Social networks and health among rural–urban migrants in China: a channel or a constraint?

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SUMMARY
This article concentrates on analysing social networks and health among rural–urban migrants in China. The function that social networks substantially play on the issue of health among migrants in China has rarely been discussed in studies. On the basis of a case study of a migrant community in Beijing, this paper examines the range of social networks among migrants, from which they can acquire support, including financial and spiritual, when they are dealing with health problems. Social networks resemble a double-edged sword to rural–urban migrants in terms of health-care access. The fact that migrants lack savings may not be the sole and essential reason for their extreme vulnerability in times of illness. Some migrants, who are in financial difficulties though, may have some assistance, including financial and emotional support from their social networks. But on the other hand, their limited social networks bring them many negative effects on their health, as well as restricting health-care access.

Key words: social networks; health-care access; rural–urban migrants; China

INTRODUCTION
The magnitude and potential social and economic impact of rural–urban migration in China has led to the topic attracting more and more attention (Wong et al., 2007). Along with the massive scale of migration in China, access to health care and other health issues is becoming increasingly important, not only to migrants themselves but also to public health bodies.

Rural–urban migration can lead to the formation of new social networks and lifestyles. A social network is a set of nodes (people, organizations or other social entities) connected by a set of relationships, such as friendship, affiliation or information exchange (Mitchell and Clyde, 1969). Because migrants are a floating population, social networks are crucial for finding jobs and accommodation and for providing psychological support and continuous social and economic information (Vertovec, 2002). Social networks often guide migrants into or through specific places and occupations and provide support when they face uncertain risks. To explore a comprehensive view of the health issues and health-care access of rural–urban migrants, the roles of their social network cannot be neglected.

The paper sets out to understand social networks by looking at the definition of strong and weak social ties in the patterns of social relationships. Several definitions of social ties have been suggested over the years, but the essential description is mainly centred on Granovetter’s definition (Granovetter, 1973, 1974). He was the first one who suggested that a tie between two agents can be strong or weak, differing in the amount of time spent in interaction, the emotional intensity, the intimacy and
the reciprocal services. And this is precisely the approach with which Bian (Bian, 1997) tried to measure tie strength in the Chinese context. Moreover, according to Yang’s (Yang, 1994) three enlisted essential characteristics of interpersonal relationships (Guanxi) observed in China during the 1980s and 1990s, the strength of interpersonal relationships (Guanxi) means much more in the Chinese society. According to Yang (Yang, 1994), in terms of it being strong or weak, an interpersonal relationship can be said to differ in (i) the frequency of contact, (ii) the intensity of trustworthiness and (iii) reciprocal obligation. Putting the two categorizations of Granovetter and Yang together, we may realize that closeness is vital to determine the level of strength of social ties. With terms similar to strong/weak ties, Guanxi is said to be made up of insider and outsider relationships. Insider relationships are characterized by niceness, trustworthiness, caring, helpfulness and empathy and are associated with family, colleagues and classmates, whereas outsider relationships are less worthy of trust and are unstable (Chu and Ju, 1993; Gao and Ting-Toomey, 1998; Gu, 1999; Hammond and Glenn, 2004). More focused in this study, the strength of interpersonal relationships, which reflects the idea of both strong/weak and insider/outside divisions, is characterized by kinship. Therefore, the discussion about social relationships that we are exploring below will revolve around the issue of kinship, whereas its particular emphasis is concentrated on the distinction between the kinship tie and the social tie outside of a kinship relationship.

Social networks are regarded as one source of social capital and the relations between them were discussed by scholars such as Lin who stated that social capital is defined as the resources embedded in one’s social networks, resources that can be accessed or mobilized through ties in the networks (Lin, 2001). Through such social relations or through social networks in general, one may borrow or capture others’ resources. The general premise that social capital is network-based is acknowledged by researchers who have contributed to the discussion (Bourdieu, 1980; Lin, 1982, 2005; Bourdieu, 1983, 1986; Flap, 1991, 1994; Burt, 1992; Putnam, 1993, 1995, 2000; Erickson, 1995; Coleman, 1998, 1990). Since the 1990s, social capital, which is usually defined as a list of components including social network, has been widely considered to have an influence on health (Hawe and Shiell, 2000; Macinko and Starfield, 2001; Almedon, 2005; de Silva et al., 2005; Abbott and Freeth, 2008). The data supporting this point consists primarily of survey data: indicators of high levels of social capital are positively associated with indicators of good health (Kawachi and Kennedy, 1999; Veenstra, 2000; Coulthard et al., 2002; Abbott and Freeth, 2008). Some literature includes social networks and social support (Cooper et al., 1999; Coulthard et al., 2002). Some research discusses trust’s influence on health, for example, trust may promote social networks, which themselves improve health (Berkman, 1995; Cohen, 1988; House et al., 1988). Although some researches, such as Meng and Zhang (Meng and Zhang, 2001) [see also (Xiang, 2005; Li, 2008; Nielsen and Smyth, 2008; Wong and Zheng, 2008; Sun et al., 2009)], have looked at migration and social protection in China, very few studies have analysed social networks and their impact on the health and health-care access of rural–urban migrants in urban China.

