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Hukou and Health Insurance Coverage for Migrant Workers

Armin MÜLLER

Abstract: Most migrant workers in mainland China are officially covered by the New Rural Cooperative Medical System (NRCMS), a rural health insurance system that operates in their home communities. The NRCMS and the system of household registration (户口, *hukou*) are tightly linked and systemically interdependent institutions. Migrant workers have difficulties benefitting from this social protection because it remains spatially separated from them. Only a minority have access to urban health insurance systems. This paper sheds light on the institutional origins of the coverage problem of migrant workers and examines crucial policy initiatives that attempt to solve it. In the context of the ongoing *hukou* reforms, these policies aim to partially dissolve the systemic interdependence of *hukou* and health insurance. While the policies provide feasible, yet conflict-prone, solutions in short-distance and concentrated bilateral migration systems, covering migrants who cross provincial boundaries remains a challenge.

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Keywords: China, health insurance, New Rural Cooperative Medical System, migrant workers, *hukou*

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Introduction

China's economy and society are changing fast. Large parts of the population are on the move, but the institutional structures governing this population are only inertly and gradually adapting to this change. In 2013 the estimated number of rural-to-urban migrants, the so-called "migrant workers" (农民工, *nongmingong*), was 268.9 million (China Market Research 2014). Most of these individuals remain tied to their native localities by a system of household registration known as *hukou* (户口), which institutionalises the urban/rural divide: a central social cleavage in Chinese society. Even though migrant workers reside in urban areas, they often have difficulties integrating into urban society, and the organs of the state treat them largely as rural citizens (Whyte 2010). This paper explores the mutual dependence between the *hukou* system and health insurance, and how it relates to the health insurance coverage of migrant workers.

Up until the early years of this century, most rural citizens had no health insurance, and only a few migrant workers were covered by urban social insurance systems. In 2002 the Chinese government introduced a largely tax-funded health insurance system for the rural population, the New Rural Cooperative Medical System (NRCMS; 新型农村合作医疗, *xinxing nongcun hezuo yiliao*), which had officially reached a coverage level of 99 per cent of the rural population by 2013 (Chinese Government 2014). In this system, villagers pay premiums, which are subsidised by the higher levels of government on a per capita basis. The NRCMS is strongly decentralised: its funds are usually managed and pooled at the county level by the local bureaus of health, which also manage the local county hospitals and township health centres – the main health providers approved for NRCMS reimbursement. Most migrant workers should in theory be covered by the NRCMS.

The current literature on health insurance for migrant workers focuses largely on their integration into urban systems of health insurance. This article takes a translocal perspective and explores the role of the sending localities in social protection (cf.: Levitt and Schiller 2004). It analyses migrant workers' position in China's fragmented, decentralised health insurance system and is structured around three leading research questions: first, why do China's systems of household registration and health insurance marginalise migrant

workers? Second, how do central and local policy initiatives try to improve insurance coverage for migrant workers? And third, what are the limitations of these approaches in the context of a changing *hukou* system? While the existing literature has largely focused on migrant workers' health insurance coverage in urban destination areas, this study focuses on the rural sending areas and rural health insurance.

The conceptual framework of this article is focused on the idea of systemic interdependence, which aims to turn core insights of Luhmann's functional structuralism into fertile input for actor-centred institutional theory. Systemic interdependence is a crucial characteristic of the institutional contexts of governing, defined as "relationships of mutual dependence and influence between different institutions or simultaneous processes" (Mayntz 2009: 92). This interdependence is based on the structural complexity of modern societies, most notably their internal differentiation into functional contexts of action, along with the multilevel hierarchies of their state organisations. Complexity facilitates parametric links between institutions, which can mutually influence their respective determining factors. Institutional structures can have either beneficial or corruptive effects on other institutions or social processes (Mayntz et al. 1988; Mayntz 2002, 2009).

The analysis focuses on the systemic interdependence between the NRCMS and the *hukou* system. The NRCMS was the first in a series of largely tax-funded social protection programmes launched by the central government since 2000. This welfare expansion was achieved with the *hukou* system as an institutional foundation: the urban/rural divide and the decentralisation embodied in the *hukou* scheme stabilised a system of different levels of public welfare spending on urban and rural citizens (cf.: Kong 2010). The static categories of the *hukou* system that tie much of the population to rural areas and their home communities increasingly contradict the dynamic processes of urbanisation and industrialisation, which require a greater mobility of the population and further undermine the capacity of the family as an institutional basis of social protection (Hussain 2007). At the same time, the *hukou* system is changing dynamically: the urban/rural divide is increasingly being abolished in a local context. This exerts pressure on the newly built institutions of social protection to adapt.

Parallel to welfare expansion, a process of functional differentiation is proceeding at the administrative level. This increases the compatibility of social protection systems with the dynamic development processes and lays the foundations for overcoming the urban/rural divide at the programme level. In the 1980s and 1990s, the administrative jurisdiction for social protection was based on the urban/rural divide: the Ministry of Health (MoH) and the Ministry of Civil Affairs were in charge of rural social protection programmes; while the urban social insurance system was placed under the jurisdiction of the Ministry of Labour and Social Security, which became the Ministry of Human Resources and Social Security (MoHRSS) in 2008. Functional differentiation has proceeded in a series of reform steps, in which jurisdiction over public insurance programmes was gradually centralised at the MoHRSS – including the NRCMS in 2013 (State Council 2013). In contrast, social assistance programmes are under the jurisdiction of the Ministry of Civil Affairs. While functional differentiation has progressed at the administrative level, the urban/rural divide remains a structural principle at the programme level; however, this differentiation decreases the pressure to adapt.

