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Care Work in China—In and Beyond the Informal Economy

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中国家庭护理工作的现状及其对非正规经济的启示

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Abstract

China's expanding workforce of rural–urban migrants is increasingly involved in care work while simultaneously facing issues of care within its own ranks for its family members. The work examined here concerns care—for the elderly and ill, for children, and in everyday domestic labor. This form of work is widely performed predominantly by migrant women in (usually) urban households in circumstances lacking labor protections. They are performing work that creates value and that constitutes a key service sector of the informal economy. Much the same population provides similar care work for family members of their own (usually) in the countryside, work that also creates value but is normally unremunerated. Rural migrant and potential migrant women may be in complex social positions where their work is needed in both circumstances, and are in both circumstances providing value for their families—through income earned and through work of direct use value. The work in both instances is socially structured through being in or outside the informal economy and in or outside ties of kinship. This article argues for an expanded and adequately gendered concept of the informal economy based on value and Maussian concepts of human economy.

Keywords

care, women, migrants, informal economy, value

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摘要
中国日益增加着由乡村进入城市的大量投入到保姆工作中的劳动力，与其同时也面临着她们对其自身家庭成员的照料问题。本文关切的是家庭护理问题，这里指的是对老人，病患，孩子的照料，以及日常家务劳动。这种工作主要是由农村妇女来到通常是城市的家庭中，在缺少正规劳动保护的环境中工作。她们劳动创造的价值构成了非正规经济服务职能中的一个核心部分。这群打工族大多来自农村，并在其自身家庭中承担着同样的照料工作。然而这种同样创造着价值的工作一般并没有得到补偿。来自乡村的打工族及潜在的妇女民工可能处于一种复杂的社会地位中，她们的工作在这两种社会环境中都迫切需要，并都为她们的家庭或通过所挣工资，或通过直接使用其劳动创造着价值。这两种工作情况——在非正规经济之中或其外，以及在亲属关系之中或其外，都是社会构成的。本文提出一种基于价值观与人类学马塞尔莫斯学派的人性经济概念，并进一步将其扩展并充分性别化的非正规经济。

关键词
护理、照料、妇女、移民、非正规经济、价值观

China's rapid economic growth sustained through decades has been a rare and remarkable economic achievement. It has been attained through a synergy in which national policy and state entrepreneurial drive harnessed the promise of a demographic dividend combined with the tireless work of hundreds of millions of rural–urban migrant workers and disemployed urban workers. Analytical weight has very duly been given to the demographic legacy, to its mobilization through the bifurcate household registration system, and to parallel changes flexibilizing the urban workforce. As China's economic transition matures and national policy strives to stabilize this emerging configuration of labor, it has been faced with the challenge of deep and widespread recognition of inequality. This has drawn increasing attention to the everyday structure of labor and specifically to the reliance of this growth on the informalization of the labor force, with its structural marginalization of workers that routinizes disparity and precarity. Sharp differences have been substantiated between those in the formal and informal sectors in terms of income and job security, and the rural–urban migrant workers are found concentrated in the informal sector (Chan, 2009; Chan, 2012; Huang, 2009; Huang, 2011a; Park et al., 2012; Solinger, 1999; Wang, 2005; Xue et al., 2014; Zhou, 2013).

Informalization brings with it an exclusion from or reduction in benefits tied to employment. In a conventional economic sense, this may be quantified as an aspect of remuneration, but it carries with it a weight that is qualitatively greater in the impact benefits have on health and wellbeing, especially when the possibility of attaining comparable benefits through the market is absent or compromised due to low and unreliable income. Such issues extend further than the simply economic and will be explored here in and beyond the informal economy, and primarily where access to health insurance raises questions about health care both received and given.

China's expanding workforce of rural–urban migrants is increasingly involved in providing care work in the informal economy, while simultaneously facing

issues of care within its own ranks for its family members. The work examined here in the first instance concerns household-based care work for hire—care for children, for the elderly and ill, and for everyday domestic labor, such as cooking meals and household tasks. This form of work is performed predominantly by migrant women workers in urban households in circumstances lacking labor protections. They are without question underpaid and precariously employed while performing work that creates value and that constitutes a key service sector of the informal economy. Much the same population also provides similar care work for family members of their own who are usually in the countryside, work that similarly creates value but is unremunerated except in some circumstances of family-based cooperation in providing care. Rural migrant and potential migrant women are often in complex and demanding circumstances where their work is needed in both circumstances, and are in both circumstances providing value for their families, either through income earned or through work of direct use value.

