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中山大学流动人口卫生政策研究中心
Sun Yat-sen Center for Migrant Health Policy

Policy Actors and Policy Making for Better Migrant Health in China

From a Policy Network Perspective

Yapeng Zhu, Kinglun Ngok and Wenmin Li

Migration and Health in China

A joint project of

United Nations Research Institute for Social Development

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The Sun Yat-sen Center for Migrant Health Policy (CMHP) is a multidisciplinary research institution at Sun Yat-sen University (SYSU), Guangzhou, China. Funded by the China Medical Board (CMB), CMHP was established by the School of Public Health, School of Business, School of Government, School of Sociology and Anthropology and Lingnan College of SYSU in 2009. CMHP aims to take a leading role and act as a hub for research, communication and policy advocacy on issues relating to health and migration in China.

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Introduction to Working Papers on Migration and Health in China

This paper is part of a series of outputs from the research project on [Migration and Health in China](#).

China is confronted by major challenges posed by the massive population movement over the past three decades. In 2009, approximately 230 million rural inhabitants moved temporarily or permanently to cities in search of employment and better livelihoods. Such large-scale mobility has huge implications for the pattern and transmission of diseases; for China's health care system and related policies; and for health of the Chinese population in both receiving and sending areas. The health and social issues associated with population movement on such an unprecedented scale have been inadequately addressed by public policy and largely neglected by researchers. Based on interdisciplinary research across the health, social science and policy fields, this project constitutes a major effort to fill research and policy gaps. Collectively, the papers and commentaries in this series aim to provide a comprehensive assessment of the health and public policy implications of rural to urban migration in China, to inform policy and to identify future research directions.

This project is a collaboration between UNRISD and the Center for Migrant Health Policy, Sun Yat-sen University, Guangzhou, China, and funded by the China Medical Board.

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Acronyms

AIDS	Acquired immunodeficiency syndrome
CPPCC	Chinese People's Political Consultative Conference
HIV	Human immunodeficiency virus
ILO	International Labour Organization
NCMS	Rural New Cooperative Medical Scheme
SARS	Severe acute respiratory syndrome
UEBMI	Urban Employee Basic Medical Insurance
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
URBMI	Urban Resident Basic Medical Insurance
USD	United States dollar
WHO	World Health Organization

Abstract/Summary

Given the phenomenal scale of internal migration in China, migrant health has become a prominent policy issue. Various policy actors are now involved in the development of migrant health policy. However, little is known about who the main policy actors are, what roles they play, how they interact with each other, and how they might improve their collaboration for better migrant health. This paper aims to identify the main policy actors and explore their roles in migrant health policy making. Applying a “policy network” approach, it finds that the marginalization of migrants in terms of health benefits is mainly attributed to a closed policy network resulting from the peculiar political structure and specific institutional arrangements. Based on these findings, the authors argue that an inclusive policy network is needed to overcome the major institutional barriers and better satisfy migrants’ health needs.

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Keywords: migrant health; policy networks; health policy; policy making; China.

Introduction

China's health system has undergone dramatic changes in recent years. Most recently the state has accelerated the development of health insurance programmes with the goal of achieving universal access to health care and better risk protection. By the end of 2011, the new rural cooperative health insurance system covered 832 million farmers, accounting for more than 95 per cent of the rural population (Xinhua News, 2012). About 473.43 million people are covered by urban basic health insurance (252.27 million under the urban employee and 221.16 million under the urban resident basic insurance schemes) (Ministry of Human Resources and Social Security of the People's Republic of China, 2012). In total, about 96.89 per cent of the Chinese population is protected to some degree by some type of medical insurance.

Despite these remarkable achievements, only 18 per cent (or 46.41 million) of the 252.78 million migrant workers have joined the Urban Employee Basic Insurance Scheme (UEBMI) (Ministry of Human Resources and Social Security of the People's Republic of China, 2012), and 97 per cent (or 832 million) farmers have joined the rural medical insurance scheme (Rural New Cooperative Medical Scheme/NCMS) (National Health and Family Planning Commission, 2012). While rural-urban migrants have been crucial to China's rapid economic growth (Wang, 2008), they remain excluded from most social benefits, and face discrimination in labour markets and employment, social protection and access to education for their children because of institutional arrangements such as the *hukou* (household registration) system (Fan, 2001). They are also more vulnerable to health risks than other groups in China because of the occupational hazards of their work environments and the poor housing conditions in which they live, namely inadequate ventilation and sanitation. In addition, they lack information about and access to the limited medical services available to them (Wei et al., 2010).

As a group, migrants are susceptible to serious health problems and risks, including lower immunization rates, higher rates of contracting contagious diseases, higher rates of smoking and occupational health problems.¹ While the majority of migrants join the NCMS, they can barely benefit when seeking medical services in the cities because of the separation between the urban and rural insurance schemes. Most do not have access to regular medical services because they cannot afford medical costs or have rigid working schedules which prevent them seeking care. Instead, they often take medication without advice from a medical professional or seek medical advice from small clinics that are often uncertified and illegal (Hong et al., 2006). Overall, migrants and their families are generally disadvantaged relative to other groups in terms of access to medical care and related benefits (Wong et al., 2007).

