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Abstract: China is experiencing the largest internal migration in human history. Given rural migrants’ poor living and working conditions, healthcare is a major concern; and they are in dire need of medical coverage. Two medical insurance schemes, in Beijing and Shanghai, are examined to provide insights on designing urban medical insurance for this population. The analysis shows that providing catastrophic insurance via the extension of the urban employee medical insurance is an efficient way to expand basic medical coverage to this population and to other urban poor. Additionally, targeted public health programs are necessary in improving health outcomes for this population.
Introduction

Economic development goes hand in hand with rapid industrialization and urbanization. The urbanization process requires not only job creation but also investment in infrastructure such as roads, schools, housing, health care facilities, etc. Experiences from European countries suggest that urban ills and urbanization go hand in hand. If the urban sector cannot absorb the additional labor and provide social services to this new population, urban unemployment and urban slums will contribute to increasing inequality, crime rates, traffic congestions, etc. Hence, the way a city incorporates new citizens into its urban social service system is integral to sustainable economic growth and “harmonious” urbanization.

China is experiencing the largest internal migration in human history, with approximately 150 million rural migrants living in urban centers. In the 11th Five Year Plan for 2006-2010, the Chinese government is expecting the level of urbanization to increase from 43 percent to 47 percent by 2010, meaning that an additional 45 million rural workers are expected to shift from rural to urban sectors (Fan 2008). In another estimate, some researchers place the recent level of migration at 15 million migrants per year, which translates to an additional 75 million migrants by 2010 (Rabinovitch 2008). By 2020, this rural-urban migration is expected to involve 350 million people (Lieberthal 2006). While this massive migration is a boon for cities by supplying them with young, cheap labor, which is vital for economic growth, the magnitude of this phenomenon is a headache for many urban social policy makers.

Since 1958, Chinese cities have been able to control rural-urban migration with the hukou system, a household registration system modeled after the Soviet propiska, which prohibits peasants from migrating into the city. At birth, every Chinese citizen is required to register his location and is designated as an urban or rural hukou holder by local authorities. Rural
population pressure due to the shortage of arable land, and urban demand for cheap labor stemming from market reforms in the 1980s, have led to the relaxation of the *hukou* system (Mallee 2003). While the *hukou* system no longer prevents migration, it still plays an important role in determining claims on public resources by tying an individual’s entitlements and rights to his residency status. In effect, the *hukou* system has created three classes of Chinese citizens, rural citizens, urban citizens, and migrants, through the allocation of social rights. Since the *hukou* system makes it difficult for migrants to gain permanent residency elsewhere and excludes them from most urban provisions, such as education and healthcare, it increases the cost of living for migrants, which can effectively create a permanent underclass in cities. As a result, the way that urban policy makers choose to incorporate migrant workers into their social service systems can greatly affect the composition of the urban poor and the level of inequality in cities.

This paper focuses on medical insurance for migrants in Chinese cities. While social welfare entitlements such as education and pensions are important, health care is especially integral to sustained economic development because it affects an individual’s life opportunities and affects our normal functioning as free and independent individuals (Deaton 2003; Daniels 2007). Although it is widely acknowledged that poverty causes poor health, poor health can also cause poverty by disrupting people’s ability to work, thereby throwing families into debt. Hence, a lack of medical coverage can widen income inequality between urban residents and migrants. Furthermore, access to quality health care has become a source of social unrest in Chinese society as patients are routinely denied care due to their inability to pay (NYT 2006; Economist 2008).

This paper is organized into four sections. The first section presents an overview of China’s medical insurance system. The second section describes the plight of migrants in
Chinese cities and their access to medical care. The third section provides a description and analysis of Beijing and Shanghai’s medical insurance systems. Based on these two models, the fourth section recommends a series of policies focusing on increasing coverage and expanding benefits to migrants. Drawing from China’s migrant experiences, this paper concludes with recommendations on how to incorporate a poor, highly mobile, and frequently undocumented population into local healthcare programs in developing countries.