The migrants central to this study are translocal holders of rural household registration who anticipate eventual return to or near their rural homes and most of whom retain close ties to family and kin in their rural homes, although many have some of their immediate family with them in their urban location. Virtually all are enmeshed in complex kin-based patterns of cooperation both for economic subsistence and for care, or are comparatively disadvantaged where this is not the case. The encompassing frame of migrant labor in which they live is structured by a triad of intersecting fields. The first of these is that of the subsistence work being done and its location on the formality/informality continuum. A portion of the migrants, poorly remunerated and disadvantaged compared with urban workers, are still able to participate at a more formal end of the continuum in relatively stable employment where they may enjoy a package of benefits for migrants that has come to approach that of the formal urban labor force. A larger portion of the migrants in this study participate in various aspects of the informal economy, whether productive (piecework garment manufacture, self-employed skilled labor, repair work), commercial (petty sales and shopkeeping), or service work (in small enterprises or in urban households). A few of the migrants are household dependents, although this is relatively rare given living costs in the urban settings, and are most commonly women caring for working migrants and accompanying children. The second structuring field is that of familial and wider kin-based ties through which subsistence, care, and lives are articulated. It would be difficult and partial to consider the work and the differences between kinds of work done by individual migrants without examining how each person's work and its products are shared in familial contexts. Members of a family or part of a family residing in a migrant location may often be situated at differing points along the formality/informality continuum, in ways tending to be associated with gender and generational distinctions. Family members share in differently positioned ways in the complex refractions of each person's work as it ricochets through the family

present and also touches translocal family and close kin elsewhere (cf. Huang, 2011b; Judd, 2008; Judd, 2010). In the present context, this means that participation in the informal economy closely touches many more people than the direct participants themselves. The third field is that of the relation between remunerated subsistence work and unremunerated but essential care work, both of which are necessary to sustain families and individuals (cf. van Esterik, 1999; van Esterik, 2007; Cook and Dong, 2011). The fashioning of lives together on the part of migrants in fluid, modest, and precarious circumstances requires constant navigating through these intersecting fields.

The work of subsistence and of care may be viewed as similar, although socially structured in different ways through being in or outside the informal economy and in or outside ties of kinship. This article will first argue for an expanded and adequately gendered concept of the informal economy based on value, building upon research work in the political economy of care, and will do so through engagement with ethnographic interview material with rural–urban migrant households. It will then proceed on this basis to raise questions about persistent modes of economic analysis and to suggest a critical view from the anthropology of human economies.

The Study

The research reported here is derived from a field study of care and kin conducted with rural–urban migrants in two metropolitan centers, one coastal (Guangzhou) and one inland (Chongqing). The focus of the study was on health care and arose from two converging directions. One was the recurrent issue of access to health care that I had encountered in earlier rural studies of gender and community in three upland sites in Sichuan and Chongqing between 2003 and 2005. The absence of available and affordable health care and the consequences of this absence, together with a wider lack of social programs and supports for rural residents, were having real and serious effects for their health and wellbeing. The second was the emerging turn toward introduction of a set of programs to create a harmonious society within a conception of scientific development in China that resonated with wider global moves toward postneoliberalism (cf. Razavi, 2007).

From 2009 to 2011 I conducted interviews with rural–urban migrants from Sichuan and Chongqing in Guangzhou (fifty households in 2009) and metropolitan Chongqing (twenty households in 2010 and thirty in 2011), eliciting systematic information about their work and livelihood, family circumstances, and access to health insurance. The specifically anthropological contribution was the elicitation of narrative accounts of instances of significant illness in their families, whether located with them in their migrant location or in their home communities. These narrative accounts comprehensively traced how each illness was identified and addressed, including diagnosis, choices of care, mobilization of human and material resources from all available sources, and outcomes. The participants initially

recruited for the study were mature migrants who were at least in early middle age and in a position to be actively involved in familial health care decisions and care processes, if not actually the ill person herself or himself. Wherever possible interviews were conducted in their households and additionally drew upon other members of their family and sometimes upon wider social networks. In some cases it was possible to extensively interview clusters of neighbors, work associates, or friends to give added facets through a deeper sense of available social networks and the range of choices and trajectories in similarly situated instances. This approach complements policy and epidemiological studies that examine steps from above toward basic health care for all by 2020 by exploring how some of those with least access to resources are—or are not—able to resolve important issues of care for themselves and their families. A total of 177 cases were recorded that met the study criteria, as well as a few outside the study frame (minor illnesses, urban household registration, or family members in other provinces).