Despite a growing literature on migration and health in China, the focus of most studies has been on the patterns, scope, and severity of specific migrant health problems or on countermeasures and policy interventions (see Zhan et al., 2002). Few studies have explored the development of migrant health policy focusing on major players and influencing factors in the policy-making process. This paper attempts to fill the gap by identifying the major actors involved and their interaction in the policy process around migrant health; it recommends the establishment of an inclusive policy network for better health policy for migrants.

¹ Gransow, 2010; Han et al., 2006; Hesketh et al., 2008; Hong et al., 2006.

The paper is structured as follows. The first section briefly reviews the existing literature on policy making in China and provides a theoretical background for the discussion that follows. The second section gives an overview of how migrant health policy has evolved in China. The third section highlights the major players and their interactions that drive the policy-making process in this field. The fourth section explains migrant health policy from a policy network perspective and discusses evidence of an emerging policy network. The paper then concludes by proposing an inclusive policy network.

Policy Making in a More Pluralistic China: A Policy Network Perspective

In the past few decades, China has undergone remarkable economic, social and demographic changes. Although many consider China’s political development as trailing behind its economic reforms, both the political regime and the policy-making process have changed considerably in recent decades. The policy-making process in China has become more open, allowing greater space for previously marginalized political and societal actors to play an increasingly important role.² In addition, the Chinese government has started to promote public participation through consultation and even in decision-making (Kornreich et al., 2012). In the context of the continuing opening up of society and its increasing exposure to global competition, external forces and factors—such as globalization, transnational enterprises, international organizations and non-governmental organizations (NGOs)—have also started to influence Chinese policy making. Reflecting these changes, the Chinese political regime has been labelled “authoritarianism 2.0” (Mertha, 2009) or “deliberative authoritarianism” (He and Thøgersen, 2010).

Western decision-making theories and models, such as the policy network framework, are increasingly being applied to the Chinese situation that help to understand profound changes in the state-society relationship, such as the interactions between government departments, mass media and cyber society, and the incremental inclusion of social organizations in the policy process.³ The policy network approach is an important framework of analysis in Western policy studies. A policy network is “a cluster of actors, each of which has an interest, or ‘stake’ in a given policy sector and the capacity to help determine policy success or failure” (Peterson and Bomberg, 1996: p. 8). Policy networks are crucial in accounting for processes of governance (Durning, 2004; Rhodes, 1997), policy formulation (Atkinson and Coleman, 1992; Wright, 1988), and policy changes or even paradigm shifts (Coleman and Skogstad, 1995; Coleman et al., 1996). According to the policy network approach, policy making should be viewed as the outcome of “games” consisting of a series of interactions among actors influencing decision making on certain policy issues as well as their implementation (H. Zheng et al., 2010). Features of network structure are among the key variables that affect policy changes and outcomes.⁴ For instance, corporatist policy networks are conducive to facilitating “the cumulative, negotiated, problem-solving trajectory to paradigm change whereas state-directed or pressure pluralist networks are more likely to be associated with crisis-driven change.” (Coleman et al., 1996: p.298). The configuration of a policy network creates the ideas and interests that influence the essence (incremental or paradigmatic) and tempo (rapid or gradual) of policy change (Howlett and Rayner, 1995).

² See Cho (2002); Mertha (2009); Saich (2000); X. Zhu (2008); Zhu (2012).

³ For instance, Groenleer (2012); Hammond (2013); Zheng et al. (2010).

⁴ Coleman et al., 1996; Howlett, 2002; Howlett and Rayner, 1995.

Although some analysts of China do not consider networks to have a major influence on the policy process, because of the relative novelty of NGOs in China (Green et al., 2011), some studies have found the application of the framework useful in analysing policy making in China. For example, analysing the case of urban health reform, Zheng et al. (2010) critically review the suitability of the policy network approach. They find that this approach serves as a useful tool for understanding China's policy making process, although it needs to be adjusted in certain ways because of structural and cultural differences between China and other countries where it has been applied (Zheng et al., 2010). Recently, more studies have applied this research tool to China (Zheng et al., 2010; Zhu, 2008, 2013). Chan and Seddon (2012), for example, contend that network governance is "an effective and legitimate way of formulating and implementing Chinese education policy". Zhu further attributes major housing problems to the fact that a closed policy network dominates housing policy making and defines the adoption of policy instruments, thus hindering significant policy change in the housing field (Zhu, 2008, 2013).

In sum, policy making in China has become more inclusive, pluralistic and accessible—subject to both domestic and external influences—which justifies the soundness of the theoretical lens of policy networks. Drawing on the existing literature,⁵ this paper seeks to explain health policy making through this lens. Before investigating the health policy-making process, the next section documents the development of migrant health policy in China.

