

# The evolution of health policy in China and internal migrants: Continuity, change, and current implementation challenges

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## Abstract

Rural–urban migration is a defining feature of socio-economic change in contemporary China. It is estimated that internal migrants in China account for 20% of its population of 1.39 billion, providing manpower to the expanding urban industries. Yet internal migrants have long faced barriers to accessing health and other social services in urban destinations, and the migration process may expose them to novel health risks and inequities. Based on the analysis of policy documents and associated material, this article reviews the historical development of health policy in China in relation to internal migrants, identifying elements of continuity and change in the policy agenda and the ways in which migrants have been framed in policy formulations. Against this background, remaining gaps in the current policy framework and implementation challenges are discussed.

## KEYWORDS

China, equity, health insurance, health policy, internal migrants

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## 1 | INTRODUCTION

Internal migration has been a key driver of socio-economic and demographic change in China over the past four decades. During the 1980s, the economic reform created new and better wage opportunities in the expanding eastern coastal cities, attracting labourers from impoverished rural areas (Fan, 1999). From the 1980s to the present, a relaxation of restrictions on labour migration and the continued growth of industrial production in and around urban centres have promoted further migratory flows (Shen, 2013). Today, internal migrants account for an estimated 20% of China's population of 1.39 billion (National Bureau of Statistics [NBS], 2017), providing manpower to the booming manufacturing industry and remittances to their households in rural villages. Despite their vital contribution to the national economy, internal migrants in China have long faced institutionalised barriers to accessing public health and other social services in urban destinations (Cheng & Selden, 1994). In addition, the migration process may expose them and their children to health risks and health inequities (Chen, 2011).

In recent years, the central government and local authorities have paid increasing attention to migrants' health as part of the wider policy agenda towards more inclusive social and economic development (Gao, Yang, & Li, 2013). Although early health policy statements on migrants tended to focus on perceived threats to public health and family planning, in the 2000s policy and practice have shifted to the formulation of strategies to reduce inequities in access to social services. Nonetheless, gaps remain in the ability of the health system in China to provide this population group with affordable care, especially those employed in the informal sector.

In this article, we examine these developments in historical perspective, identifying elements of continuity and change in health policy statements related to internal migrants and associated implementation challenges. In keeping with constructivist approaches to policy analysis (Fischer & Forester, 1993), particular attention is paid to the differing ways in which internal migrants have been framed in policy formulations, reflecting changes in the wider context of political economy and governance. Research for this article involved the collection and analysis of a variety of data and information sources, including policy documents from ministries and government departments, published studies and reports, and demographic and health-related data on internal migrants from the National Bureau of Statistics. Policy documents were sourced between October 2017 and February 2018, following extensive searches in the public domain online repositories of the State Council ([www.gov.cn](http://www.gov.cn)), the Ministry of Finance ([www.mof.gov.cn](http://www.mof.gov.cn)), the Ministry of Human Resources and Social Security ([www.mohrss.gov.cn](http://www.mohrss.gov.cn)), and the National Health and Family Planning Commission, now National Health Commission ([www.nhc.gov.cn](http://www.nhc.gov.cn)). Appendix A provides an ordered list of all policy documents reviewed in this article, referenced in the appendix and the main text below using the unique identifier *doc-n year*.

## 2 | BACKGROUND: INTERNAL MIGRATION AND THE HOUSEHOLD REGISTRATION (*HUKOU*) SYSTEM

Internal migration in contemporary China has been shaped in unique ways by state policy and the changing context of political economy. Free movement of people was enshrined in the Constitution of the People's Republic of China, adopted in 1954, which established that all citizens enjoy "freedom of residence and freedom to change their residence" (Article 90).