The choice of a focus upon translocal issues in care and correspondingly upon mature migrant workers, together with the restriction of including only participants who retained rural household registration, resulted in the exclusion of most of the more successful migrants, as these were often able to convert to urban household registration relatively quickly when their economic circumstances improved. The emphasis on mature workers also limited the extent to which participants were drawn from the somewhat younger workforce in large factories or other large workplaces where benefits packages were being introduced for migrant workers. While the range of people included is wide and intentionally diverse within these parameters, it is also somewhat concentrated toward the more informal and less well remunerated or protected segments of the migrant labor force. Exploring access to the means of care broadly and of health care specifically required attention to the political economy of care and to the micro-management of scarce resources. The implications of having household members located in the informal economy or in the unremunerated care economy had an impact directly on access to differing qualities of health insurance and indirectly on capacity to maintain health and to purchase uninsured care. Difference in benefits attached to informal employment compared with formal employment is a major source of economic hardship—in addition to the severe wage gaps between the two (Park et al., 2012)—and is a significant factor in health differences, extending to differences of life, disability, and premature death.

An Emergent Health Insurance Regime

In response to a widespread and urgent sense of social injustice as the disparities between growing affluence and remaining absolute poverty became increasingly jarring by 2003 (see O'Brien and Li, 2006; and Lee, 2007), there was a series of steps

taken to reduce the barriers faced by the rural population. Health was a major concern, especially as market provision of health care made it unaffordable for the poorer rural residents, resulting in households being forced into poverty by a serious illness of any member, and in people suffering disability, ill health, and premature death when unable to meet health care costs (see Li, 2008; Wang, 2009). National policy moved toward a plan to provide basic and affordable health care throughout the country by 2020 (Chen, 2008), with gradual work toward this goal in test sites from 2005 and wider application shortly thereafter (see Han and Luo, 2007; and Weishengbu, 2007). The programs have continued to be revised and expanded, with increases in funding levels and reductions in some barriers to access. To match the field data, the present discussion will present the situation in the field sites at the time of the interviews, with some notes added on later changes.

The health programs share a broad national vision and framework of state subsidy, but are locally based and variable between provinces and vary even down to the level of the county, which is the key location for both financing and delivery of health care for rural residents. Guangdong and Chongqing were in the forefront of initiatives in improving health insurance in these years, and indicate some of the best levels provided.

Migrants are predominantly and problematically located within the realm of the rural health care system in their officially registered localities—no matter how far away they may be—with two exceptions. The minority of migrants who cross over to non-agricultural registration lose access to the rural system and potentially gain access to urban health care as they are incorporated into the urban population. And by 2009, there had begun to be programs specifically for migrants who are in relatively stable long-term employment with larger and more established employers, although these programs reach relatively few (Fei Guangzhoushi, 2009). By late 2011, there were moves announced in Chongqing toward allowing rural residents to opt for a more costly plan providing higher remuneration and reducing the distinction between rural and urban neighborhood insurance plans, although these changes had not then been introduced in practice.

Consequently, the key for access to health care for the overwhelming majority of migrants, and especially for those with marginal and poorly remunerated work, has been the program for rural health care. The New Rural Cooperative Medical System (*xin nongcun hezuo yiliao zhidu*, commonly shortened to *xinnonghe*), as it is known nationally, is a highly ambitious and important social program that is critical to the national goal of basic health care for all by 2020. Within shared national parameters, it is a set of locally based systems that enroll rural residents on a voluntary but actively encouraged and subsidized basis. Each officially registered rural resident (including migrants) is eligible to join, but households must join as a unit, in that all household members who hold agricultural residence at a given place join together. Joining initially required payment of RMB 10/person/year (rising generally to RMB 20/person/year by 2011 and then due to rise higher), which is collected for the household around the time of Spring Festival when