This paper[1] will not analyse the historical process but will instead investigate the resulting systemic interdependence between health insurance and *hukou*; the problems that emerge from this interdependence; and ongoing local and central policy initiatives to cope with these problems. The argument thus consists of two parts, the first being that the systemic interdependence between *hukou*, on the one hand, and social protection and health insurance, on the other, undermines the coverage of migrant workers by both urban and rural programmes. When people move, their household registration stays in the place they came from, the sending area, and this often means that they are entitled to social protection in a place where they cannot use it. The next two sections of this paper present this first part of the argument, and the section thereafter provides a review of the existing literature on migrant workers' health insurance. After that, the second part of the argument delineates that local experiments generate policy adaptations to restore health insurance coverage for

1 The author would like to thank the German Research Foundation (DFG GK 1613) for its financial support and is indebted to Peggy Levitt, Jocelyn Viterna, Flemming Christiansen, Thomas Heberer, and Martin K. Whyte for their advice and constructive comments on earlier versions of this paper.

migrant workers, and that these adaptations can overcome the systemic interdependence to some extent, but may also cause substantial conflicts of interest between different bureaucratic actors. The difficulties for the migrants increase corresponding to the rising administrative levels of the boundaries they cross during migration, which facilitates local and, to a lesser extent, regional solutions, but leaves interprovincial migrants largely uncovered. The last section presents the conclusions.

This study relies on various sources of data, including semi-structured interviews and grey literature collected during four research stays in China in 2010, 2011, and 2014. Fieldwork was mainly conducted in the rural and urban areas of four larger urban centres in Eastern, Central, and Western China. Furthermore, the paper relies on expert interviews with Chinese academics, a series of internal reports from the research organs of the State Council and the Ministry of Health (MoH), and a recorded speech from a conference in China. The author also consulted administrative documents and Chinese academic publications for additional data. Chinese statistics on the number of migrant workers are estimates. This study uses them mainly to illustrate the relative size of different groups of migrant workers and does not interpret them as fully accurate in the absolute numbers.

T City in Inner Mongolia, where fieldwork was conducted for eight days during August and September 2011, is analysed as a case study and described in more detail later in the article. The evidence from other field sites largely provides examples of the interdependence of institutions. The analytical value here is less dependent on the specific local context, but some background information is given in the text. Fieldwork was conducted in C District of H City in Hubei Province for eight days in late 2011, in Z City and its D County in Shandong Province for four days in late 2010, and in A County in Jiangsu Province for eight days in 2011. Semi-structured interviews were conducted mainly with representatives of the local health administration, with the staff of county hospitals and township health centres, and with village doctors. Informal interviews with villagers were conducted in the absence of cadres where possible.

The cases discussed in this article are highly relevant for the current and ongoing reforms of the NRCMS and the *hukou* system, even though the data was collected several years ago, and some literature-based cases discussed in this paper are even older. T City, C District,

and A County were all above-average cases in terms of state capacity and policy development. By the time of data collection, they were not representative of China, but could be considered as "advanced" compared to most other localities. Such localities often piloted the policy initiatives that are currently being promoted by the central government – for instance, abolishing the distinction between agricultural and non-agricultural *hukou*, or centralising the NRCMS at the city level (NHFPC and MoF 2013; State Council 2014). The experiences of these pioneers are thus of crucial importance for the current extension of these policies.

Systemic Interdependence: *Hukou*, Migration, and Social Protection

The systemic interdependence between *hukou* and social protection in the context of China's decentralised polity is a crucial structural determinant of migrants' social protection problems. The *hukou* system provides the administrative foundation for social protection: financial transfers for tax-financed services are largely allocated on the basis of *hukou*, which also defines in what locality a citizen is entitled to public services and social protection, and whether this entitlement concerns rural or urban programmes (Wang 2011). Social protection and public service provision, therefore, reinforce *hukou* as a factor of social stratification, which supports a system of inherited inequality that largely marginalises migrant workers. At the same time, the *hukou* system remains in a constant process of change and adaptation: the recent policies of the central government aim to abolish the institutionalised cleavage between urban and rural society and to improve migrant workers' integration into urban society and urban systems of social protection (State Council 2014). Provided that there is a rigid and thorough implementation, these reforms will exert substantial pressure on health insurance systems for adaptation in the coming years.

As a basis of social protection, the *hukou* system, first and foremost, defines the administrative category of "household" and assigns each individual to one administrative household. Second, it distinguishes between two types of *hukou*: agricultural and non-agricultural, according to which a household is assigned to either the rural or the urban part of society. This differentiation is being phased out gradually. The *hukou* locality connects households to their constituent

members' place of legal residence, and this feature is very likely to endure. The *hukou* system also provides an information mechanism for the central government about the number of people living within its territory and their place of residence. Even though *hukou* figures are often inaccurate, they still serve as an accounting basis for fiscal transfers for public service provision and social protection. Such transfers are of considerable importance for local governments, which often struggle with massive fiscal imbalances (Chan and Buckingham 2008; Chan and Zhang 1999; Wang 2011).