During the 1950s, however, new rules were introduced to control population mobility amid concerns that the so-called “blind flow” (*mangmu liudong*) of peasants to cities could increase urban poverty and deprive the countryside of the labour supply that was needed to maintain the collective farming system (Cheng & Selden, 1994). State control of rural to urban migration was achieved primarily through the household registry system, known as *hukou*, whereby every citizen inherited a unique location of residence and residential status, classified as agricultural or non-agricultural. In practice, a farmer seeking to resettle in urban areas to take up non-agricultural work would need to change *hukou* registration and status, a process which was subject to strict eligibility criteria (Chan & Zhang, 1999). Further, without local *hukou*, migrants were excluded from welfare and social services in urban destinations, including housing, education, food supply, and health care. With these regulations in place, enforced from the early 1960s, rural to urban migration in China virtually halted until the late 1970s (Liang, 2001).

During the 1980s, this policy became inadequate to keep up with structural changes resulting from economic reform. Following China’s transition to a “socialist market economy”, which began under Deng Xiaoping, labour demand in the expanding urban factories, construction sites, and the service sector grew. At the same time, mechanisation and the transformation of collective agriculture into household farming increased agricultural productivity, generating a surplus of rural labour (Li, 1996). In this context, the government was forced to relax restrictions on population mobility. In 1984, the State Council issued a directive that allowed migrants to obtain a temporary residency permit, open to those who could not change their *hukou* registration (Chan & Zhang, 1999). As a result of these changes, waves of rural migrants moved to cities and towns in the eastern coastal regions, attracted by job opportunities and prospects of better income. It is estimated that more than 100 million Chinese moved to cities between 1980 and 2000 (Duan, Yang, Zhang, & Lu, 2008), a trend that has continued to the present day. Despite these developments, the *hukou* system remained in place, producing two categories of citizens with different status and entitlements: *hukou* residents, with full citizenship and access to state-sponsored social services, and non-*hukou* residents (often referred to as “the floating population” or *liudong renkou*), with lower paid jobs, lower social status, and unequal or no entitlements to social services in the place of migration, including medical care and health assistance programs (Chan & Zhang, 1999). In the first two decades of economic transition, these inequities were compounded by health sector reforms involving the introduction of user fees, market-based incentives, and a decreased reliance on state funding (Bloom, 2011). Although the quality of care in major urban centres improved (Deng, Dou, & Gong, 2013), disadvantaged groups, such as non-*hukou* migrants, could not afford higher medical costs and were not entitled to health insurance schemes for regular urban residents (Yip et al., 2012).

### 3 | THREATS TO PUBLIC HEALTH AND FAMILY PLANNING

The problem of inequitable access to health care was not addressed in early policy statements on internal migrants. The government was rather concerned with two threats this enlarging population group could pose to social order and population health. First, health authorities were worried that population mobility could promote disease transmission, undermining efforts to control and eradicate infectious diseases such as malaria. In 1985, the

Ministry of Health and other ministries jointly issued a new regulation that required migrants who were travelling from malaria endemic areas to keep a certificate proving that a malaria test had been undertaken (doc-1 1985). In addition, large construction sites and industrial units were mandated to monitor and check migrant workers regularly for compliance with malaria control policy. Second, concerns emerged that internal migrants could evade family planning regulations. The one-child policy was introduced in 1979 in response to the rapid population growth, followed by “a period of intense implementation of the campaign with sterilization, abortion and insertion of IUD [intrauterine devices]” (White, 1990). Towards the end of the 1980s, however, government surveys found that the efforts to achieve an average fertility level of 1.7 children per couple were failing (Kane & Choi, 1999). The floating population, frequently moving between jobs and cities, was seen as a major challenge to policy implementation and increasingly scrutinised. In an article published in the *Beijing Review*, one anonymous reporter noted:

One of the difficulties is controlling the birth rate among China's increasingly large floating population. It is estimated that some 50 million people have been moving around the country to make their fortune since China adopted its economic reform policy in the late 1970s ... Of the approximately 200,000 people from other provinces staying in Gansu, 10,000 are women of child-bearing age. Most of these women ignore the requirement to use birth control measures, and many take advantage of their situation to have more children than allowed. Unplanned pregnancies and births are commonplace among them. (*Anonymous* 1988)