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

**METHODS**

The fieldwork took place in Dengcun Village, a rural–urban migrant community in the Fengtai district of Beijing. Beijing is a centre for national and international exchanges, including tourism and businesses, and also a city with a high density of migrants. Fengtai District, one of Beijing’s suburban districts, has been a concentrated migrant community for low-skilled manual workers and their families for nearly two decades. Dengcun Village is not an officially defined village by the administration. It is
a migrant community that transcends the geographical, social, administrative and ideological boundaries essential to the established system. The majority of migrants surveyed were originally from the rural areas of South China. Many were from the rural Zhejiang Province and spoke the Zhejiang dialect. They were not new migrants and all had been resident in Dengcun Village for more than 3 years.

The interviews were carried out with a semi-structured, open-ended questionnaire, but participants were encouraged to discuss any aspects of their health issues that they considered important. In total, 36 interviews with rural–urban migrants were conducted. A theoretical sampling strategy was used, with participants selected according to selecting people which involves a search for validity for the findings rather than an attempt to be representative of the study population (Mason, 1996). This study chose 36 participants in Dengcun Village, within five categories: first, the participants had direct experience of illness in the past or currently, or they had experience of illness in an immediate family member; secondly, the sample was selected from different employment status, that is, both employers and employees were included; thirdly, the sample was also selected by length of migration, which was at least 36 months; fourthly, the participants comprised male and female migrants; and finally, the interviewees included those with different marital statuses.

Ages of interviewees ranged from 18 to 50, and the mean was 28.5. Sixteen interviewees were women, and 20 interviewees were men. Twenty-two interviewees were single, and 14 were married, of whom 13 had one or more children. Each interview took from one hour to one and a half hour to complete. When the interviewees were answering questions, they were not interrupted and were allowed to elaborate on issues they found important. The interviewees were asked to answer questions on why they came to the city, employment history, income and family, working conditions and living conditions, health status and health history, perceptions on health-related issues, health-seeking behaviours, constraints when seek health-care services, social networks, relationships with urban locals, sources of financial support, availability of and participation in social schemes and their living with spare time.

The ‘snowball approach to sampling’ and ‘contingency method’ were utilized in gaining access. Most of the participants were obtained through contacts with migrants that had taken part in another study (the project title was: Epidemic Risk Control: A Case Study of the 2003 SARS Outbreak in Beijing) in 2006. A few participants were obtained by visiting and revisiting the migrants in the research area to negotiate access.

Data analysis was informed by a grounded-theory approach, which emphasizes discovery and the conceptual understanding emerging from an examination of material guided by and constructed from participants’ accounts (Babbie, 2001). The data collected from semi-structured interviews were tape-recorded, with the participants’ agreement, and notes were taken to enable the precision of statement. The interviews were transcribed verbatim into English.

**FINDINGS**

**The social networks of migrants**

The most common social networks among the rural–urban migrants interviewed composed a range of social relationships. The availability of such relationships was found to be significantly important, for it enabled the migrants to cope with uncertain risks including health problems. Nearly, all the interviewed migrants stated that having a good social relationship with family members, relatives, laoxiang (fellow villagers), migrant friends and colleagues is of great help when faced with a crisis.

However, the social networks of the migrants in this study were found to be relatively small. Network size and composition were basically assessed by asking the participants to name people in their networks to whom they felt close, or with whom they had regular contact. Although all the participants in the sample named at least one network member with whom they had close contact, the network members most frequently mentioned in this regard were circled around kinship, mainly brothers and sisters and spouse’s brothers and sisters. Provided that a good relationship had been maintained since migration, 9 among 36 participants said that they felt close to their migrant friends and laoxiang.