From Neglect to Inclusion: The Migrant Health Policy Shift in China

Rural-urban migration has generated phenomenal change in contemporary China. Despite their remarkable contribution to China's economic growth, migrants are generally excluded from social security schemes, and their social needs have been largely ignored, making them "a super-exploited segment of the working class" (Croucher and Miles, 2010: p. 2).

Broadly speaking, health policy for migrants in China can be separated in two phases. The first phase, from the 1980s to the mid-2000s, is characterized by long-term neglect of migrant health needs. From 2006 onward, the government made a concerted effort to establish a universal health insurance system and to actively respond to migrant health needs.

At the outset, the only concern about migrants' health came from the State Family Planning Commission, which tried to make sure that migrants complied with the one-child policy (Holdaway et al., 2011). Even the Labor Contract Law, which took effect in 1995, required employers to provide a proper working environment and prohibited them from breaking their contracts with workers suffering from occupational diseases or on maternity leave. However, the law did not protect migrants because of its ambiguous definition of workers. It was only in 2002 when the government passed the Occupational Disease Prevention and Cure Law that rural migrant workers were explicitly included as part of the national workforce and granted equal protection with regard to the prevention and treatment of occupational diseases. With limited skills, migrants tend to work in labor-intensive sectors with low salaries and low status, and in

⁵ Coleman et al., 1996; Howlett, 2002; Howlett and Rayner, 1995.

extremely risky and dangerous environments where they may have great difficulty in meeting their basic health needs (Wang, 2006).

Acknowledging this situation, in 2003 the central government issued documents extending the coverage of industrial injury insurance to rural migrant workers. The “Regulation for Work-Related Injury Insurance,” effective 1 January 2004, specifies the rights of, and the amount of compensation for, employees who suffer from work-related injuries and provides equal protection to both urban employees and migrant workers. This marked the beginning of national social legislation for migrants (Li, 2004). Noticeably, what the government was most concerned with in this period was improving migrants’ working environment and preventing occupational diseases, implementing family planning policy, and reducing public health risks associated with migrants. However, the government was much less concerned with addressing individual health needs of migrants or their unaffordable medical care. In terms of migrant policies, 2006 was a watershed. The SARS crisis and the change in China’s top leadership brought a policy shift in China. Under the catchphrases of “establishing a scientific outlook on development” and “building a harmonious society,” the priority in policy making shifted from an overemphasis on economic growth to a focus on sustainable development, involving a balance between economic development, social equality and environmental protection (Ngok and Zhu, 2010). Propelled by this general policy shift, 2006 witnessed a milestone in public service provision and rights protection for migrants in China. In March 2006, the State Council formulated a comprehensive guideline entitled, “Some Opinions on Resolving the Problems Faced by Migrant Workers”. This was the first central directive specifically focused on rural-urban migrant workers and was designed to tackle the various problems faced by migrants. Significantly, the directive emphasized the significance of solving the problems of migrants, stating that this “concern[s]...the overall economic and social development,” and is “a salient issue to be tackled,” and “a strategic task of building up socialism with Chinese characteristics”.

The document covers almost all aspects related to the livelihoods and work of migrants, from low salary and delayed payment, labour management and training, to social security and access to public services. In order to achieve the policy goals, a coordinating conference mechanism—consisting of related ministries and mass organizations like trade unions, youth leagues and women’s associations—was proposed and officially established in March 2006. In addition, there was a clear separation of work between central and local government in terms of rights protection and service delivery to migrants (the lack of which was a major reason for the mistreatment of migrants). In terms of health care, local governments were required to (i) establish a system regulating occupational safety and sanitation; (ii) provide industrial injury insurance coverage to migrants; (iii) implement sickness protection for migrants and provide immunization service to migrants’ children; (iv) offer birth control counselling; and (v) improve migrants’ housing conditions. This document marks a significant shift in migrant health policy from management-oriented, passive, piecemeal responses focused on narrow issues to a comprehensive, rights- and needs-based health protection system.

Following this central directive, the Ministry of Labour and Social Security specified approaches for rural migrant workers to access health care services and medical insurance in cities (for example, “Notice on Involving the Rural Migrant Workers into the Medical Insurance”). It also launched a special campaign to include migrant workers in the medical insurance system, attempting to extend the coverage of the medical

health insurance to contract-based migrant workers in manufacturing, construction, mining and service sectors in major and capital cities in China. This major shift in migrant health policy was further reinforced by the 17th Party Congress in October 2007, in which the top leaders committed to establish a universal health insurance system and make health care more affordable and accessible.