Amid these concerns, the local governments in Beijing, Shanghai, Tianjin, Fujian, and other cities adopted new measures to inspect the circumstances of migrant workers, requiring the presentation of a family planning certificate in the application for temporary residence permits and business licences. Subsequently, the National Family Planning Commission, the agency established in 1981 to implement the one-child policy, extended these provisions nationwide, requiring local authorities to promote and enforce birth control measures in migrant workers (doc-2 1991). The first order was updated in 1998, with new penalties for the falsification of family planning certificates and allocation of responsibilities to other parties, including urban employers and landlords (doc-4 1998). Unlike the 1991 version, this document also noted the importance of safeguarding the “legitimate rights and interests” (*hefa quanyi*) of migrants. Yet a rights-based approach was not prioritised in early policymaking. Similar to the 1960s, policy development and implementation focused on perceived threats associated with the “blind and disorderly state” (*mangmu wuxu zhuangtai*) of the floating population (doc-3 1995).

#### 4 | MIGRANT HEALTH IN THE “HARMONIOUS SOCIETY”

In the early 2000s, the focus and content of state policy concerning internal migrants changed. Under the administration of Hu Jintao, the party leadership promoted a more inclusive approach to national development in recognition that the benefits of economic reform had accrued to a fraction of the population, whereas large sectors of society were left behind and marginalised. Based on the ideal of the “harmonious society” (*hexie shehui*), the government committed to poverty alleviation and increasing support to disadvantaged regions and

population groups (Zheng & Tok, 2007). In the process, the policy framing of internal migrants gradually shifted from concerns with the control of perceived threats to a greater emphasis on their vital contribution to the national economy and the need to protect their rights, prevent discrimination in the workplace, and improve access to public services. To achieve these goals, the State Council established an interministerial committee on migrant workers, which was mandated to discuss joint solutions to long-standing issues in the areas of social security, social integration, employment rights, and occupational health (doc-8 2006); concurrently, research and data collection efforts to provide evidence that could inform the policy process intensified (Lu, 2006). In 2008, the National Bureau of Statistics established a dedicated research unit, responsible for delivering the annual migrant workers monitoring survey, which tracks trends in geographic distribution, living conditions, and employment status (NBS, 2009). Further, the government outlined several policies that local authorities and employers were required to advance in support of migrant workers, with a focus on compulsory education and immunisation for their children, access to basic health services, equal and fair treatment in the workplace, and better integration in the receiving communities (doc-5 2003, doc-6 2003, and doc-7 2006).

Yet ensuring access to affordable health services for migrant workers in urban destinations posed significant challenges. As part of people-centred policy reforms, Hu Jintao promised a “bigger government role in public health, with a goal for everyone to enjoy basic health care service to continuously improve their health and wellbeing” (in Yip & Hsiao, 2008, p. 463). During Hu’s tenure (2002–2012), an important policy move to achieve this goal was the institutionalisation of two voluntary health insurance schemes, financed by a combination of direct government subsidies and individual contributions: the New Rural Cooperative Medical Scheme (NRCMS), introduced in 2003 to revitalise the former rural health insurance based on collectivisation, and the Urban Residents Basic Medical Insurance (URBMI), introduced in 2007 to cover the non-working population in the cities, such as children and the elderly, as well as those employed in the informal sector. Although these arrangements considerably expanded health insurance coverage for the whole population (Yu, 2015), they were ill-adapted to the circumstances of internal migrants. The NRCMS was designed to reimburse rural residents for care received in designated health facilities, located in their home county. Refunding of medical expenses incurred in urban areas was difficult to achieve, limiting the extent to which the NRCMS could be used by rural residents who moved to the cities (Mou, Griffiths, Fong, & Dawes, 2013). Similarly, eligibility to the URBMI was based on *hukou* registration, meaning that migrants with temporary residence permits could not access this scheme nor the mainstream insurance scheme for those employed in the formal sector (the Urban Employee Basic Medical Insurance [UEBMI]), in effect since 1998 (Qiu, Yang, Zhang, & Ma, 2011). In order to address these issues, new insurance schemes open to migrant workers without *hukou* registration were piloted in a number of metropolitan areas. In 2005, for example, the local government in Shenzhen introduced a Medical Insurance System for Migrant Employees, which was scaled up into a large program with more than 700 designated health facilities, covering 5.3 million migrant workers (Fong & Mou, 2014). Following this experiment, the Ministry of Labor and Social Security (subsequently incorporated in the Ministry of Human Resources and Social Security) issued guidelines to encourage other local authorities to develop occupational health insurance packages for migrants, based on “low fees and employer contribution” (doc-9 2006 and doc-10 2006). As a result, large cities such as Beijing, Shanghai, and Chengdu introduced novel approaches to expand health coverage for migrant workers, prioritising those employed in high-risk sectors such as mining and construction (Qin, Pan, & Liu, 2014).