In particular, a kinship-dominated network (family members and relatives) comprised the largest proportion of the migrants’ primary
networks. The significant role of this kinship-dominated network can be said to be ‘a rich web of inter-familiar help’ at a time of financial difficulty, which is identified by Chinese people [(Wilding, 1997), p. 257]. Although contact numbers vary over time, 20 participants made constant face-to-face or telephone contact with both their family members and relatives. There was stability in the networks of these migrants, and there was a primary core of significant network members who had remained in the network. This primary core was assessed by asking the participants to name three individuals with whom they would have contact if they were to fall upon hard times (such as, whom they would like to seek help from when they lacked money but needed funds for medical treatment). Three types of persons on the list that the participants named in the entire network were composed of their brothers and sisters, their spouse’s brothers and sisters and their nephews. This finding provides evidence of the important role of kinship in their lives, on which the interaction of the participants is almost entirely based.

Social ties

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

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

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

In urban areas, most migrants only live among their own social circle with limited horizons (Wang, 2006). In terms of social life, many of them have no contact with local city residents and city society; they are separated from city society and only live in their own community in a ‘rural’ manner similar to that found in their home villages. Their circle of contacts is limited to their own community and they rely on communication among themselves so as to dispel the feelings of alienation from urban society.

I have been in Beijing for around ten years...I have no friends of Beijing origin, and have never been to the home of Beijing natives (Mr Liu) (This and other names are pseudonyms)

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

Adverse health as a result of social networks

Psychological health

As suggested by Christakis and Fowler (Christakis and Fowler, 2007), social relations, comprising friendship relations, are often established between people who share multiple characteristics, including their personal attributes and
the environments in which they live and work. Many of these characteristics have been shown to be related to health outcomes and psychological states. From the previous discussion, we notice that many migrants live in a socially disadvantaged position with very limited social networks, and their social circle is relatively closed. In this situation, they could easily suffer from poor psychological health. Indeed, according to the data of this study, the findings suggest that migrants have experienced or are experiencing, some symptoms related to psychological health. The most prominent clusters of symptoms found among the interviewed migrants were long-term anxiety, unhappiness, sleep disturbance, depression and nervousness.

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

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

This study suggests that the migrant participants suffered from poor psychological health and that such health conditions were linked to the following reasons: their much closed social circle, their closed contact with the outside, their financial difficulties and the stress they experienced at work.

This study is relatively small in scale and is not primarily concerned with the psychological health of rural–urban migrants. It is suggested that more large-scale studies on the psychosocial consequences of rural–urban migration among migrants in urban China be conducted.

Limited information

Social interactions among network members have an impact on individuals’ attitudes and behaviours (Carrington, 1988; Bongaarts and Watkins, 1996; Friedkin and Johnsen, 1997; Kohler et al., 2001). Personal networks have the capacity to provide individuals with examples of behaviours that may be considered and copied. They also help migrants to meet their emotional needs and to accept instrumental assistance, information and advice (Katz and Lazarsfeld, 1955; Shye et al., 1995).

Generally speaking, information is valuable in the prevention and detection of diseases, management of illnesses, decision-making, improving knowledge and promoting health, administration, behavioural change, overcoming misconceptions and community support. The use of social networks can be an effective source of information (Musoke, 2005). The information supplied by social networks usually comprises availability of services, their locations and institutional details. However, due to the limited social networks of migrants in urban areas, it is difficult for them to obtain useful health information or information sources at the right time. Besides, research has found that health knowledge (illness, health services and health policies) among migrants is poor, therefore the information they could utilize from social networks is lacking. For instance, illegal private clinics are very welcomed by migrants for their medical treatment.

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

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

Delays in getting help when suffering medical emergencies

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

Although the extent to which the migrants gained help through the social network was often vital, once they experienced illness, the practical assistance provided for their medical treatment, as this article has argued, was normally narrow, coming from the restricted range of their first and second social ties. In some cases, the closed social network of migrants delays them from obtaining assistance in time when they suffer medical problems, and it may even turn out to be a barrier to health-care access. Although kinship and second ties were very supportive and valuable resources, the narrowness of kinship and second ties caused a restriction in the prompt help that they could
obtain, especially when a migrant did not have any social networks in the city.

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

The findings indicate that neighbourhood relationships in rural China are very important, but the importance of neighbourhood is very much reduced for migrants after they enter cities. This is an evident difference between social networks in terms of migration. The following example is illustrative of this point.