some members may return home, although registration and payment may be done on their behalf by relatives in their home rural community. This charge is low enough that a high rate of registration and payment (exceeding 90 percent) was quickly reached, although the amount in the fund is so small that it does not provide for a high level of coverage. Those who make no claims in a year may be provided (depending on local regulations) with a yearly amount of RMB 40, which can be used toward medicine or health costs not otherwise covered. However, the main purpose is to provide partial economic relief for more serious illnesses that typically (but again, this varies) require at least three days stay at the township hospital. The coverage then will still only be for a proportion of the cost and will be subject to a ceiling. In general, this may facilitate greater use of local health care facilities, although there is widespread preference for avoiding medical care and for self-medicating, practices which are encouraged by the deductibles that must be paid prior to receiving almost any coverage through this system. While this avoidance is in part a shared normative practice and arises from a concern for the wellbeing of the family together with an acceptance of declining health when aging, the field data in this study indicate that economic differences in access also play a role. In more affluent families, older members may actively seek health care where they think this possible and without excessive burden on their families.

Each county has its own specific plans, regulations, and rates of reimbursement for xinnonghe, but one instance from rural Chongqing may serve as a useful illustration (Chongqingshi Shuangqiaoqu, 2008). While the regulations specify financial sustainability and limitations, they also present a positive picture in some important respects. For instance, combined financial resources per person were set at RMB 10 from household enrollment fees, RMB 40 from the central government, RMB 30 from Chongqing City (provincial level), and RMB 10 from the district (county level). The major anticipated expense of hospitalization at an approved (*dingdian*) hospital was to be reimbursed at a rate of 65 percent for a town(ship) level hospital (with a RMB 50 deductible), 50 percent at a county level hospital (with a RMB 200 deductible) and 25 percent at a city level hospital (with a RMB 1,000 deductible), with a total maximum across all categories of hospital of RMB 30,000. Care for nine chronic illnesses was also specified as eligible for reimbursement at a level of 50 percent up to RMB 500/year, provided there was pre-authorization and treatment at an approved hospital.

Each county level system varies, but all share the feature that the highest rate of reimbursement is within the township level and where the care involves inpatient care in the town(ship) hospital, with lower rates of reimbursement at the county level hospital and lower still at the prefectural level or city level hospital. There is commonly no provision for reimbursement of expenses incurred elsewhere, although in some cases receipts may be taken to the migrants' official rural home for a low level of reimbursement, contingent upon local approval. In addition, there is beginning to be a system of designated hospitals that can serve migrants

within the limited framework of the xinnonghe in locations where there are concentrations of migrants from a given province. Nevertheless, the usual pattern is a return of migrants to their rural homes for health care when at all possible, and rarely a move of rural dwellers to urban facilities except for diagnosis and treatment plans. There is very limited provision for medicine costs. There is no provision for home care, which is a major issue for the many migrants who are contributing to the support and care of aging parents, even when these are in the countryside.

The limited access of rural–urban migrants to health care while working in cities where designated urban residents may have access to superior health care plans has resulted in measures to introduce plans for health care for migrant workers (for example, see the leading case of Guangzhou, in Fei Guangzhoushi, 2009). These plans are mandated and regulated by local governments where the migrants work and are implemented through their workplaces. They are relatively comprehensive programs for regular health care coverage and for catastrophic health care coverage. They may be part of a package that also includes a pension provision. Workplaces that provide such coverage will also have coverage for work-related injury, as do some workplaces that do not offer health or health and pension packages. This initiative is an important step in reducing disparities between urban workers and rural migrant workers, but is not widely available and, where offered, migrant workers commonly opt out or cash out their benefits where and when this is possible. Both published reports and the interview data in this study show considerable reluctance to enroll in these programs (Shi and Zhang, 2007; and Hesketh et al., 2008). The chief reasons appear to be related to the relatively high deductions from wages that are required to fund these benefits, together with widespread lack of clarity about what is being provided in return for these deductions and restrictions on portability. There is also lower participation by women workers who face earlier retirement ages and greater difficulty achieving the required number of years for the pension component.

Access to Health Care

One of the greatest difficulties in this health care regime is the localized nature of the program combined with the mobility of the vast number of migrants away from their rural home communities even as this regime was first being crafted. Ultimately the alternative approach of the urban-modeled programs for migrant workers, with their much better provisions for employees although not for their family members, will improve this situation, as will adjustments in the household registration system.