The systemic interdependence between largely tax-funded social protection and *hukou* is multidimensional. At the programme level, there are separate social protection systems for urban and rural residents – for example, in health insurance, pension insurance, and social assistance. First, *hukou* determines the target beneficiary: programmes are directed at households rather than individuals; they assign agricultural households to rural programmes and non-agricultural households to urban programmes. Second, financial resources are allocated accordingly. In other words, the financial transfers by the central, provincial, and city governments are carried out only for eligible populations. Third, access to public service units for service provision is often restricted to the home locality: villagers insured in the NRCMS, for example, are usually expected to seek treatment at their local village doctor or township hospital first, rather than going to an urban hospital directly. Fourth, financial services, such as reimbursements, pensions, or social assistance, can often be claimed and received only at the place of registration. At the administrative level, jurisdiction over urban and rural programmes can be divided between different line bureaucracies. These dimensions affect different programmes to differing degrees. Health insurance was arguably the last field in which administrative separation was practised, and it is currently being phased out. Overall, however, tax-funded social protection programmes remain closely tied to *hukou*.

Formal rural-to-urban migration, including a legal change of "residency," is a complicated process with multiple stakeholders. It can include both the change of the *hukou* status from agricultural to non-agricultural, and the change of the *hukou* locality. The regulatory competence for specifying the quantitative and qualitative conditions for in-migration has been largely decentralised in recent years. Access to small- and medium-sized cities has been eased for migrants,

whereas large cities continue to restrict access. In order to transfer *hukou* from one place to another, a household or individual needs the consent and cooperation of government departments in both the sending and receiving areas (Chan and Zhang 1999; Davies and Ramia 2008; State Council 2014).

Non-*hukou* migration benefits many local governments in the sending and receiving areas. Large and prosperous urban centres continue to use *hukou* as a filter mechanism, granting preferential access to groups like wealthy investors or skilled workers. Unskilled workers provide a source of cheap labour for the urban industries, while the social privileges of the local urban population can be protected, and public expenditure on the social integration of migrants remains low. For local governments in the sending areas, non-*hukou* migration directs remittances into their local economies, while at the same time allowing them to uphold their claim to *hukou*-based fiscal transfers. While the specific incentive structures can vary substantially between different localities, local governments in urban and rural China often benefit from the social marginalisation of migrant workers (Chan and Buckingham 2008; Davies and Ramia 2008; Wang 2011).

A large share of internal migrants in China, thus, remains a "floating" population (流动人口, *liudong renkou*). They move, but leave their household registrations and entitlements to social protection behind, and thus fall through the gaps in the system. Of an estimated 268.9 million migrant workers in 2013, 102.8 million remained within their locality of registration (本地农民工, *bendi nongmingong*). Of the 166.1 million floating migrant workers (外出农民工, *waichu nongmingong*), 88.7 million remained within the boundaries of their home province, while 77.4 million crossed provincial boundaries. Where social entitlements remained restricted to the locality, those who left could use these entitlements only as a fallback option upon return (Chan and Buckingham 2008; China Market Research 2014).

In the destination areas, only a small share of the migrant workers was able to integrate into urban society and get access to social protection. Most notably, the level of skills they brought with them was often insufficient to access the formal labour market and enter stable, well-paid employment relations. Only 35.3 million of the floating migrants took their families with them to their destination areas (举家外出, *jujia waichu*), which is an indicator of stable employment

and the wish to integrate into urban society (Han, Jin, and He 2011). The vast majority (130.9 million) pursued a split-household strategy (住户中外出, *zhuhu zhong waichu*), in that they left (part of) their family behind and engaged in circular migration between two or more places. The sending area remained the centre of their lives and their interest in a formal *hukou* transfer or urban social insurance was often limited, especially with regard to non-portable pensions (China Market Research 2014; Jin 2011; Wang 2011; Zhu and Lin 2011).

Fragmented Health Insurance and the Coverage of Internal Migrants

China currently operates three large public health insurance systems, which are directed towards different parts of the population. The Urban Employees Basic Medical Insurance (UEBMI, 城镇职工基本医疗保险, *chengzhen zhigong jiben yiliao baoxian*) is part of a social insurance system established in the 1990s that also includes pension insurance, unemployment insurance, maternity insurance, and industrial accident insurance. In recent years, two largely tax-funded health insurance systems have been established to cover the remaining population: the NRCMS, which was introduced in 2003 for the rural population; and the Urban Residents Basic Medical Insurance (URBMI, 城镇居民基本医疗保险, *chengzhen jumin jiben yiliao baoxian*), which was introduced in 2007 for urban residents not covered by social insurance. Some key facts about the three systems are summarised in Table 1. In addition to these, various localities have also created their own insurance systems, which may complement, integrate, or replace any of the three main systems. Furthermore, commercial insurance companies offer individual and complementary health insurance contracts. Statistical figures about coverage are, however, contradictory, and the figures presented here might include a substantial number of "double insurances" – referring to people who are registered in more than one system either by accident or due to fraudulent activities (cf.: MoH 2012: 73; NHFPC 2013: 344–348).

From a legal perspective, migrant workers are required to have a labour contract and participate in the UEBMI (Darimont 2010). But, in 2013, only 46.7 million migrant workers were covered by the UEBMI. According to central administrative guidelines, migrant workers not covered by the UEBMI should be allowed to choose

between the NRCMS and the URBMI (State Council 2009). The *hukou*-based URBMI has been opened up to migrant workers in some cities (Yip et al. 2012) and, as of 2013, the overall number of migrants insured under this scheme was 3.5 million. NRCMS coverage among rural populations officially reached 99 per cent in 2013, including migrant workers. The NRCMS is, therefore, arguably the most important health insurance system for migrant workers (Chinese Government 2014).