Overview of China’s Medical Insurance System

China’s transition from a centrally planned to a market-oriented economy transformed China’s health care system from one that provided affordable preventive and basic health care to most people to one where most people cannot afford basic care and many families are driven into poverty as a result of large medical expenses (Liu et al 2003; Hsiao and Yip 2008). According to a 2000 World Health Organization (WHO) survey, China ranked 188 out of 191 nations in terms of health care access. Compared to Western Europe, the U.S. and other East Asian countries, which spend between 10 to 15 percent of their GDP on health care, China spent a mere 4.7 percent of its GDP on health care in 2005 (WHO). Recognizing this lag in health care spending and worsening health outcomes, the Chinese government plans to spend an additional $123 billion by 2011 to provide universal basic medical coverage for its population (State Council 2009). To date, China has set up three types of medical insurance, Urban Employee Medical Insurance (UEMI), Urban Resident Medical Insurance (URMI), and the New Rural Medical Cooperative (NRMC). These three medical insurances cover 1.13 billion people in China, which is around 87 percent of its population.
For urban areas, UEMI and URMI were put in place in 1998 and 2007 respectively. Under the central government’s guidance, all cities have set up a UEMI scheme that offers workers medical savings accounts combined with catastrophic insurance. Employer participation in this insurance scheme is compulsory. The minimum premium contribution is set at 8 percent of total wages, shared between employers and employees at 6 percent and 2 percent respectively. Depending on local conditions, local governments may choose to set their premium above 8 percent, but not below it. Benefit packages may vary between cities, but both inpatient and outpatient services are covered. Under the principle of broad coverage, the new social insurance program is intended to provide basic medical insurance for all formally employed urban employees. Dependents of employees are not covered. Currently, the UEMI covers approximately 200 million people (MOH 2009).

In 2007, the central government piloted the URMI program in 79 cities to cover urban residents not engaged in formal employment. By 2009, URMI had been expanded to all cities. The population covered includes students, children and the unemployed. Participation is voluntary, and the plan is financed with government subsidies and household premiums. The plan is a catastrophic insurance that covers hospitalization and major illnesses. To date, around 118 million people are covered under this insurance (MOH 2009).

For rural areas, China began rolling out NRMC, a voluntary insurance system, in 2003. It is a voluntary insurance that insures rural residents against catastrophic health expenses. The financing is shared between the central government, the local government and the individual. To expand the benefits package, the combined premium was increased from Y30 to Y120 per year, where the central government contributes Y60, the local government contributes Y40 and the individual contributes Y20. Local governments are free to choose the contents of the benefits
package and the administrative arrangement of their NRMC according to local conditions as long as they follow the policy guidelines of voluntary enrollment and major illness coverage. Some locales are experimenting with outpatient coverage to members. According to official statistics, the NRMC currently covers over 90 percent of the rural population and is projected to reach 100 percent by the end of 2010 (MOH 2009). The current total population covered under this insurance is around 815 million (MOH 2009).

While urban and rural medical insurance covers over 85 percent of the population, most people have very shallow coverage under the UEMI and NRMC. Less than 10 percent of Chinese have medical insurance benefits that are comparable to those enjoyed by citizens in the West. Additionally, there are no linkages between urban and rural insurances. For example, a Shanghai NRMC member will not be reimbursed at a Shanghai urban community clinic. Moreover, no linkages exist between locales. A Beijing urban worker requiring medical treatment in Shanghai will not be covered by his Beijing medical insurance. This disconnectedness in China’s medical system makes it very difficult for people to use their medical benefits, especially for those who have moved or are mobile.

**Chinese migrants and their access to medical care**

Overall, migrants are typically younger and healthier than their urban counterparts. In a 2003 Ministry of Health survey, researchers found that migrants in Beijing and Guangzhou are significantly younger than the national average; while 33 percent of the general population is age 45 and above, only 7-10 percent of migrants are in this category (Zheng 2007). Migrants are also 2-3 times less likely to describe themselves as being in poor or fair health than their rural
and urban counterparts (MOH 2004). Moreover, given their youth, migrants suffer from less chronic illness.

Although migrants are healthier than the general population, they have poorer outcomes in terms of incidence of communicable diseases, child/maternal health, and occupational health than their urban counterparts because they usually work in harsh conditions, live in crowded and shabby housing, and earn a minimal income. Migrants are highly susceptible to communicable diseases. In the late 1990s, regional studies in the Yangtze River delta find that migrants are 12-27 times more likely than local residents to suffer from malaria (PKU 2007). Since the late 1990s, there has been a significant increase in the incidence in Hepatitis A among migrants (PKU 2007). Moreover, among the migrant population, the maternal death rate is more than 3 times the local rate, and the under 5 infant mortality rate is 2 times the local urban rate (PKU 2007). Additionally, according to the International Labor Organization, approximately 90 percent of the workers suffering from occupational diseases are migrants (Amnesty International 2007).