## 5 | TOWARDS UNIVERSAL HEALTH COVERAGE

In 2009, the government issued a landmark health policy document to promote universal access to health services. In the *Opinions on deepening the health system reform* (doc-12 2009), the Central Committee of the Communist Party of China and the State Council reinstated the government's role in the health system, identifying goals, priorities, and strategies to improve access to affordable and equitable health care and essential medicines (Tang et al., 2008; Yip et al., 2012). In practice, sustained financial investments were made to expand coverage of the three mainstream insurance schemes. In addition, a major policy move was the establishment of a Basic Public Health Service (BPHS), which aimed to provide free of charge essential health services for all citizens at point of care (i.e., community health care centres, township hospitals, village clinics, and specialised public health institutions such as the department of communicable disease control). Since then, the BPHS has been implemented incrementally, with an increase in funding from 15 yuan per capita in 2009 to 25 yuan per capita in 2011 and 50 yuan per capita in 2017 (doc-26 2017). Further, the initial package of services has gradually been expanded, currently including services for health promotion, immunisation, child health, maternal health, geriatric health, hypertension and diabetes management, severe mental illness, surveillance and control of infectious diseases and other public health emergencies, traditional Chinese medicine, and the management of tuberculosis (Yang et al., 2016).

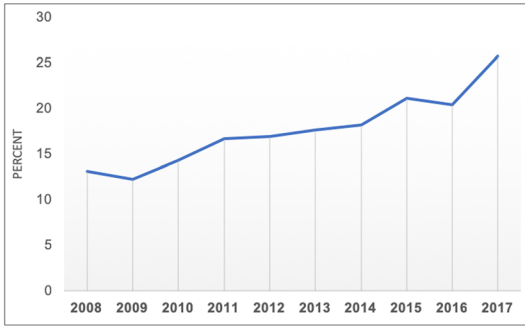
In this round of policy developments, the imperative of demographic control remained on the policy agenda. In 2009 and 2010, the National Population and Family Planning Commission issued new regulations to encourage local authorities to enforce, monitor, and manage the implementation of family planning in migrants, including educational programs to promote a “scientific, civilized and progressive concept of marriage and childbearing” (doc-15 2009) and to prevent unethical practices such as gender-based abortion (doc-17 2010). However, in keeping with the wider policy drive towards the “equalisation” (*jundeng hua*) of the BPHS, the question of access to health care for migrants was given more attention. Notably, the National Population and Family Planning Commission launched a pilot project in 29 administrative districts to strengthen infrastructure, human resources, and the information system in order to offer free prevention and treatment for different health issues, including infectious diseases (particularly mother to child transmission of HIV) and immunisation, non-communicable diseases (through regular blood pressure checks and promotion of healthy lifestyle), and occupational and mental health (doc-16 2010). From 2013, the incorporation of the former Ministry of Health and the National Population and Family Planning Commission under a single body, the National Health and Family Planning Commission (NHFPC), has provided stronger institutional bases to support a more coherent and integrated health service delivery. Soon after its establishment, the NHFPC initiated a new round of pilot projects in 40 cities with large migrant populations, focused on the implementation of BPHS among internal migrants in seven priority areas: information systems, health education, child vaccination, infectious disease prevention and control, maternal and neonatal health, family planning, and the development of new mechanisms to deliver these services (doc-20 2013). At the end of 2014, the NHFPC together with four other ministries issued further guidance on the management of basic public health services for migrants, aiming to fully integrate migrant workers in the local system of community health centres and to establish a unified urban and rural household registration system for medical care (doc-23 2014).