Table 1. The Basic Characteristics of China's Three Main Public Health Insurance Systems

	UEBMI	URBMI	NRCMS
Target population	Formal employees	Urban citizens	Rural citizens
Financing	Employers' and employees' contributions	Premiums and tax-funded contributions	Premiums and tax-funded contributions
Population coverage 2012	19.6%	20.0%	59.5%
Introduction	1998	2007	2002
Institutional basis	Labour contract	*Hukou*	*Hukou*

Source: NHFPC 2013.

The existing academic literature has strongly focused on the integration of migrant workers into urban insurance systems. Nielsen and colleagues (2005) found various factors to have a positive effect on the social insurance coverage of migrant workers: employment in state-owned enterprises; being skilled and having stable, long-term employment relations; and migrating within the home province. There is a strong institutional connection between social insurance coverage, formal labour contracts, and employment in the public sector (Cheng, Nielsen, and Smyth 2014; Gao, Yang, and Li 2012; Davies and Ramia 2008; Zhu and Lin 2011).

Some major in-migration cities have initiated special health insurance programmes for migrant workers. Pioneers in this direction were the cities of Shanghai and Chengdu, which initiated such programmes in 2002 and 2003, respectively (Darimont 2010). Shenzhen started a similar system in 2005 (Mou et al. 2009). Zhao and colleagues (2011) found the Shanghai Migrant Worker Health Insurance system had achieved only 36.5 per cent coverage within their sample,

even though membership of the system was formally mandatory for all migrant workers. Coverage depended largely on the employer, many of whom were reluctant to pay for coverage before the work relationship had stabilised. The administrative bureau in charge of the insurance system was understaffed and lacked the administrative authority to penalise employers. Furthermore, among those who fell sick, only a few seemed to actually receive reimbursements from the system.

The vast majority of migrant workers are, or should be, enrolled with the NRCMS, but comparatively little is known about the details of this coverage. Survey-based studies found NRCMS coverage among migrant workers to be about 70 per cent in Shanghai in 2010 and less than 50 per cent in Fuzhou in 2009 (Zhao, Rao, and Zhang 2011; Zhu and Lin 2011). This is low compared to the quasi-universal enrolment indicated by official statistics. Furthermore, both types of figures may be distorted: Chinese NGOs report that migrants are often unaware of their insurance status and the over-reporting of NRCMS enrollees by local governments has been criticised by the central government (MoF and MoH 2009; WHO 2010).

The NRCMS remains very tightly coupled to *hukou* and thus primarily targets the population with an agricultural household registration residing at its place of origin. The systemic interdependence between the NRCMS and *hukou* defines the household, rather than the individual, as the unit of participation (Anonymous 10 2011; State Council 2003). Furthermore, it usually leads to the automatic assignment of the rural population to the NRCMS. In C District, for example, only agricultural households were eligible for enrolment (Anonymous 7 2011). Where the distinction between agricultural and non-agricultural *hukou* was abolished (as it was, for example, in Chongqing), a local *hukou* remains the condition for enrolment (Chongqing Government 2007). In 2007 only 0.94 per cent of NRCMS enrollees (6.75 million) did not have an agricultural *hukou* (Fu and Wang 2009). Migrants covered by an urban insurance programme are officially not required to enrol in the NRCMS and those who migrate with their entire household are unlikely to pay premiums in their rural homes (Han, Jin, and He 2011; Anonymous 11 2011; State Council 2009). But usually, when a migrant is not ready to enrol, the entire household loses NRCMS coverage.

Hukou figures determine how much in financial transfers for the NRCMS a locality can receive from higher levels of government. In T City, for example, the floating population from outside its jurisdiction was allowed into the local NRCMS, but they had to pay the combined amount of premiums and state transfers, whereas locals had to pay only premiums. The link between *hukou* and enrolment seems to be weaker in Eastern China, where central transfers are less important. The eastern counties studied here both allowed non-agricultural populations into the NRCMS: D County had abolished the division of agricultural and non-agricultural *hukou* and A County mainly integrated workers in township enterprises (Anonymous 2 2010; Anonymous 11 2011). Of the 330 counties that allowed non-agricultural households to enrol in the NRCMS in 2007, 208 were located in Eastern China (Fu and Wang 2009).

The revenues and expenditures of the insurance funds were tightly linked to the *hukou* system as well. Enrolment rates and targets for premium collection were often calculated based on *hukou* figures (Anonymous 7 2011). Reimbursements could be claimed only at the designated organ in the locality of registration, and *hukou* registration booklets were often one of the proofs of eligibility that rural households were required to present when claiming reimbursement. In a more indirect fashion, the network of approved healthcare providers (定点医疗机构, *dingdian yiliao jigou*) was usually limited to the home county. The services of non-approved providers were either not eligible for reimbursement or were eligible only at reduced reimbursement rates (State Council 2003; Anonymous 4 2011; Anonymous 6 2011; Anonymous 7 2011).

In addition, the administration of the various health insurance systems was separated along the urban/rural divide: the MoH and its line bureaucracy were in charge of the NRCMS and the rural population, and the MoHRSS was in charge of the urban population. At the local-state level, cases of double insurance due to overlaps in programmes' target populations and the processes of urbanisation could cause problems. In C District, for example, some farmers switched from agricultural to non-agricultural *hukou* in the course of urbanisation. Some of them managed to illegally obtain two *hukou* registration booklets and used them to enrol in both the URBMI and the NRCMS. The exchange of information between different departments is generally a problem in China and, in this case, neither had

access to the *hukou* data of the bureau of public security. However, both departments compared samples from their respective lists and were thus able to identify a few hundred cases of double insurance every year (Anonymous 7 2011).