Furthermore, compared to their local counterparts, migrant workers are less likely to access the urban health care system. A 2005 survey finds that over 73 percent of migrants use home remedies in the event of illness instead of seeking professional care (State Council 2006). Three factors contribute to this low utilization rate. The first is migrant income levels and the cost of urban medical services. According to a 2004 survey, the average monthly income for migrant workers is Y780, which is just half of the national urban average (State Council 2006). Given their income, it is difficult for migrants to use urban health centers because an average outpatient visit to a city hospital costs around Y200, which is more than a quarter of his average monthly income (MOH 2009). The second factor is the low rate of medical coverage of
migrants in cities. Generally, only 10-20 percent of migrants have medical insurance in cities (State Council 2006, PKU 2006). Of the urban poor with no medical coverage, 40 percent of those are migrant workers (PKU 2006). Moreover, though 80 percent of migrants are employed, compared to 54 percent of urban residents, employment is not a significant factor in determining coverage for migrants. (PKU 2006). This data implies that migrants are typically engaged in low paying jobs that offer little to no medical benefits. The third factor is the disconnect between urban and rural medical insurance systems. While only a small percentage of migrants have urban medical insurance, an increasing number have joined the NRMC at their hukou residence. However, this has not translated into better medical access because most migrants cannot get reimbursement from their NRMC outside the program’s designated area. In cases where they can file for reimbursement, they have to pay the entire treatment cost upfront and file for reimbursement later.

In conclusion, while migrants are younger and healthier, they are more vulnerable to diseases than their urban counterparts. Moreover, they are at risk for health related impoverishment. The lack of medical coverage and high medical costs means that many migrants delay treatment. In doing so, ordinary diseases develop into major illnesses, which destroy their health and bring financial ruin to their entire family. These conditions create a scenario where migrant workers potentially make up the sickest and poorest of the Chinese urban population.

**The Beijing and Shanghai Medical Insurance Systems**

Medical insurance for migrants is evolving. In the 1998 health care reform, migrants employed in the formal sector were recognized as participants in the urban medical system, but the central government did not require cities to cover this population. In the 2009 health care
reform, the central government required that migrants be covered either through urban or rural insurance, but no specific plans have been laid out as to how they are to be covered. For the most part, cities do not want to expand medical insurance to migrants because their welfare is the responsibility of their hukou governments. A city’s main responsibility is to provide health care for its registered urban residents. Moreover, many urban governments bemoan the difficulty of designing an appropriate insurance for migrants given their transient nature. However, studies have shown that migrants are less transient than is commonly believed. Only 24 percent of migrants stay less than 1 year in a city, about 40 percent stay 1-4 years in a city, and 36 percent stay more than 5 years in a city (MOH 2004, Zheng 2007). It may be understandable that city governments pass over migrants that stay in the city for less than a year because they are less likely to become urban citizens. However, city governments cannot ignore migrants that stay 1-4 years as they make a significant contribution to the local economy as well as being semi-permanent residents in their host cities. City governments have a responsibility to migrants that stay more than 5 years. By default these people are urban citizens and they should be recognized as such through the provision of social programs such as medical care. As shown above, despite the supposedly mobile nature, close to 75 percent of migrants are staying in cities on a semi-permanent to permanent basis. City governments cannot continually “pass the buck” on delivering health care to this population.

Against this backdrop, two medical insurance models have emerged to extend medical coverage to migrants. One is the Beijing model, which is an extension of its UEMI to migrants; another is the Shanghai model, which is a special insurance program set up for migrants and completely separate from its UEMI.

*The Beijing Model*
In 2003, Beijing’s UEMI only covered 3.4 percent of migrant workers (MOH 2004). To expand coverage to this population, the Beijing government issued two regulations on medical and occupational injury that required employers to pay premiums for migrant workers’ medical insurance in 2004. The contribution was set at 2 percent (Y45).¹ Instead of covering inpatient and outpatient care, this insurance only covers inpatient services, ER services, and three outpatient services, including chemotherapy, kidney dialysis, and anti-rejection drugs for kidney transplants. In essence, Beijing is providing catastrophic insurance for migrants under its UEMI.