## 6 | CURRENT IMPLEMENTATION CHALLENGES

Over the past two decades, the Chinese government has made sustained efforts to improve access to health care for the whole population and support disadvantaged population groups. Medical insurance schemes have rapidly expanded and, according to official reports, today more than 95% of Chinese citizens are covered by at least one insurance scheme; given the sheer size of the country and its population of nearly 1.4 billion people, this is a remarkable achievement, heralded as the “largest expansion of health insurance coverage in human history” (Yu, 2015, p. 1145). Increasing investments from the central government in basic public health services, available free of charge to all Chinese citizens, have further contributed to an intensification of preventive and curative care in the communities (Yang et al., 2016). Yet gaps remain in the ability of the national health system to provide affordable care to internal migrants and thus to achieve a truly universal health coverage, defined by the World Health Organization as “ensuring that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship” (World Health Organization, 2010).

One important challenge is associated with employment status. By law, all workers employed in the formal sector are eligible for the UEBMI, which provides the most comprehensive package of benefits compared with the other mainstream health insurance schemes (the NRCMS and the URBMI) and was associated with higher reimbursement rates and higher utilisation of health facilities (Chen et al., 2017; Li et al., 2017). However, as documented in the annual survey of migrant workers, the majority of internal migrants (63.3% in 2016) are engaged in temporary works based on informal agreements with no labour contract (NBS, 2017). As such, they are not entitled to social and health benefits in the workplace, including medical insurance. Furthermore, even those who have a formal labour contract often decide to opt out from the UEBMI (and other social protection schemes), due to limited benefits and the need to pay higher insurance premiums (Jiang, Qian, & Wen, 2018). Indeed, despite an increase in the uptake of the UEBMI, in 2014 this scheme covered only 26.4% of internal migrants (Chen et al., 2017). As described earlier, a number of cities, such as Shanghai and Chengdu, have initiated special insurance schemes for migrant workers that can cover those employed in the informal sector. However, enrolment in these schemes is largely dependent on the employers, many of whom are reluctant to pay insurance contributions, especially for workers who are recruited on a short-term temporary basis (Müller, 2016). In Shanghai, for example, the Migrant Worker Health Insurance system achieved only 36.5% coverage, even though membership was mandatory for all migrant workers (Zhao, Rao, & Zhang, 2011).

The other two health insurance schemes, the NRCMS and the URBMI, are also inadequate to protect internal migrants, given the persistence of the *hukou* system. In 2014, it was estimated that the majority (66.6%) of internal migrants were enrolled in the NRCMS (Chen et al., 2017); however, subsidised care under the NRCMS is still provided only in designated health facilities in the county of household registration; thus, health expenditures incurred by rural migrants in urban destinations are usually not reimbursed. For example, a survey in Sichuan and Hubei provinces found that only 35% of migrants with the NRCMS received reimbursement for inpatient care (Qiu et al., 2011). Additionally, as Chen et al. (2017) pointed out, many migrants choose to return to their hometown when they need health services due to limited support in the receiving areas—a strategy that can cause delays in seeking medical care and increase treatment costs. Similarly, eligibility to the URBMI is tied to the local *hukou*, despite



**FIGURE 1** Internal migrants with medical insurance in the place of migration (2008–2017). Data source: National Bureau of Statistics (stats.gov.cn)

efforts and policy guidance to promote portability of insurance schemes (doc-14 2009). In some counties and municipalities, pilot programs have been introduced to facilitate the integration of the URMCS and the URBMI, such as the Urban–Rural Citizens’ Cooperative Medical Insurance scheme in Jiaxing City (Müller, 2016). Yet integration is difficult to achieve nationwide because insurance schemes are subsidised partly by local governments with variable capacity for funding and administrative support as well as differing costs of care in urban and rural areas (Mou et al., 2013). Many migrants are also unaware of available options or may face formidable challenges in navigating the complexity of rules and procedures that are required to transfer insurance schemes or household registration (Qiu et al., 2011). As a result, in 2017, it was estimated that only 25.7% of internal migrants were enrolled in a health insurance scheme in the place of migration, although an increase over time can be observed (Figure 1).