Currently, China has established universal coverage through NCMS, UEBMI and the Urban Resident Basic Medical Insurance (URBMI).⁶ This insurance system is supplemented by public medical services, commercial health insurance, and health aid schemes in both rural and urban areas (Liu, 2009). There are, however, large disparities between these schemes (Cook and Dummer, 2004). Migrant workers are entitled to join one or several insurance schemes (see table 1). Because of the low threshold, most migrants participate in NCMS. However, this provides limited benefits when they seek medical services in the cities. They are often required to return home for reimbursement, which is costly in terms of both time and money. They are subject to various restrictions, including a complicated processing system and the requirement to provide certification and proof; and NCSM schemes are usually designed to have a lower rate of reimbursement outside the county, or in urban health facilities. All of these issues inhibit migrants from getting appropriate health care and support.

Table 1 Eligibility and benefits for migrants in main health insurance schemes

Insurance Scheme	Effectuation time	Eligibility for migrants	Finance and benefits
NCMS	2003	All farmers are eligible to join; family as a unit; migrants are required to return hometown where they participate the insurance scheme to reimburse, subject to various limitations	Co-funded by the state, collectives and individual with the state playing a major role; covering mainly in-patient cost and catastrophic illness; reimbursement are also provided to outpatient for minor and chronic diseases in some cities
UEBMI	Piloted in 1988; expanded in 1996 and established in 1998	Covering migrants employed in formal sectors; compulsory; expanding to migrants with flexible jobs in some areas	Contributed by both employers and migrants; two separated accounts i.e. a pooling account and individual account, respectively covering in-patient and major diseases, and clinical services, medicine and self-paid medical service
URBMI	Piloted in 2007 in 79 cities; carried out nationally in 2010	Covering migrants in informal sectors, without fixed jobs; minor, the elders without pensions; non-compulsory; individual as unit	Mainly rely on individual contribution and supported by the government; covering mainly in-patient and clinic cost for major diseases; extending to clinical services in some areas

Source: Adapted by the author.

⁶ While the medical insurance coverage is almost universal, it does not bring universal access for many reasons.

Many migrants are not eligible to join the UEBMI scheme because they work informally, or without formal contracts. Employers (including in formal enterprises) can take advantage of a “loophole” in the labour laws that permits employers not to provide health insurance coverage to “temporarily-employed” staff (Zhan et al., 2002). For those migrants workers who are entitled to participate in URBMI, the majority choose not to join because they have to pay a high proportion of the cost themselves. By the end of 2011, only about 18.36 per cent (46.41 million) of migrants had joined URBMI (Ministry of Human Resources and Social Security of the People's Republic of China, 2012). Responding to this, in 2012 the government piloted a scheme in one or two provinces to give migrants access to medical care in places other than their hometowns and made plans to expand the scheme to other provinces during the 12th Five-Year Plan (2011-2015) (Xinhua News, 2012).

The above discussion of the changing contours of migrant health policy in China raises other questions. Why have the health needs of such a large population group been neglected for so long? Why has migrant health policy evolved in this way? The next section seeks to address these questions, focusing on major players and their roles in the policy-making process.

Policy Actors and Their Role in Health Policy Making

The policy-making process has become more open in China (Mertha, 2009), giving both state and societal actors more opportunities to be heard and to get involved in policy formulation and implementation. In China’s multi-level of governing structure, two types of state actors can be identified: central state actors and local state actors. While the central state actors include central government departments and officials, local state actors come from government at the provincial, municipal, county and town/township levels. In the field of migrant health policy, state and societal actors as well as international factors all have a role to play. The central state actors include the health bureau, human resources and social security departments, development and reform committee, and the finance department. Local state actors are government departments at the county and municipal levels dealing with affairs relating to migrants in both “home” and “host” localities. Societal actors consist of social organizations and NGOs, mass media and experts. All these actors interact with each other and shape the development and implementation of health policy for migrants within a rapidly changing political, social and demographic setting.

Fragmented health administration and dominance of state actors at the central level

In China, state actors still dominate the policy process, though societal actors are involved and play an increasingly important role (Mertha, 2009; Zhu, 2012). In the health policy field, the state is vital to the health care needs of the vast majority of the population (Cook and Dummer, 2004). The state’s significant role in migrants’ health services stems from at least three areas in which the state has control. First, the central government has absolute authority to set agendas and make decisions. State policies and regulations are the biggest barrier for migrants to exercise their social rights and claim benefits in towns and cities where they make remarkable contributions every day (Ngok, 2012a). Second, the state plays a major role in defining the parameters of health care (Cook and Dummer, 2004). It shares the responsibility of providing medical services with employers, family and individuals. Third, the state owns, controls and distributes most resources.