For those using the xinnonghe system, there is an advantage in its requirement that all members of a rural household be enrolled in order for any to be enrolled and in its affordability. In this study there were high rates of enrollment in xinnonghe and widespread efforts to access it for remuneration, together with

a willingness to seek medical and hospital care in rural locations for combined reasons of cost, trust, the availability of caregivers, and lower subsistence costs during an illness of some duration. Those who attempted to seek care in the city, especially in distant Guangzhou, found it difficult to access care in a facility and on terms that would be eligible for remuneration and to navigate the remuneration process at a distance. For many of these migrants, this program was not working at all except for in-hospital care in their rural home communities. This was a difficult choice for many as the usual requirement of a minimum stay of three days, combined with the deductible and the limited portion that would be remunerated, meant that a family had to commit to substantial costs before there would be any possibility that the xinnonghe would lighten the burden. Families commonly chose to return to rural communities for other economies while avoiding in-hospital care, unless it was a matter of minor surgery. The xinnonghe was unsuited and ineffective for either catastrophic illness or long-term chronic care.

Some of the barriers to care were formal and administrative in terms of limiting access to health care in another province, except in specially designated facilities, but others were less formal and more practical in being a direct matter of distance. The generally more satisfactory situation of many migrants in the informal sector in Chongqing was only partly a matter of greater administrative ease and the better process and information flows of the slightly later date. The largest difference appears to have been related to distance and to the relative ease of both physical travel to and from the city and the greater availability of the familial and wider social connections necessary to provide care and support beyond what is offered by insurance plans and health facilities. The fundamental resource essential for health is a functionally available and adequately populated social unit. Both the reduced size of family units, beginning to make a perceptible difference in the small cohorts of younger adults, and the geographic and mobile dispersal of family and kin migrating to other locations sharply limit the familial resources that are the basis of health provision. The simple step of migrating closer to home appears to make a significant difference in wellbeing. While access to medical, hospital, and pharmaceutical resources remains economically restricted, a wider range of social resources for care is especially critical.

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

For the purpose of addressing the interface between the informal economy and the care economy, it will be helpful to turn more specifically to two classes of cases where this interface is especially evident. The first of these is that of the situation of precariously subsisting hourly domestic workers faced with the necessity of care for catastrophic illness within their families. The second is the widespread challenge of elder care, with attention to the diffuse demands of caring within families and the particular issue of providing live-in elder care for employing urban families. The details of the challenges faced are somewhat different in these classes and indicate the range of difficulties the informal economy poses for care.

Domestic Care

One of the least visible and most precarious sectors of the informal migrant workforce consists of women doing hourly domestic labor in the homes of urban residents. These are rarely young women, who would be employable in factories and in shops, but are middle-aged women who have familial responsibilities of care as well as responsibilities to provide family livelihoods. They may be key to their family's migration history and even the main source of a meager family income. Exploring both their marginal economic situation and their burden of health care highlights what is at stake in and beyond the informalization of the economy.

One extreme and a second closely related case embedded within a cluster of related women in domestic service may highlight the multiple issues involved. Lin Dasao (Elder Sister-in-law Lin) had followed the pattern of other early middle-aged women in her eastern Sichuan village of migrating for domestic work, and in turn brought her younger sister-in-law, Liu Dasao, to follow a few years later. In both cases the women migrated first and, when settled, their husbands joined them, also doing informal and poorly paid work as guards, care workers, and unskilled construction workers. The women's migration appeared to be timed to occur when their children were marginally able to look after themselves in the countryside and, in Lin Dasao's case, when the older daughters (aged 14 and 12) were able to care for their younger brother (aged 9). As the children grew up, they migrated in turn, either joining their parents or seeking potentially better work elsewhere, and all seemed located insecurely on the edge of the informal economy.

The domestic work was a patchwork of hours for different employers, paid usually at a rate of RMB 8–10/hour or even as low as RMB 7.10/hour (in late 2009). Hours might be kept low, even to the point of an employer saving by asking for work to be done in 2.5 hours rather than 3, meaning that multiple employers would need to be recruited, maintained, and juggled in order to meet expenses. The workers lived in rooms in urban villages providing rental accommodation to migrants. The women in this cluster were in small single rooms in which a bed

serving also as a couch took up most of the floor space and there might be a bunk or sleeping loft for an adult child or another domestic worker. In other cases visited, accommodation was of a makeshift dormitory nature, with half a dozen women sharing a large room furnished with bunks. Cooking was in a shared space, which might be little more than a hotplate and some shelves at the end of a corridor. There was no job security or benefits. All the domestic workers I spoke with reported being enrolled in the xinnonghe shortly after it came into existence, usually from 2006.