I recollect that in 2002, my wife and my son almost lost their lives. When I lived in a small bungalow with poor ventilation, we used honeycomb briquette at that time, and my wife and my son got carbon monoxide poisoning. Thanks to the Mid-autumn Festival on that day, my work unit gave us some festival stuff and I brought it home. On arriving home I found my wife and son lying on the ground and they seemed to be at death’s door, I was really frightened by this, I knocked at the door of my neighbour for help, but they did not answer, although I saw that their light was on. They (being native) usually regarded us as outsiders and did not speak with us ... Fortunately my nephew lived nearby. I found him and we got a platform lorry, we sent my family to the hospital ... It was a little cold during the Mid-autumn Festival, my wife and son came to their senses because of the cold. We hurriedly sent them to the Xuanwu Hospital, and finally they got well. Oh, it was very dangerous and an experience that I will remember all my life. (Mr Shi)

A channel to mediate against medical emergencies

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

Financial difficulties and health-seeking behaviour

The practical reason for the lack of health-seeking behaviour is migrants’ financial difficulty. Very few migrants have access to financial assistance for medical treatment. Some cases can be found from previous research. In a survey conducted in Chengdu City (Sichuan Province) and Shenyang City (Liaoning Province), not one single migrant had medical insurance [(Guan and Jiang, 2002), p. 258]. Guan and Jiang (Guan and Jiang, 2002) reported that migrants could only afford ～100 RMB (RMB is the Chinese unit of currency) for medical treatment a month. According to surveys carried out in 2000 and 2002, 46% of respondents had been ill during their stay in Beijing, 17% more than three times. Despite this, a full 93% had not received any payment for their medical expenses from their employers (Huang and Pieke, 2003).

The economic polarization within the society and lack of social security system makes the poor more vulnerable in terms of affordability and choice of health provider (Asenso-Okyere, 1998; Nyamongo, 2002; Shaikh and Hatcher, 2004). Financial difficulties not only exclude people from the benefits of the health-care system but also restrict them from participating in decisions that affect their health, resulting in greater health inequalities (Shaikh and Hatcher, 2004). In this study, the financial constraints do affect the health-seeking behaviour among migrants when they face health problems. The findings show that, of all participants, seven of them did not take any treatment upon falling ill, they would typically wait and see, hoping the illness would go away by itself. Twelve of the migrants chose self-medication because of the low cost. Although 17 migrants sought treatment, 13 of them chose private clinics. This investigation also indicates how the migrants use medical services for illness. If they get minor ailments, for instance a cold or headache, generally they buy medicine from a pharmacy. If they are unable to treat the illness themselves, with regard to a cheap health service, their first choice is a private clinic, followed by a small public hospital, then a city level hospital. In Dengcun Village, there are many small private clinics which are all illegal. Many migrants are attracted by the private clinics because of the cheap price. The high cost of public hospital services makes their use by the migrants, prohibitive.

Borrowing money

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

In this study, the options for money-borrowing which are taken into consideration by migrants are: the lowest possible interest rates, flexibility, loan terms and money from family members, relatives or friends. People are much more comfortable asking for the money from family members and relatives. For 20 participants, the family members and relatives were seen to be willing to lend money when asked. Of course, borrowing can be dangerous; relationships can be ruined if people are still in financial difficulties when it comes to the time to pay it back. If they borrow from relatives or friends but fail to pay them back, they could lose their relationship, friendship and further support. To avoid the emotional strain on the relationship, there should be a kind of trust between two agents in relation to the situation. That is why keeping a good relationship is the key to successful money-borrowing from close acquaintances.

Despite this potential danger, the participants revealed that they still preferred to borrow money from their family members, relatives, migrant friends and laoxiang when they needed money for medical treatment but lacked savings. The findings show that there is a sequence of people from whom they can borrow money. According to the data, family members or relatives are their first choice, 20 participants chose family members and relatives for financial help, whereas 9 participants chose their migrant friends or laoxiang.

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

In the case of Mr Feng, below, it indicates that laoxiang also plays an important role for migrants in getting assistance for their medical treatments.

I have been working as a motor tricycle driver in Dengcun Village and the Dahongmen area for around 10 years. I fell ill with rectocele and strained my lumbar muscles because of this manual work. This ill-health has preyed on me for years, and when I was in great pain, I only visited the private illegal clinic for pain-killers because of cheaper charges there . . . I do not have any friends who are urban residents in Beijing and my social circle is limited to relatives, migrant friends and Laoxiang (migrants who are from same village, county or province). I think that discrimination against migrants is still common in Beijing, and believe that the social networks among migrants are very important for living, including health-care access, for example, a few years ago I borrowed some money from my Laoxiang and bought a motor tricycle for this business, and when I need medical treatment but lack money, I usually seek financial support from my migrant friends. (Mr Feng)