Crucial to migrant health policy making is coordination and cooperation among different central ministries. Because of the overlapping party and state structure and the fragmented nature of the administrative structure, several ministries are key in policy making and policy implementation (Lin et al., 2010). For instance, the Ministry of Health (renamed the National Health and Family Planning Commission since 2013) is in charge of supervising and managing public hospitals and running NCMS. The Ministry of Human Resources and Social Security is responsible for social insurance management and funds, civil service insurance, as well as for UEBMI, URBMI, and medical aid. The Ministry of Finance is crucial in distributing regular budget allocation for health care. The National Development and Reform Committee plays a key role in formulating long-term health development and planning. Besides these, the Ministry of Personnel, the Ministry of Education, the Ministry of Civil Affairs, the National Administration of Prices, and the State Administration of Taxation, all have a role in health care, though problems with the division of labour lead to the duplication of efforts as well as gaps in results (Fang, 2008). As rational players trying to maximize their bureaucratic power, each has different goals, perceptions and strategies, and they interact with each other in the policy-making process (Zheng et al., 2010).

The fragmentation of the administrative structure has distinctive drawbacks. It prolongs decision making, increases the costs of coordination and worsens problems in policy implementation.⁷ It partly accounts for and reflects the limitations of the Chinese health regulatory system (Fang, 2008). It also leads to a fragmented system of health insurance, which not only increases the administrative costs of providing medical services to both urban residents and migrants, but it also affects the quality of medical services provided.

Even worse, the weak and passive role played by the central government in migrant health care has led to local variations and hindered the improvement of migrant health benefits. As Xin Gu, a well-known health policy expert, when interviewed by a journalist, asserts:

“The missing role of the state in health insurance lawmaking is the root reason for local variance in health insurance policy.... ‘Everything is ambiguous; local governments have to make all specific regulations themselves’.” (Zheng 2012)

Naturally under this condition local governments adopt different standards of health benefits, which leads to a situation where people strive to move into cities with higher standards of benefits while there are fewer participants in cities with lower standards.

Differentiated local governments

Local governments are key actors in both the formulation and implementation of policy in China. They are not only responsible for mobilizing resources and “getting things done,” but they also take the initiative to work out solutions to various social problems. Many central policy directives have drawn upon local initiatives and policy innovations, which is regarded as a distinctive feature in China’s policy-making process (Heilmann, 2007, 2008; Zhu, 2012).

Local policies and regulations largely determine the health benefits of migrants. First, efforts to meet the health needs of migrants are made at the local level. Due to the lack of specific central policy directives to tackle migrants’ health needs, major hubs for migrants such as Beijing, Shenzhen and Shanghai have been trying to figure out a way

⁷ Lieberthal and Lampton, 1992; Lieberthal and Oksenberg, 1988; Lin et al., 2010.

to respond to the increasing pressures of providing health protection for migrants. In terms of coverage, finance, benefits and management of migrant medical insurance, these cities have adopted different models (Li and Yang, 2009). In other words, the extent to which migrants benefit from health care services depends largely on the local governments where they work and live.

Second, there are substantial differences between the positions of sending and receiving governments when it comes to health care for migrants. Most sending governments, often located in the underdeveloped western and interior areas, have limited capabilities and little incentive to meet the health needs of peasant workers who live and work elsewhere. They tend to hold the viewpoint that, since migrants greatly contribute to the cities where they live and work, the wealthier receiving governments in these cities should be primarily responsible for providing health services to migrants. At most, they are serious in promoting the development of NRCM, which migrant workers are entitled to join. However, practically speaking, migrant workers do not benefit from NRCM. NRCM requires its participants to receive medical services in designated clinics and hospitals in their hometowns or to go back home to seek reimbursement for their medical bills through a complicated procedure with harsh restrictions. Usually working far away from their hometowns, most migrants cannot afford the time, money and energy to claim their benefits.

Host cities are mainly concerned with three aspects of migrant health—infectious diseases, maternal health, and occupational disease and injuries—rather than the basic medical needs of migrants. Thus, most host cities face the dilemma between not wanting to overburden local finance by extending medical coverage to migrants on the one hand, and preventing potential public health crises on the other (Hu et al., 2008). As discussed in the above section, receiving governments strive to minimize their investment in migrant health care by limiting beneficiaries to employees who work in formal sectors, reducing medical benefits and services for migrants, and imposing strict restrictions. The reluctance of host cities to meet the medical needs of migrants is an illustration of how reluctant stakeholders are to share resources and incorporate migrant workers into urban medical care schemes (Biao, 2005).

Even worse, some local governments take advantage of migrants to the benefit of local residents. For instance, coastal cities tended to formulate policies to incorporate migrants into local social insurance schemes. However, one of the main motivations was to take resources away from the migrants to subsidize local residents by taking advantage of a better health status of the migrants and imposing a restrictive eligibility and low payment standard (Xiao, 2011).

International actors in the context of globalization

In the context of globalization, international bilateral or multilateral organizations, international NGOs and foundations, and educational and research institutions play a very important role in the health policy-making process in China. Major international “players” who have been influential in China include the World Health Organization (WHO), United Nations Children’s Fund (UNICEF), United Nations Joint Programme on HIV/AIDS (UNAIDS), World Bank and the International Labour Organization (ILO) (Lin et al., 2010). For example, international NGOs have helped shape China’s policy on HIV/AIDS (Zheng and Lian, 2005). From 1998 to 2009, China participated in 276 international cooperation projects focused on HIV/AIDS prevention and control. During this period, international partners not only contributed more than USD 526 million for HIV/AIDS efforts to make up for insufficient public funding, but they also

achieved remarkable success in terms of policy advocacy, improving the policy environment, and supporting social organizations and strengthening their capacity (Sun et al., 2010). Broadly speaking, these international actors affect health policy making in China in three ways: (i) by providing technical assistance for policy development; (ii) by providing financial assistance and donations; and (iii) by promoting the transfer of knowledge and medical education (Lin et al., 2010).