Lastly, many local health departments have insufficient capacity to provide all internal migrants with the full package of basic public health services. Although specific health programs for internal migrants have been developed, fiscal transfers to local authorities for public service provision are generally based on the number of *hukou* residents. Thus, many counties or municipalities lack sufficient resources to implement public health programs, especially in cities where non-*hukou* migrants account for a large share of local residents and the local economy is less developed. For example, in keeping with guidelines from the central government (doc-25 2016), local health departments have introduced health education programs for migrant workers, usually delivered through lectures at factories and other work places. However, as documented in interviews with health sector managers in Tongchuan and Xi’an, a lack of adequate funding and qualified health staff often constrains the ability of local health providers to deliver these programs (Zheng, 2015).

In sum, challenges remain to the provision of equitable health care for migrant workers, resulting in high out-of-pocket expenditures and unequal opportunities in access to health care (Mou et al., 2009; Peng et al., 2010; Sun et al., 2010). Notably, a recent study in Jiangsu province found that, compared with local residents, migrants were five times less likely to attend prenatal examinations, three times less likely to have postnatal visits, and less likely to attend health education during pregnancy (Gu et al., 2017). There are, of course, differences within and across provinces, depending on local resources and different implementation strategies. In Kunshan City, for example, a comprehensive package of benefits was developed to attract migrants and thus redress shortages in the local workforce that is needed to support the booming local industry (Kunshan Municipal People’s Government, 2010). However, such benefits are not available in other places, especially in the central and western parts of the country, where local authorities have less incentive to attract and retain migrant workers and local resources to implement equalisation programs are generally lower. Inequities also exist within the same urban



destinations, depending on the nature of the employer and the employment agreement. Although state-owned enterprises are more likely to offer formal employment contracts and associated benefits (Nielsen et al., 2005), migrant workers have little or no entitlements in the many underground sweatshops, where compliance with regulations is less monitored and working conditions are often more hazardous (Weiyuan, 2010).

## 7 | CONCLUSIONS

Despite improvements in housing and wages (NBS, 2017), internal migrants in China are still a vulnerable population group. Although migrant workers are generally young and healthy as they move from rural areas to urban destinations (Chen, 2011), the migration process may expose them to novel health risks due to poor work environment, marginalisation, and barriers in access to preventive and curative services (Gong et al., 2012). Several studies indicate that Chinese internal migrants, compared with other citizens, are more vulnerable to work-related injuries and illness (Wang et al., 2008), infectious diseases (Yang et al., 2018), and reproductive health (Tang et al., 2008) and mental health problems that may be associated with limited access to full labour rights and experience of discrimination (Li & Rose, 2017). As documented in this article, over the past four decades, the health policy focus in China concerning internal migrants has shifted from a concern with threats to social order and family planning to an increasing attention to their needs and rights—a shift that is further promoted by the recent relaxation of the one-child policy (Qian & Yongai, 2018). In this context, policy efforts have been made to improve the health and social protection of this population group, resulting in a gradual increase in the uptake of medical insurance schemes in the place of migration. Thus, our analysis is in keeping with other studies of the effects of change in welfare and social policy in China, which found an increase over time in social benefits for migrants and their redistributive role (see, for example, Gao et al., 2013). Nonetheless, ensuring adequate health protection for internal migrants remains a significant challenge, requiring continued policy efforts, innovative approaches, and a modernisation of the overarching institutional framework, particularly in relation to the inequities produced by the *hukou* system. In the ongoing progress towards universal health coverage and the achievement of the Sustainable Development Goals, these issues should be given priority on the agenda of the central and provincial governments.

## DATA AVAILABILITY STATEMENT

A copy of all reviewed documents is available from the first author upon reasonable request.