Health issues inevitably arise and were densely concentrated in this cluster. A usual means of economically addressing major or chronic health care for migrants involves a return to their rural homes for less expensive medical and hospital care, for lower living expenses, and for the support of family members in providing personal care. The last can be especially important for long illnesses or for major chronic care, as the cost of hospitalization and other medical expenses pushes rural residents and migrants out of the formal medical system and into a home-based and self-reliant mode of care. For this, caregivers are essential, and short-term accompanying family members may not be enough. Liu Dasao's experience is an illuminating exceptional case and, while her husband's illness for the most part preceded any health program including the xinnonghe (which covered a small portion at the end), the terms of available coverage would have excluded almost all that he required. Her husband had a stroke while visiting family in the countryside and was left partially paralyzed in 2003. After a short period of hospitalization and care for him there, Liu Dasao concluded that she needed to work to support her family and took him back to the city with her where she proceeded both to care for him as his health declined and to work. As she expressed it, "I did everything myself." There were no public supports for his care and her income was too limited to allow market-based support, although she did occasionally hire a related domestic worker to stay with her husband while she worked. As her husband's health declined further she took him to their rural home for his final few months and at this point, in 2007, received some assistance from the now available xinnonghe for his hospitalization there. She emerged from these years deep in debt, continuing to self-medicate her own chronic stomach illness with inexpensive medicine brought from the countryside, and firmly indomitable.

Her sister-in-law's parallel experience was closer to the norm for the economically less well-off migrants. Her husband self-medicated and declined tests or medical care until he was gravely ill and diagnosed with stage four liver cancer in 2007. His family sought a second opinion at West China Hospital with the same result, and were advised against treatment, advice for which they were grateful for its honesty and concern for their dire economic circumstances. The family went to their rural home for palliative care in the local hospital, where he died in 2008. There was limited support at that final stage from the xinnonghe, and the family

sold all its possessions and went into debt. The availability of loans from kin in times of serious illness is a major form of social support, but leaves a burden virtually beyond low income survivors unless the children achieve greater economic success.

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

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

Elder Care

An adequate treatment of care work requires attention to the social and cultural construction of what we consider work to be and how that is related to our concepts of economy. An illuminating route into this issue can be found through looking at health care for elders. Some of this care is provided through the formal economy, as in homes for the elderly and hospitals, and is outside the scope of this article. I will instead examine informal and diffuse practices that involve migrants in the health care of elders, both as caregivers in the informal economy and as caregivers beyond our conventional understanding of economy.

Of the 177 cases of recent family illness elicited in this study, 82 involved illnesses of elderly family members. Care for the elderly is a diffuse issue since it is

constructed and practiced as a filial responsibility of the children. Nearly all of the parents of the poorer informal sector migrant workers are located in the countryside when they are no longer working, due to the high costs of urban living. Migrants remain members of translocal families defined primarily as rural and strive to care for elderly family members in the countryside, especially when ill, at the same time as working elsewhere to support themselves and to provide for their own children. Members of the senior generation lighten the load by working until advanced ages, looking after themselves and very commonly declining medical care, especially when it seems nonessential, unlikely to be definitively helpful, or expensive. Formal public supports in the countryside are presently very limited and rarely extend beyond the modest provisions of the xinnonghe, although the economic burden was beginning to be lightened by 2011 with the introduction of income support for the rural elderly.

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

The migrant women who were providing live-in elder care in the informal economy were each placing herself in an anomalous and at least potentially conflicted situation. Each of these women was spatially and in diverse ways socially distanced from her family in order to do this work. At the very least, she would be living separately even if her family were in the same city, diminishing her quality of life and social connection, as well as her family's. All but one reported that their parents and parents-in-law were deceased, so that they could not be construed as leaving their own filial obligations. But there were still complex tensions involving the unavoidable distancing from ties of kinship and care that their work and living arrangements entailed, for women of their generation are often key to care of spouses and both younger and older generations and their constrained circumstances can have further effects cascading through their families.