Societal actors in health policy making

Global forces and domestic societal actors greatly influence health policy making in China. Among these forces, mass media, think tanks, experts and NGOs, as well as important events that act as triggers, play an increasingly important role in shaping migrant health policy. First, public health is steadily becoming a hot-button issue in China, which provides a growing opportunity for civil society organizations to play a role (Morrison et al., 2007: p.8). For instance, Beijing Yilian Legal Aid and Research Center of Labor, a civil society organization, has demonstrated its commitment to advancing labour rights in China and to improving the labour law. It conducts research on labour rights and law, advocates for positive changes to Chinese labour law and policy, and raises awareness of labour rights. The centre played a vital role in shaping the Law on Prevention and Control of Occupational Diseases by investigating the seriousness of occupational disease in Beijing, drafting a proposal for modifying the law, and actively taking part in the policy formulation process. In November 2010, when the Legislative Affairs Office of the State Council openly sought their advice on amending the law, the centre seized the opportunity and published a 17-page report, containing many suggestions that were then adopted and incorporated into the new version of the law promulgated in 2012 (Xie, 2011).

Aside from NGOs, policy entrepreneurs (for example, experts, scholars, stakeholders and officials) are playing an increasingly important role in health policy making in China.⁸ They are also active in promoting migrant health policy development. An example is Gao Yaojie, who is an advocate, well-known both in China and worldwide for her AIDS prevention work during the HIV epidemic in Henan province and for bringing much greater attention to people suffering from and children orphaned by AIDS.

In addition, mass media is crucial in directing public attention to key social issues by reporting on social problems, analysing the causes and recommending options. Although mass media traditionally serves as a propaganda tool of the party-state and is subject to strict censorship, it has gained considerable autonomy in setting the agenda. This is because of the introduction of private investment in the market, which has intensified competition. For instance, on 29 July 2005, *China Youth Daily* published the results of research conducted by the Development Research Center of the State Council (with technical support from the WHO and financial support from the UK Department for International Development). The message was that health reform in China has not been successful. The report contributed to public debate on health policy issues that led to a new wave of health reform in the following years (Lin et al., 2010). Health reform in China has moved away from focusing on marketization to reasserting the role of the government in financing health reform and promoting health equality. This can potentially benefit disadvantaged groups, including migrants.

⁸ Hammond, 2013; X. Zhu, 2008; Zhu, 2012.

Moreover, the Internet is a critical force affecting policy making in China. It not only provides a fast and revolutionary way of transferring information and communicating, but also means increased supervision of the government by the public. The rise of cybersociety has resulted in a wider public sphere and has greatly transformed agenda-setting processes in China (Zhu and Cheng, 2011). The role of the Internet is clear from the Zhang Haichao event discussed below.

Last but not least, triggering mechanisms or focusing events are a key factor driving policy change (Birkland, 1997, 1998; Kingdon, 1995). For instance, many migrants are working in very poor, dangerous and even hazardous environments. They are susceptible to various occupational diseases and hazards. By the end of 2010, there were a total of 750,000 cases of occupational diseases, including 653,000 cases of pneumoconiosis and 47,000 cases of occupational poisoning. Of these, 27,240 were newly reported in 2010, an increase of 50 percent from 2009 (Wang and Tao, 2012). However, patients, particularly migrant workers, are often not officially recognized as patients with occupational diseases. In June 2009, Zhang Haichao, a young migrant worker, had to undergo a lung biopsy in order to prove the diagnosis of pneumoconiosis (a serious industrial hazard he had suffered from his job as a factory worker) because of the legal restrictions and hurdles he faced in getting the treatment he needed. National mass media, including major websites, brought attention to his case. This provoked harsh criticism of unreasonable policies and laws on occupational disease prevention. On 30 July 2009, 15 mass media outlets openly called for a revision of the Law on Prevention and Control of Occupational Diseases.

Under pressure from society, government departments and law-making organs took active measures. The local authority intervened, and Zhang Haichao received reasonable compensation that should have been given to him without the unnecessary operation. The Ministry of Health modified the regulations on the application procedure for occupational disease check-ups, launched a national investigation on occupational diseases and introduced new standards for pneumoconiosis (Li, 2009). In March 2010, members of the People's Congress and deputies of the Chinese People's Political Consultative Conference (CPPCC) recommended the modification of laws on occupational disease control and prevention.