Abolishing the distinction between agricultural and non-agricultural *hukou* can create problems, as the example of D County illustrates. With this reform, the local government lost the basis for calculating NRCMS enrolment rates and formulating enrolment targets. Instead of being able to give grassroots cadres a target rate for agricultural population participation (参合率, *canhelü*), they had to operate with an absolute number of expected enrollees (应参合人数, *ying canhe renshu*), which was based on the enrolment figures of previous years. Moreover, citizens were free to choose between the NRCMS and the URBMI. Wealthier farmers could enter the urban system, while poor urbanites could switch to the rural system; some might enrol with both and others might not be covered at all. So even while D County officially had 100 per cent NRCMS coverage, there may have been considerable gaps. This becomes a crucial problem when the distinction of *hukou* status is abolished on a larger scale (Anonymous 2 2010; State Council 2014).

Rural-to-urban migrants are largely marginalised with regard to health insurance and the NRCMS. Those who stay in their registration jurisdiction are less affected, but even they may lose coverage during urbanisation and *hukou* reforms. Those who leave their jurisdiction without their families usually have to remain in the NRCMS, but there are often no approved NRCMS hospitals in their destination areas. Therefore, services consumed out of town either are not eligible for reimbursement, or reimbursement rates are lower than at approved hospitals and payment is conditional on administrative formalities such as referrals or deadlines (dds2088 2007; Zhao, Rao, and Zhang 2011). A migrant worker from Chongqing explained that, after seeking treatment in Hangzhou where he worked, he would only have three months to claim reimbursement back home (Anonymous 13 2011). In order to fully benefit from the NRCMS, migrants usually have to return to their home locality (Zhao, Rao, and Zhang 2011).

Landless farmers are another marginalised group of rural-to-urban migrants: they often lose their land and rural *hukou* in the course of urbanisation, but may not gain access to urban social protection or the urban labour market. They account for a substantial

share of the non-*hukou* population enrolled in the NRCMS, most notably in Western China. In Eastern China, they could often remain in the NRCMS due to less strict regulations. Local governments in Western China arguably often resort to informal practices to have people without a rural *hukou* insured instead of non-*hukou* migrants, who left a claim to transfers behind with their registration. Landless farmers and people born beyond the birth control quotas are both potentially marginalised by the systemic interdependence (Fu and Wang 2009).

Policy Options for the Coverage of Migrant Workers

Urban–Rural Integration of Health Insurance

The following sections explore strategic policy experiments with health insurance that improve the coverage of migrant workers. Local governments' motives for such experiments are not always easy to pin down precisely, but they are generally a mixture of their own economic self-interest, the requirements of bureaucratic evaluation systems, and the preferences of political elites and patrons in the higher levels of government. Experiments that pioneer new policy options are often conducted in a socio-economic context conducive to them, or they constitute solutions to policy problems emerging from local circumstances or specific configurations of the local policy agenda (cf.: Heberer and Trappel 2013; Heilmann 2008).

In 2008 a joint document issued by the MoH and the Ministry of Finance called for experiments to link up the NRCMS and the URBMI in order to improve the health protection of migrant workers, landless farmers, and other special groups (MoH and MoF 2008). However, the NRCMS and URBMI were administered by two different lines of administration, and the coordination between social insurance departments and NRCMS bureaus was often difficult and ineffective. The urban–rural integration (城乡一体化, *chengxiang yitihua*) of health insurance administration and funds creates conflicts over financial resources and competences, which can undermine the readiness of the two administrations to cooperate and thus weaken the effectiveness of the reforms. Administrative integration provides crucial institutional support for the integration of agricultural and

non-agricultural *hukou* status. As the following paragraphs will show, different localities have engaged in competing experiments with urban–rural integration at different degrees under the competing line bureaucracies of the MoH and the MoHRSS.

Among the earliest to implement experiments in urban–rural integration policies were the counties of Suichang and Tonglu, and the prefecture-level city of Jiaxing in Zhejiang Province in 2003 and 2004. Suichang and Tonglu delegated the administrative responsibility for the NRCMS to their urban social insurance bureaus. Both the UEBMI and the NRCMS were based on common regulatory standards. Enhancing the administrative capacity of the social insurance bureaus was deemed more efficient than establishing dual administrative structures and did not require very large investments in capacity, as both counties had comparatively small rural populations. Jiaxing City, by comparison, had begun to abolish the distinction between agricultural and non-agricultural *hukou* in 2002 (Jiaxing Government 2002). Lacking an administrative basis for determining the boundaries of a regular NRCMS, everyone with a local *hukou* who was not covered by the UEBMI was eligible for enrolment in the "Urban–Rural Citizens' Cooperative Medical Insurance" (城乡居民合作医疗保险, *chengxiang jumin hezuo yiliao baoxian*), as the local system was called. Both approaches solved basic problems associated with *hukou* reform and urbanisation, and both depended on cooperation between the bureaus of health and social insurance, which had potentially opposing interests. But in Jiaxing, this cooperation arguably only extended to avoiding double insurance under the UEBMI, whereas in Tonglu and Suichang the cooperation of rural healthcare providers under the jurisdiction of the bureau of health was crucial for the functioning of the NRCMS. Integration under the MoHRSS bureaucracy is, however, arguably more vulnerable to obstruction by the health bureaucracy than vice versa (*Jiaxing Online News* 2012; Shao 2007: 118–152). When the URBMI was launched in 2007 under the jurisdiction of the MoHRSS, its latent conflict with the MoH intensified (State Council 2007). At that time, 71 county-level jurisdictions in 11 provinces had already put NRCMS administration under their social insurance bureaus or had initiated the transfer to take place within that year (Wang et al. 2009). Both ministries subsequently sponsored programmes of research into urban–rural integration within their respective jurisdictions. Table 2 lists some important sites of experimentation, and dif-