Emotional support

Another aspect of support availability when coping with ill-health is emotional support from their social networks. The perception of emotional support among the interviewed migrants can be shown as reducing the feelings of isolation and insecurity and enhancing the feelings of integration and well being. The migrants in the sample perceived that both family members and relatives could be relied on to provide various forms of emotional support, such as encouragement and comfort from their brothers and sisters. It also appears that the feelings of security and belongingness provided by family members and relatives might have maintained the moderate state of minds of those participants who were exposed to the risk of social exclusion. This finding suggests that social networks, which have the effect of being encouraging, affirmative and constructive, must be very supportive to the participants in alleviating ill-health and keeping them from social exclusion. It is quite consistent with Wellman and Wortley’s statement (Wellman and Wortley, 1989) that highly interconnected networks, especially kinship-dominated networks have a number of advantages because they may foster an intense social support system, thereby reducing the feelings of isolation and decreasing the risk of relapse.

Moreover, from the participants, it can be seen that not only the kinship relationship can provide emotional support, but support can also be available from a group of people outside of a kinship relationship. In the case of Mr Shi, emotional support from outside a kinship relationship is also an important help in his restoration to health.
I remember that I got a serious health problem, pleurisy, in 2004. I received an operation in the Tiantan Hospital in Beijing and spent almost ten thousand RMB Yuan at that time. I borrowed some money from my laoxiang to pay for this treatment. During that time, I had to stay in bed for two months. My wife gave me much emotional support and she covered everything including housework. Besides, I normally kept on good terms with my employer, and he gave me kind help during my illness. He visited me and promised that he would keep my job open until I got well. My employer's support made me fell good and also helped me to get better sooner. (Mr Shi)

DISCUSSION

A limitation of the paper is that it is based on findings from a small fieldwork study, in a migrant community in Beijing. Although it has a potential to seed a lively and constructive debate, in view of the lack of studies on the social networks and health-related issues of migrants, it should be considered a necessity to conduct a larger-scale study of migrants in urban China to take account of the interests and health promotion of migrants.

The study highlights the nature of social networks and the findings also highlight that social networks, although helpful, are limited given that they are based on small kinship and friendship networks. The findings indicate that the social networks resemble a double-edged sword to rural–urban migrants in terms of health-care access. The fact that the migrants lack savings may not be the sole reason making them extremely vulnerable at times of illness. Some migrants, who are in financial difficulties though, may have some assistance, including financial support and emotional support from their social networks. But on the other hand, their limited social networks may cause negative effects on their health as well as their health-care access.

One way suggested to improve the lives of migrants and protect their rights is to organize them and help them to be involved in effective networks of support. As stated by Zhao (Zhao, 2000), there are various types of informal mutual-aid organizations being run by migrants. Some of these organizations are economically oriented (e.g. informal organizations for migrants in the transport and loading industries), and some are socially oriented (e.g. fellow villagers, kinsmen or relatives). Apart from satisfying basic material needs, such as food and housing, these organizations facilitate the collection and exchange of information and provide a sense of security for migrants. At the current stage, some of these organizations are loosely operated, and they can be a sensible alternative for the central and local governments to more ably care for the migrants. If the government can guide and prompt the development of these organizations, they can substantially help the migrants with regard to health services in the city.

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

The discussion reflects the consequences of current discriminative public health policies towards rural–urban migrants. China has a long history and tradition of the Household registration system (Hukou system). After the People's Republic of China was founded, the household registration system was continued since the end of 1950s. For a few decades, it played a positive role in reducing the pressure and burden of cities, slowing down the speed of urbanization and maintaining social stability. Along with the persisting role of this system, it has gradually become a barrier for people in rural areas to share opportunities and resources with urban residents and has shut rural–urban migrants out from the formulation of urban ‘rules’. Rural–urban migrants have no say in health policies and no rights in using public health facilities (Xiang, 2005). Thus, there are some implications for the policies: first, a general perception is expected to establish that the legitimate rights and needs of migrants should be respected and protected. Governmental divisions working with migrant administrative matters should change from the old role of extensive control and management to that of service, and the awareness of equal treatment between migrants and resident needs to promote. Second, enhance the support from government further and improve the collaboration between the health sectors and other governmental divisions.
As to the government branches, especially the health divisions, their function should cover both medical services and administrative work among migrants.

To broaden the social networks of migrants, this study suggests that migrants might be covered by the community-based medical services. As a part of the social network, the community-based medical services can be a new means for health support to migrants. Community medical services for migrants are also expected to be integrated with local health planning, and the employment units or neighbourhood committees should be placed in charge of the planning work. With the development of grassroots public hospitals in residential communities, comprehensive preventative services and treatment for common and minor diseases within the neighbourhood can be provided to all the registered residents, including migrants.

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