On 31 December 2011, the amendment of the Law on Prevention and Control of Occupational Diseases was passed by the 24th Conference of the Standing Committee of the People's Congress. The new law explicitly expands the options of medical institutions for diagnosis, simplifies administrative procedures for the diagnosis and evaluation of occupational diseases, and includes more types of work-related diseases. It makes substantive progress in labour protection. Many believe that the passing of this new law is a direct response to the Zhang Haichao case (Lan, 2011).

The exclusion of migrants from the policy-making process

In general, the public, and the groups targeted by policy in particular, are rarely directly involved in the policy-making process (Green et al., 2011). This is certainly the case when it comes to marginalized groups like migrants in China. Migrants are second-class workers in urban China, earning much less than urban workers (Démurger et al., 2009) and constantly facing severe social stigma (Chen et al., 2011). They are also excluded in terms of political rights, though there are exceptions. Since 2008, for instance, two migrants have been chosen as members of the National People's Congress, and it was expected that more migrants would be selected to the 12th National People's Congress (Huo and Cui, 2012). Migrants also have the chance to be representatives in various

local people's congresses and local party's congresses. In cities such as Guangdong, migrants are even entitled to take the civil servant exam, and if they pass, they can become civil servants in their host cities. Despite these developments, compared with local residents, migrants' political rights are not, on the whole, well protected, and they have little influence over policies concerning issues pertinent to them, including their health.

For example, according to a survey of government officials associated with service delivery for migrants in Guangzhou in 2010, 63.4 per cent of the 112 officials who gave valid answers (71 people) said that their agencies consulted with migrant workers and other stakeholders through various channels and incorporated their opinions into decision making when formulating policies and measures about migrant workers. Of the rest of those surveyed, 9.8 per cent answered "no" and the rest answered "unclear" (Ngok, 2012b: pp. 98-99). However, information gathered from a survey of 359 migrant workers shows that 3.9 per cent of the interviewees said that the local government consulted them only once about employment and livelihood policies. As many as 81.3 per cent said that the local government never solicited opinions from them. The remaining 14.8 per cent answered "unclear". The stark difference between 63.4 per cent and 3.9 per cent shows that government efforts to promote the participation of migrant workers are inadequate.

The exclusion of migrants from health policy making could be ascribed to the limited channels for their involvement in the policy process and the barriers they face in pursuing their interests through collective action. Legally speaking, migrant workers have the right to set up or join trade unions regardless of their employment, gender, nationality, race, religion and education. In reality, however, they are either not savvy enough to join unions or are denied membership by the official trade unions, which serve as a part of bureaucratic control (Zhu, 1995) and represent the interests of both workers and enterprises and local governments (Wong et al., 2007). Overall, while trade unions may represent the interests of workers in state-owned enterprises to some extent, their role in protecting migrants in small private and foreign enterprises is extremely limited (Wong et al., 2007) because of the power of corporatism and the prevalence of capitalism (Chen, 2003). The lack of collective action and interest representation accounts for the neglect of the various social needs of migrants in social policy making.

Explaining Migrant Health Policy: A Policy Network Perspective

At least in the health policy field, a policy network approach proves to be a suitable lens through which the policy-making process in China can be better understood (Zheng et al., 2010). In particular, the migrant health policy process includes the major features conceptualized by the policy network framework, such as interdependence and interaction among multiple actors, the erratic nature of the policy process and the effectiveness of network management.⁹

As discussed above, the social needs of migrants have been long neglected and received little attention from the state before the SARS crisis in 2003. This can be attributed to two facts. The first was the central government's monopoly over policy making in the authoritarian regime, under which NGOs, mass media and ordinary people were under strict state control and had little chance to engage in the policy-making process to

⁹ Kickert and Klijn, 1997; Rhodes, 1990; Zheng et al., 2010.

pursue their interests (Saich, 1981). The second was the fragmentation of the administrative structure. Government departments sought to maximize their interests in policy formulation and implementation, making coordination and cooperation extremely difficult (Lieberthal and Lampton, 1992; Lieberthal and Oksenberg, 1988). This can account for the disjointed and fragmented policies related to migrants' health—including policies concerning family planning, maternal health, occupational injury, contagious diseases and AIDS prevention—among different ministries.

Though still authoritarian in nature, the Chinese policy-making process has become more open and inclusive, accommodating more actors and interests. This change has occurred alongside an evolving state-society relationship and the rise of a cybersociety in China. As shown in the previous section, international influences, state actors and societal actors all play a role in the health policy process. To some extent, migrant health policy making has become embedded in a network setting, and the policy paradigm shift is the outcome of the interaction between different actors.

First, these actors are not static and isolated. Instead, there is frequent interaction and interdependence between them, a distinct feature of policy networks. For instance, Kaufman investigates how domestic NGOs supported by transnational NGOs interacted with the government and ultimately succeeded in transferring international norms and approaches for the prevention, treatment and care of AIDS to China, as well as in promoting policy adjustment in government responses to related issues (including sex worker rights, legal protection, compensation for people infected as a result of medical procedures, and access to essential medicines) (Kaufman, 2012).