ferentiates between mere administrative integration and more fully integrated insurance systems. The cities of Chengdu and Chongqing were highly visible due to their experimental policies. They also represented the most influential approaches: Chengdu's approach focused on administrative integration and was similar to that of Suichang and Tonglu, with social insurance bureaus managing various insurance systems for urban residents, rural residents, and migrant workers. Tianjin adopted a similar approach. Chongqing, meanwhile, followed the Jiaxing approach that aimed to create an integrated system (Anonymous 9 2011; Anonymous 3 2011).

Then, in 2008, the government of Qinghai decided to have the URBMI managed by bureaus of health at the county level, with the exception of three larger cities. Urban populations in rural Qinghai were very small and the administrative resources were perceived to be too scarce for dual administrative structures. Huzhu County became a pilot for this approach: the funds and names of the insurance systems were kept separate, but they were governed by the same administrative committee and management office, and key administrative and financial processes were integrated. But according to an MoH researcher, the experiment was abandoned after two years because the MoHRSS intervened and directly pressured the provincial leadership to put a halt to it and to operate the URBMI separately. Xiangfen County in Shanxi Province took a similar approach, which likewise was subsequently abandoned due to unsatisfactory local outcomes (Anonymous 3 2011).

Other localities also experimented with the integration of health insurance funds under the jurisdiction of the social insurance bureaus, though this approach was taken rather seldomly. Taicang City in Jiangsu Province integrated the NRCMS and the URBMI in 2007 under the jurisdiction of the social insurance bureau, which was also in charge of the UEBMI and a separate health insurance programme for landless farmers. Urbanisation was the main reason for the integration of the insurance systems: in the course of economic development, most of the local farmers had become urban citizens and the differences between urban and rural populations had decreased substantially. The resulting Citizens' Health Insurance (居民医疗保险, *jumin yiliao baoxian*) featured the same level of premiums and the same benefits for all of the insured. The city of Dongguan in Guangdong Province also stands out for integrating the UEBMI, URBMI, and

NRCMS into one insurance system that was open to migrant workers and to residents. Due to its high economic dependence on migrant labour, Dongguan became a pioneer of integration: it had opened its basic health insurance system to workers without a local *hukou* as early as 2000. In 2004 it established an integrated health insurance system for agricultural and non-agricultural *hukou* holders, and in 2008 it integrated both systems into one social insurance system with equal benefits for all (Anonymous 9 2011).

Table 2. NRCMS and URBMI Integration Experiments up until 2011

	Administrative integration	Insurance integration
MoHRSS line administration	Chengdu City (Sichuan) Tianjin City	Taicang City (Jiangsu) Dongguan City (Guangdong)
MoH line administration	Huzhu County (Qinghai) Xiangfen County (Shanxi)	Jiaxing City (Zhejiang) Chongqing City

Sources: Anonymous 9 2011; Anonymous 3 2011.

In 2013 the MoH officially lost jurisdiction over the NRCMS to the MoHRSS in the course of governmental reforms, during which the MoH was integrated with the National Population and Family Planning Commission to form the National Health and Family Planning Commission (NHFPC) (State Council 2013). However, the implementation of this change in jurisdiction appears to have been delayed, and the NHFPC continued to co-author important administrative documents for the NRCMS in 2014. The MoHRSS-based approach integrated the administration of all major health insurance systems, and thus provided a better basis for the ongoing *hukou* reforms (State Council 2014). The urban–rural integration of health insurance is crucial to overcoming the systemic interdependence between *hukou* and health insurance at the administrative level. At the programme level, it reduces the interdependence in terms of target population and financing in a local context, thus avoiding double insurance and coverage gaps due to *hukou* reforms and urbanisation.

Extending the Network of Approved Hospitals

In recent years, it has become common for the NRCMS to cover services consumed out of town, but reimbursement rates are often lower and the respective regulatory guidelines problematic. After the

NRCMS was launched in 2003, only services from the home county were eligible for reimbursement because the approved NRCMS providers were local county hospitals, township health centres, and increasingly also village doctors (State Council 2003). Up until 2008, the decision to extend coverage to services provided to migrant workers outside their home counties was largely at the discretion of county governments. In particular, those sending counties with large migrant populations had an incentive to cover out-of-town services, which were usually reimbursed at lower rates than those of the approved providers (Klotzbücher and Laessig 2009). Local NRCMS regulations often remained restrictive and, in 2009, the central government emphasised the need for premium collection and reimbursement regulations to be better adapted to migrant workers' needs (MoH et al. 2009).

