medical and financial resources, the income-related pressures to work away create spatial problems, exacerbated by the regulatory barriers to portability of health care and the greater cost of accommodation and food in the city. The result is that the elderly are almost always cared for wholly in the countryside when ill, although in a minority of cases they may come temporarily to the city seeking a medical solution they could not find in the countryside. This is most likely to involve medical consultation for a diagnosis or recommendation of treatment and medication, followed by return to the countryside.

Travel to the countryside for the serious illnesses of parents is normative and relatively common, even when it may require terminating employment. Long-term direct personal care of ill parents is more difficult due to problems of lost income and conflicting family obligations in the city. The generation now elderly may, however, have several children who can share care. This may be done directly, as in rotating trips of a month or more to the parent's bedside, or may involve hiring care locally. Migrants working away may hire a relative remaining in the countryside as a substitute for staying in person for a prolonged period when it is their turn in the family rotation of elder care. In one family, children had pooled resources to hire an elderly bachelor (a poor man without family) in their father's village to be his dedicated caregiver. Several families described exceptional efforts to ensure prolonged care, while there were also cases where children and daughters-in-law were less willing or able to do so, and where the rural elderly were facing illness on their own. In a single case, the families of brothers working

in stable long-term employment in the inland city site had brought their frail father to live in a home for the aged in their city shortly before he had a stroke. The home is a residence rather than a personal care home and they still need to resolve his medical problems and care, but are able to do so in proximity.

Elder care is an important issue and a moral imperative within the Chinese framework of filial piety. Migrant work generates greater financial resources for families, but does so under very demanding circumstances. Discourses of rural "surplus labour" hide the extent to which truly essential labour is being drained from the countryside, especially as much of it is the socially invisible and unpaid work of care commonly performed by women (and also performed by men, especially as sons and husbands). Current improvements to rural health care will, as they are extended, increasingly address the direct medical aspects of this problem; eventually the rural pension plan just beginning to be offered will help further. At present, the rural health system appears only modestly helpful with procedures and reimbursement for relatively treatable and mid-range medical problems. Deductibles discourage regular checkups or early treatment that could provide timely diagnosis and treatment, and limitations in remuneration levels mean that it is not yet adequate for catastrophic care. The exclusion of personal care from the system, while comprehensible, is a major limitation, and one that has especially serious consequences for migrants and their families.

Health Care Plans for Migrants

A major recent response to the issue of migrant health care has been the creation of programs to provide a comprehensive benefits package, including health provisions, for migrant workers through their employers. This currently reaches only a portion of migrant workers with relatively stable formal employment with a fairly large employer. There were nine families in the coastal sample and three in the inland sample who had family members with some access to this package (dependents are not eligible for coverage), and a larger number who had some coverage for workplace injury. In addition, there was a highly diverse range of purchases of private insurance in several categories – major illness, accidental death and disability and life insurance – on an individual or family basis. While the private purchases show emerging interest in selective insurance, and this is a means through which some form of safety net was potentially available (although not affordable) for Liu Dajie, Lin Dajie and their families, matching insurance and risk in an appropriate and effective manner is difficult and probabilistic. The more comprehensive publicly mandated packages offer greater security, but do not appear to be widely used, apart for the small amounts carried on health cards and accessible for minor expenses. Indeed, the most common observation of those few enrolled in the comprehensive public package was complaint about the high level of deduction from wages (for example, in the case of one cleaner, RMB150/month from a pay of RMB1200/month). Where workers were able to opt out of coverage, either at the point of enrolment or at year-end for extra funds to take home at spring festival, I was told that this was a common choice. From a policy and equity perspective, the comprehensive public package is

a positive step, but it is difficult for many migrant workers to afford or to choose. The largest difficulty is with the pension component which, while including a contribution of as much as 2/3 from the employer, requires 15 years of stable employment in one place, as the pensions are not portable. This is a challenge given the insecurity of employment and the geographical mobility of many workers; it is especially difficult for women workers who are highly vulnerable to discretionary lay off, at 55 or even 50 years of age.

The sole case in these samples of clear-cut eligibility and use of the publicly mandated migrant health package was that of a young mother of two school age children who worked in a domestic garment factory in the inland city. She had surgery to remove a benign growth on her liver that had been found in a factory checkup. She was recovering well and was being cared for by her brother's wife who lived in the apartment above her. In this instance the system appeared to have worked well for her, and she was satisfied with it. Coverage such as this could have made a decisive difference in the case of the husbands of Liu Dajie or Lin Dajie or in cases of early heart disease that were also encountered in this study. With warning, heart and other major diseases can be treated at a rural home and at least partly covered there, which reduces the cost and increases accessibility. In the case of a woman cleaner of about forty in the distant coastal site, her situation was too urgent for travel and her family – already dealing with recent illnesses and losses on both sides of the family – went deep in debt for her medical treatment. She expects her pacemaker to require replacement within a few years and that the cost may be more than she is willing to incur.

The route to a more comprehensive system is being mapped, but the path is narrow and strewn with obstacles, especially for migrant workers in China's cities. Among the most severe obstacles are those of strictly localized eligibility and benefits; deductibles, limited reimbursement and the exclusion of many costs as ineligible; and lack of provision or reimbursement for home care.

In this study I had originally sought to explore the workings of the new health care systems and how migrants could access them. I planned to do so by interviewing and recruiting assistance from migrants who were of an age to be familiar with the issues and who were actively managing family health care. This research has inadvertently led beyond the original framework and toward engagement with an unmarked and largely invisible migration of middle-aged women caregivers from the countryside to the city, and the redistribution of their caregiving. Existing systems of health care provision set limits and leave enormous unmet needs which these women substantively resolve. Looking at these needs and limits as they directly affect the health of the women and their family members reveals terrible demands and losses, and this is only the most apparent element. There is a larger picture of a gendered political economy that draws women away from life and caregiving in their own homes, families and communities and systematically appropriates their caring, while leaving their own prospects for care precarious.

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