The narrative of one of these women, Zhang Dasao, underlines the extent of this in her long-term involvement with the care of her husband's older brother, a man whose frail health had made him unmarriageable and who remained with his mother until her death. Further decline of his health in the past three years had resulted in near-blindness and multiple hospitalizations. As a destitute man without children he had at this point become a "five-guarantee" household, which meant he was supported through local government at a very basic level, including basic health care, which is a recourse not available to the rural elderly who do have children. Nevertheless, Zhang Dasao and her husband visited him from time to

time, and provided some personal care and supplemental medications. Neither was in the countryside by this time, and each was tied to continuous live-in care of an elderly person, but in different households. The life Zhang Dasao recounts is one of staying in the countryside to care for her daughter until the daughter reached residential upper middle school, at which point she left to work in the city and became less available for the immediate care of her teenage daughter, as well as of her mother-in-law and brother-in-law. This strong and cheerful woman is a major support for the livelihood of her family, especially as her husband's declining eyesight has ended his work as a carpenter, although he sees well enough for unskilled elder care. The demands placed on her by the requirement to work in such constraining conditions reduces her larger availability to a family that needs her, and it is a considerable tribute to her that she has been able to see her daughter through college (*dazhuan*).

Another woman within the same group of loosely connected caregivers may also serve to indicate the challenges along the border of the informal economy and the care economy. Chen Dasao's parents and only brother are deceased and her two sisters are far away in Xinjiang. She works on her own providing elder care, or at other times in domestic labor in private homes, depending on what work is available. Her husband has suffered a stroke and is no longer working although, at the time of our interview, he was able to live on his own in the countryside, without a caregiver or close relative at hand. She had recently quit her job and spent half a year caring for him and reported previously having quit a number of jobs in order to go home to provide care as this type of work does not allow time off, and time away from informal employment for migrant workers commonly means leaving a job. Chen Dasao and her husband have a 29-year-old son working elsewhere in urban Chongqing who sends money home to help support his father but who is not married and may not be able to provide a future home for his parents. Chen Dasao has for several years held privately purchased health insurance for herself as the family's primary economic support and as someone who evidently views herself and her own work as her sole resource.

The situations of these women is less immediately dire than in the case of those faced with combining work with care of a terminally ill member of their own families, as in the previous section of this article, although they have no protection or benefits available to assist them in such an eventuality. What these cases add is a sense of the weight of care in a conventional—informal and precarious—economy in which it appears without economic value and the multiple ways this reverberates through families.

The gamut of elder care the migrants report giving within their own families is very broad. It extends from the extreme of a migrant woman leaving her family in the city while she returned to the countryside to care for her mother, who was living with paralysis and dementia through her final five years, to the other extreme of people reporting that they give very little care or support. Between these

extremes, there are commonly cases of migrants returning at times of serious illness to provide personal care and emotional support. Where a specific intervention might be useful, there are cases of hospitalization and surgery, such as removal of a kidney or resolving a gastric obstruction, and the xinnonghe is now available to help with these costs. There is commonly also some attention to medication for chronic illnesses such as diabetes and high blood pressure. However, ailments considered part of aging may not be actively treated, including loss of sight, hearing, or mobility. Major interventions, as for cancer, are rarely reported for elderly rural people. Much of the practical concern families face is for devising ways to provide the personal care required by long-term frailty and untreated or undertreated infirmities.

Apart from the direct problem of illness and limited personal and public medical and financial resources, the income-related pressures to work away create spatial problems, exacerbated by the regulatory barriers to portability of health care and the greater cost of accommodation and food in the city. The result is that the elderly are almost always cared for wholly in the countryside when ill, although in a minority of cases they may come temporarily to the city seeking a medical solution they could not find in the countryside. This is most likely to involve medical consultation for a diagnosis or recommendation of treatment and medication, followed by return to the countryside. Travel to the countryside for the serious illnesses of parents is normative and relatively common, even when it may require terminating employment. But long-term direct personal care of ill parents is more difficult due to problems of lost income and conflicting family obligations in the city. The generation now elderly may have several children who can share care, as in rotating trips of a month or more to the parent's bedside, or sharing in the cost of informal hiring of care locally. Migrants working away may hire a relative remaining in the countryside as a substitute for staying in person for a prolonged period when it is their turn in the family rotation of elder care. In one family children had pooled resources to hire an elderly bachelor (a poor man without family) in their father's village to be his dedicated caregiver. Several families described exceptional efforts to ensure prolonged care, while there were also cases where children and daughters-in-law were less willing or able to do so, and where the rural elderly were facing illness on their own.