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## APPENDIX A

## HEALTH POLICY AND INTERNAL MIGRANTS IN CHINA: KEY POLICY DOCUMENTS (1985–2017)

Code	Year	Name	Institutions	Focus
doc-1	1985	Interim measures for the management of malaria control in the floating population	Ministry of Health, Ministry of Public Security, Ministry of Urban-Rural Development and Environmental Protection, Ministry of Water Resources and Electric Power, and Ministry of Agriculture	Malaria control
doc-2	1991	Measures for the administration of family planning in the floating population	National Family Planning Commission	Family planning
doc-3	1995	Opinions of the Central Committee on public security and the management of the floating population	Central Committee of the Communist Party of China (CPC)	General administration
doc-4	1998	Measures for the administration of family planning in the floating population	National Family Planning Commission	Family planning
doc-5	2003	Notice of the General Office of the State Council on doing a good job in the management of migrant workers' employment conditions	State Council	General administration, education, and employment conditions
doc-6	2003	Notice on relevant issues concerning the allocation of funds for the management of migrant workers from the general fiscal budget	National Population and Family Planning Commission, Ministry of Finance, and Ministry of Education	Financing
doc-7	2006	Opinions of the State Council on solving the question of migrant workers	State Council	General administration
doc-8	2006	Consent to establish a joint committee on migrant workers	State Council	Institutional developments
doc-9	2006	Notice on initiating action to extend health insurance for the floating population	Ministry of Labor and Social Security	Insurance
doc-10	2006	Three-year "safe plan" to increase coverage of insurance for occupational injuries in the floating population	Ministry of Labor and Social Security	Insurance

(Continues)

Code	Year	Name	Institutions	Focus
doc-11	2008	Notes on the implementation of the “safe plan” for migrant workers	Ministry of Human Resources and Social Security	Insurance
doc-12	2009	Opinions on deepening the health system reform	Central Committee of the CPC and the State Council	Health reform
doc-13	2009	Opinions on the equalization of basic public health services	Ministry of Health, Ministry of Finance, and National Population and Family Planning Commission	Public health services
doc-14	2009	Interim measures for the transfer and continuation of basic medical insurance for migrant workers	Ministry of Human Resources and Social Security, Ministry of Health, and Ministry of Finance	Insurance
doc-15	2009	Regulations on governing family planning in the migrant population	National Family Planning Commission	Family planning
doc-16	2010	Notice on launching a pilot project on health care for internal migrants	Ministry of Health	Public health services
doc-17	2010	Guidance on the administration and equalization of public health services and family planning for migrants	National Population and Family Planning Commission, Ministry of Finance, Ministry of Human Resources and Social Security, and Central Public Security Comprehensive Management Commission	Public health services and family planning
doc-18	2012	Health Service Development Plan (2011–2015)	State Council	Public health services
doc-19	2013	Notice of the State Council on the establishment of a working group on migrant workers issues	State Council	Institutional developments
doc-20	2013	Guidance on the implementation of pilot projects for the administration and equalization of public health services and family planning for migrants	National Health and Family Planning Commission	Public health services and family planning
doc-21	2014	Opinions of the State Council on improving services for migrant workers	State Council	General administration and social services delivery
doc-22	2014	Notice of the working group on migrant workers	State Council (Working Group on Migrant Workers)	General administration

(Continues)

Code	Year	Name	Institutions	Focus
doc-23	2014	Guidance on the management of basic public health services and family planning for migrants	National Health and Family Planning Commission, Central Public Security Comprehensive Management Commission, State Council (Working Group on Migrant Workers), and Ministry of Civil Affairs; Ministry of Finance	Public health services
doc-24	2014	Interpretation on the pilot workplan to equalize basic public health and family planning services for migrant population	State Council	Public health services and family planning
doc-25	2016	Action plan to support health education and promotion activities in migrants (2016–2020)	National Health and Family Planning Commission	Public health services and health education
doc-26	2017	Notice on the delivery of basic public health services	National Health and Family Planning Commission	Public health services and family planning