The extension of the network of approved hospitals beyond the boundaries of the home county is crucial to facilitating the access of migrants to healthcare. The most common direction, along which this extension has developed, is up the hierarchy of public hospitals. NRCMS counties started integrating hospitals at the city and provincial levels so that patients with severe illnesses could access these medical facilities via referrals. This process was usually accompanied by the establishment of NRCMS offices at the higher administrative levels. A second approach was to establish multilateral NRCMS provider networks between the counties and districts within one prefectural-level city. Such networks require investment in the development of digital systems of administration for the NRCMS and usually result in the introduction of integrated electronic health cards (一卡通, *yi ka tong*), which can be used at all providers within the network. H City established one such multilateral network. According to an NRCMS administrator in C District, rural citizens could have their health service costs reimbursed at home rates all over the city if they went to approved NRCMS hospitals (Anonymous 7 2011). However, the approved providers were not always rated very highly: one villager explained that he thought the care provided by the approved hospitals in H City to be substandard and said that he would prefer to seek treatment at a private hospital, which was not eligible for reimbursement (Anonymous 8 2011). In 2013, 90 per cent of NRCMS pooling districts already had some approved providers outside their jurisdic-

tions and 61 per cent were developing *yi ka tong* initiatives (Chinese Government 2014).

Another approach to extending coverage was the bilateral extension of the provider network across prefectural and provincial boundaries. Gushi County in Xinyang City, a prefectural-level city in Henan Province, was one of the pioneers of this approach. Gushi had an estimated overall population of approximately 1.6 million people, of whom about 500,000 were migrant workers permanently residing outside the county. Gushi implemented the NRCMS in 2005, and in the following year the county started to contract hospitals in those localities with the highest concentrations of its migrant workers, including Beijing, where about 150,000 migrants from Gushi lived. Most of the contracted hospitals were private, while the local-approved hospitals were usually public. For example, Changfeng Hospital in Beijing specialised in providing medical services to migrant workers. As an approved NRCMS provider, the hospital became more popular with migrant workers and was thus keen to accept Gushi County's conditions regarding pricing, even offering various discounts. The reimbursement processes here were more complicated than in the home county: migrant workers seeking treatment first had to place a deposit of CNY 5,000 at the hospital, which would be returned to them on leaving, after out-of-pocket payments had been deducted. The NRCMS bureau in Gushi transferred a total amount of CNY 50,000 from its NRCMS funds to Changfeng Hospital. The latter used this prepayment to channel reimbursements to the migrant workers directly after they received treatment. This mechanism left the hospital in charge of a part of the financial administration, and it left the NRCMS bureau in Gushi the option of not sending further funds to the hospital as a sanctioning mechanism. It was said to save Gushi's migrant workers about CNY 3 million in traffic costs and other expenses a year. In 2014 Changfeng Hospital became a contracted provider for all NRCMS pooling districts in Xinyang City, and an outpost NRCMS office was installed in the facility that came to be in charge of the reimbursements. Furthermore, Henan provincial authorities planned to establish a second migrant worker hospital in Beijing in cooperation with the local health and social security departments (*Sunflower* 2011; *Xinhua* 2007; *Zhongmin* 2014).

As early as 2007, the innovation was recommended for application in other areas by the central government (MoH, MoF, and TCM

Administration 2007). There are, however, several factors limiting the applicability of Gushi's approach: with regard to largely tax-funded and partly locally financed programmes like the NRCMS, local governments have a strong preference for those funds to benefit their local economy rather than be funnelled into the economies of other localities, and to benefit their own public hospitals, rather than private hospitals. The higher levels of health costs in the receiving localities could result in an outflow of resources from the rural to the urban areas. Furthermore, the Gushi approach requires relatively stable and concentrated migrant populations; where migrants are scattered and mobile, the approach would be ineffective (*Sunflower* 2011; *Zhongmin* 2014).

Extending approved provider networks can resolve much of the programme-specific systemic interdependence regarding enrolment, approved hospitals, and claiming reimbursement in the context of local, small-distance migration systems or strongly concentrated bilateral migration systems. In recent years, the central government has increasingly called for provincial NRCMS networks to be linked on a national level in order to facilitate cross-border reimbursement, which indicates that the difficulties of crossing provincial boundaries are still considerable (NHFPC 2014).

City-Level Pooling

In 2008 the central government also called for experiments with city-level pooling (市级统筹, *shiji tongchou*) in the NRCMS under the jurisdiction of the health bureaucracy: areas with a relatively small rural population or otherwise favourable conditions were encouraged to centralise pooling and administration at the city level (MoH and MoF 2008). The term *shiji tongchou* should be interpreted carefully, however, as it is sometimes used ambiguously to mean a harmonisation of NRCMS regulations within a city rather than actual centralisation. T City in Inner Mongolia followed the central government's call and centralised the NRCMS. Preparations took place in 2008 and 2009: calculations and forecasts were conducted, the different NRCMS regulations of the localities were harmonised, and a new NRCMS administrative centre under the jurisdiction of the city bureau of health was established. In 2010 the NRCMS insurances of the county-level jurisdictions – urban districts, banners, and counties – were

integrated into one system with one integrated fund (Anonymous 5 2011).

The administrators in T City listed several reasons for this endeavour. Many of the county-level jurisdictions had very few rural citizens, some as few as 10,000 to 20,000 people. Their NRCMS funds were small and unstable. They offered comparatively little risk protection and their relative administrative costs were comparatively high. While each villager paid the same amount in premiums, reimbursement rates differed between districts. Most funds were managed conservatively and some districts retained very high surpluses prior to centralisation. Furthermore, there was substantial internal migration within the city's boundaries, as many people came from the vast, but sparsely populated rural areas to the urban districts to work. Before centralisation, the county-level governments decided whether and how migrants could participate in the NRCMS. Migrant workers would need a referral to seek treatment at a city hospital outside their home county, and received lower reimbursement rates for treatment at such facilities (Anonymous 5 2011).