Observations

Migrant work generates greater financial resources for families, but does so under very demanding and often unstable or even precarious circumstances that are now largely inscribed and routinized within the structures of the informal economy. Beyond the immediate and quantitative differences in remuneration and its terms and reliability, the disparity in benefits between the informal economy, where the migrants are primarily located, and the benefits of the formal economy raise

additional questions about the limitations of current economic frameworks. Discourses of rural "surplus labor" hide the extent to which truly essential labor is being drained from the countryside and being allocated toward production valued in the marketplace, but not necessarily or adequately contributing to human livelihood and wellbeing in any but a narrow monetary sense.

Current improvements to health care insurance will, as they are extended, increasingly address the direct medical aspects of this problem, and eventually the income support program for rural elders beginning to be offered will help further, but the inequitable structure will require more fundamental change. This is not a situation unique to China—the present exclusion of personal care from the health care system is comprehensible and consistent with its undervaluing in much of international practice. Especially for families facing the imperatives of elder care, this is a major issue and one that falls extremely heavily on migrants and their families. Its resonance with global practices of the informalization of care work and of its gendered familialization raise wider conceptual and comparative questions about what constitutes work and what counts in an economy.

Feminist critiques can provide an opening toward what strongly appears and is continually reiterated in the narratives of care and nurturance at the heart of this study. The gendering of work in China and elsewhere tends to place women disproportionately on the margins of receiving care and at the forefront of providing it. In the impact of the informalization of labor on access to health care, this is seen in the marginality of women in the labor force, their risk of forced early retirement, and their exclusion from remuneration and benefits when they choose to be familial caregivers. Women also carry a disproportionate burden of caregiving, much of it socially invisible and unrecognized. At the same time, it is essential to observe that men—especially as husbands and sons—encounter very similar issues as they arise from both informalization and the narrowly monetarized concept of what is recognized as work. This resonates deeply with the argument that feminist critique pertains not only to women but to our broader conceptualization of the human condition in placing nurturing at its core (van Esterik, 1999; van Esterik, 2007).

The potential for rethinking work and sociality in terms that allow the recuperation of the place of care in human activity is sharpened by a critically gendered vision, and is also present more widely in discomfort with received models of economic activity (Huang, 2009; Huang, 2011a). And it appears in the actual practices of working people as they demand, conceptualize, and create spaces for an expanded vision of what is to be practiced and valued in human conduct (Judd, 2014).

Such an approach is firmly in line with the Maussian tradition in anthropological thought in which human economies based on gifting take a preeminent place in conceptualizing how people everywhere construct social worlds that are based on value and that are realized in complexly structured fields that include activity,

belief, and sociality (Mauss, 1954 [1925]). Within such a framework, and provided one does not reduce the Maussian gift to a mere thing, it is possible to see practices intrinsic to being human operating throughout the multiple dimensions of human social life. In this frame, persons and things are not separate and the gift is not reducible only to reciprocity, but is an offering of oneself in a relationship. Such offering lies at the core of human sociality and is central to Maussian anthropological conceptions of being human. We might recognize this in the present ethnographic descriptions of health care or care, when we see not only the health insurance and provision programs but the layered human offering of self and sociality embodied in care. From this perspective, it is markedly strange that we inhabit a world of monetized economies in which the necessary practices of care through which we realize and offer elements of ourselves to others lack recognized economic value. Critiques of contemporary capitalist economics and economic thought can be and are being made from a Maussian human economy perspective (Graeber, 2001; Graeber, 2014). They have the potential to offer an extended and deepened view of the contribution of emergent practices and concepts of care.

Within this analytical and comparative perspective, informalization appears as contrary to the prerequisites of constructing a human economy. Debates about the restriction and denial of benefits and the extrusion of care from the core of economic activity appear as the ground of a fundamental questioning of our ideas of economic activity and structure. Where people work to create spaces for care and persist in its practice, resources for a human economy are discernible in and beyond the informal economy.

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