Second, the government seeks to promote cooperation through network management. In order to overcome bureaucratic fragmentation and problems of coordination, which are major flaws of China's political structure, the central government established the Joint Conference for Work Related to Peasant Workers of the State Council in March 2006. This trans-ministerial organization, consisting of 31 ministries and agencies and headed by leaders of the State Council, aims to exchange information, formulate policies related to peasant workers, and coordinate related ministries when there is discrepancy among them.

There are also attempts being made at the local level, for example, regional cooperation between sending and receiving local governments to better respond to the health needs of migrants. In November 2006, a so-called Yangtze River Alliance, made up of 29 cities along the Yangtze River, was established. These cities signed joint agreements to get rid of discriminatory regulations and fees and promote social security for migrants, including health insurance, insurance for occupational injuries, and education for the children of migrants (Bao, 2006). This is a major step towards breaking administrative boundaries, redefining local interests, and promoting service delivery and rights protection for migrants. Substantial progress in this regard was made in November 2009, when three provinces (Anhui, Jiangsu and Zhejiang) and Shanghai signed the Yangtze River Delta Regional Medical Insurance Management Services Agreement. The agreement aimed to build a system for recognizing designated medical institutions for social medical insurance and a system for cross-regional medical reimbursement (Human Resources and Social Security Department of Jiangsu Province et al., 2009). The three provinces also created a workable guideline that was incorporated into the "Opinion on Employees' Basic Medical Insurance Transfer and Renewal," which went into effect in January 2010 (Qi, 2010). Since then, the medical insurance status of employees can be transferred across the three provinces. After the transfer and renewal

of an individual's status, medical insurance is available at the new workplace. This is a step that can truly benefit non-local employees, including migrants, in their access to health services.

The evolution of migrant health policy is closely related to the structure of the gradually inclusive policy network. The increasing involvement of NGOs, mass media and stakeholders in migrant health policy making, which also resulted in the introduction of new ideas, eventually led to a significant shift in migrant health policy. However, despite favourable policy adjustments at both the central and local levels, migrants are still marginalized in terms of health care. This is mainly due to the closed nature of the current policy network.

Currently, although the Chinese political system has been pluralized as a whole (Mertha 2009) and more actors are involved in the migrant health policy-making process, state actors still dominate the policy network and are largely insulated from societal actors and ideas. This closed network structure tends to lead to a gradual policy change rather than a fundamental paradigm shift (Howlett, 2002). Even when there is a change in the policy objective, previously perceived to be a distinct feature of a paradigm shift, a closed policy network that is dominant in the policy-making process may limit the choice of policy instruments and thus prevent a paradigm shift from taking place (Yapeng Zhu, 2013). Thus, even though the state claims to provide better health services to migrants, it will be a long road before this politically and socially marginalized group gains substantive benefits.

Conclusion

Migration is both a major determinant of and a challenge for global public health (Gushulak et al., 2009). Similar to the experience of international migrants, who are affected by health care policies within their host country (Zimmerman et al., 2011), the health care benefits that internal migrants in China receive largely depend on the capability and discretion of the cities and provinces where they work. Consistent with trends in policy making commonly seen elsewhere in the world, governments in host cities and regions tend to formulate and implement separate health policies for migrants that lead to unequal access to medical services, even when this might eventually harm public health (Zimmerman et al., 2011). As a result, migrant workers are still disadvantaged in terms of health and other social benefits despite remarkable policy developments at the central and local levels.

The unequal treatment of migrants in the realm of health care is a result of the closed policy-making process. Moreover, slow progress in the improvement of migrant health policy formulation and implementation can be attributed to the closed policy network and the dominance of state actors and weak role of societal actors. Policy making that does not incorporate the groups being targeted by the policy can neither be responsive nor effective.

International experiences are useful for China to deal with the health issues of internal migrants. In order to improve the health benefits and protection for migrants, there needs to be an open and inclusive policy network that incorporates actors such as international actors, governmental agencies, NGOs, experts, researchers and even migrants into the policy-making process (Gushulak et al., 2009).

Because of the crucial role of state actors in the formulation of policy, increased cooperation and coordination between different government branches and levels is extremely important for overcoming institutional hurdles against migrants. Given the high mobility of migrants, emphasis should be put on both the sending and receiving governments, as policy interventions should cover each stage of the migration process (Zimmerman et al., 2011). In addition, in line with the current focus on social construction at the top of the political agenda, the state should adjust the state-society relationship and allow for more space for social organizations and NGOs to play a role in health service delivery and policy advocacy for migrants. Further reform of the household registration system and urban public financing system is also recommended. Better information about services and their utilization should also be provided to migrants. Ultimately, in order to provide better medical services to these migrant workers, empowering them and allowing them to engage in the policy-making process are of fundamental importance.

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