After the centralisation of the NRCMS, every rural citizen in T City could have their health services reimbursed at the same rate regardless of which NRCMS-approved hospital in the entire city area they had visited. The enhanced administrative capacity of the city-level administration facilitated the extension of direct reimbursement for inpatient and outpatient services; villagers would only have to pay out of pocket for their co-payments, rather than paying for the entire amount first and seeking reimbursement later. This arrangement is of particular advantage to the poorer strata of the population, for whom high out-of-pocket payments constitute a barrier to access to healthcare. Furthermore, NRCMS premiums could also be paid throughout the entire city jurisdiction: to a village committee, a hospital, or an NRCMS bureau (Anonymous 5 2011; Anonymous 6 2011).

Fieldwork was conducted during the second year of centralisation, when this type of approach was still very unusual. The government of Inner Mongolia subsequently mandated the extension of city-level pooling throughout the entire autonomous region (IM Health Department 2010), and the central government subsequently called for an extension of city-level pooling and further experiments with centralisation at the provincial level (NHFPC and MoF 2013). City-level pooling was found to ease the systemic interdependence

considerably regarding enrolment, financing, approved hospitals, and reimbursement in the context of a prefectural city, and potentially even at the provincial level in some areas. However, city-level pooling is arguably difficult to apply in Jiangsu and other provinces that handle public finance affairs directly between the provincial and county level, thus bypassing the cities. Some cadres in A County were very reluctant to believe that the centralisation of the NRCMS at the city level was even possible. Even in provinces like Shandong, where the city plays a more influential role, the centralisation of NRCMS funds sparked substantial conflicts of interest. In Z City, for example, one county was much wealthier than the others, so equalising insurance standards would have required it to lower its reimbursement rates and/or to share its wealth with the poorer counties around it, a factor which city-level NRCMS administrators highlighted as the greatest obstacle to city-level pooling. Thus, it was arguably the administrative particularities and the comparatively good economic development of T City that facilitated this experiment (Anonymous 1 2010; Anonymous 2 2010; Anonymous 5 2011; Anonymous 11 2011).

Conclusion

The *hukou* system has provided a comparatively stable institutional foundation for the NRCMS, which has allowed health insurance to be extended to the vast majority of China's citizens at comparatively low costs. But the tight connection between the NRCMS and *hukou* also exerts substantial pressure on the NRCMS to adapt: in the context of industrialisation and urbanisation, the *hukou* system is changing gradually but continuously, and this forces change on the NRCMS and on other areas of social protection and public service provision. The functional differentiation of the respective administrative structures, along with the fading of the urban/rural divide, shifts the logic of how *hukou* influences social stratification. Rather than assigning citizens to the rural or urban spheres of society, *hukou* is becoming increasingly important in tying them to their locality of origin (Chan and Buckingham 2008).

The conceptual lens of systemic interdependence has provided in-depth insights about the institutional mechanics between *hukou* and the NRCMS, and how they affect the health insurance coverage of migrant workers. The inertness of core institutions of social ad-

ministration to adapt to rapid socio-economic change facilitates the social marginalisation of rural-to-urban migrants, who largely fall through the gaps in social protection. Conversely, the reason that migrant workers are marginalised with regard to social protection is not so much the *hukou* system itself, but the systemic interdependence of *hukou* and social protection in the context of China's decentralised polity – that is, the role it plays in the institutional context. In its classic form, the *hukou* system assigned migrant workers to the NRCMS and undermined their coverage at the same time. Policy approaches meant to close the gaps in health insurance coverage for migrant workers attempt to do so by loosening the systemic interdependence, while the reforms of the *hukou* system arguably allow the rural population to enter the URBMI in their home locality.

As a rule of thumb, the higher the administrative level of the boundaries crossed during migration, the greater the difficulties of extending coverage to those migrants. Local governments prefer NRCMS reimbursements to benefit their local economy and finance local hospitals, unless the share of migrants evading premium collection negatively affects coverage rates, or the small size of the rural population makes NRCMS ineffective and expensive to administrate. In short-distance migration systems within the boundaries of a prefectural city, the local governments of the sending and receiving areas are under the common jurisdiction of the same city government, which can use its influence to find solutions.

More research is needed to assess how broadly approaches such as urban–rural integration, the extension of approved provider networks, and city-level pooling can be applied in rural China. For the NRCMS programme, the administrative dimension of systemic interdependence is being abolished with the centralisation of competences at the MoHRSS. On the programme level, the problems of access to approved hospitals, reimbursement, and, to a lesser extent, premium payment in the destination locality appear solvable with the available policy options, at least within city and provincial boundaries. The financial interdependence – the connection between financial transfers for social protection and the *hukou* system – is a more difficult issue to resolve. Recent proposals to experiment with commercial insurance companies as carriers of public insurance systems may provide an alternative, as such companies can be expected to have

less trouble with cross-border financial operations than state organs (NHFPC 2014).

The social marginalisation of migrants depends largely on the trajectory and destination of their movement. Those moving to smaller cities can register and socially integrate more easily than those who move to larger cities. Those who remain within their locality of registration remain eligible for social protection and public services, and those who remain within their native province are more likely to receive extended coverage of some sort. Migrants crossing provincial boundaries arguably face the biggest problems. In the absence of effective nationwide health insurance networks, a strategy of double insurance via social or migrant insurance alongside the NRCMS may be the most effective way to ensure their coverage.

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