Unlike UEMI, individual accounts are not set up. The premium goes into the city’s social fund and major illness fund, 1.8 percent and 0.2 percent respectively. Migrants do not pay to receive these two insurances as the contribution comes entirely from employers. There is no waiting period to receive benefits. As soon as the contribution is made, employees can receive benefits. Besides not having outpatient services, benefits terms such as the deductible, reimbursement, and benefit cap are the same as for other Beijing employees. The annual deductible is Y1300 for the first account settlement and Y650 for each account settlement thereafter. The reimbursement rate is 80-97 percent depending on the amount of the treatments. The annual benefit cap is Y50,000 (BHRSS 2004).

Overall, the Beijing model is an easy way for cities to extend coverage to its migrant population. The insurance program is administered by the Beijing Human Resources and Social Security Bureau, who is also in charge of UEMI. A separate administrative unit does not need to be created to extend coverage to this population. Moreover, this program can be easily scaled up to include additional benefits by increasing the premium without any substantial changes to the current medical insurance system.

¹ Based on 60 percent of the average city monthly wage, Y3736, at 2 percent contribution rate.
This model is also considered more egalitarian. On one hand, Beijing migrants do not enjoy the same medical benefits as Beijing resident employees, but on the other hand, migrants are not paying to receive this benefit and their employers only have to pay a 2 percent contribution as compared to 9 percent for urban residents. Thus, the differences in contribution should translate into a difference in the benefits package. However, once a migrant is admitted into emergency care and inpatient care, he enjoys the same benefits in terms of provider choice, deductible, copayment, etc., as his urban counterpart. Moreover, this equal benefit system can create a common shared experience between migrants and urban residents, which can reshape community identities because the provision of social services is not only about leveling the playing fields, but is about reshaping class structure through narrowing social inequalities.

While the Beijing medical insurance system is easy to adopt and is considered an inclusive model, it is flawed in several areas. Close to half of Beijing’s migrants cannot be covered under this insurance policy. Migrant workers employed by registered enterprises are the only ones covered because workers with no labor contracts, such as home care workers and hourly wage earners, are not eligible to enroll in this insurance. Moreover, insurance accounts are set up by enterprises and not individuals, so even if a migrant wants to personally pay for this insurance, he cannot. Currently, only 51 percent of migrants are employed in the formal sector, thus 49 percent of migrant workers are not eligible for this insurance (Zheng 2007). Additionally, migrant workers do not reap substantial benefits from this insurance. Most migrants are healthy and do not require inpatient care. As a result, migrants do not see many direct benefits in their daily lives from having this insurance, and therefore are less likely to demand that their boss pays for this insurance.

*The Shanghai Model*
In contrast to Beijing, Shanghai created a separate social insurance system for its migrants in 2002. In its “Interim Regulations on Out-of-Town Employees’ Comprehensive Insurance,” the government stipulates that all employees and their employers, except home care services and agriculture workers, must participate in this plan. Migrant workers without a work unit can also enroll in this insurance. This program is separate from the city’s main insurance system, which includes the UEMI, URMI and NRCM. From 2002 to 2009, the Shanghai government has employed private insurance companies, Pingan, China Life, and Taiping to manage this insurance program.

This insurance covers pensions, occupational injuries and medical insurance for migrant workers. A monthly premium is set at 5.5 percent for construction companies (does not include a pension benefit) and 12.5 percent for all other companies. Of the 12.5 percent, 7 percent is for the pension benefit, 3-4 percent is for the medical benefit, and 1-2 percent is for occupational injury. For every 12 months of enrollment within a 3 year period, a pension card is given to employees, which can be redeemed at retirement (age 50 for women and age 60 for men).

Based on the previous year’s average monthly city wage, the insurance cost per employee is around Y247 at the 12.5 percent contribution rate, where Y59-Y79 is allocated to medical insurance.\(^2\) Benefits start the month after contributions are made. Similar to Beijing’s plan, this is a catastrophic insurance that only covers hospitalization and major illnesses. The annual deductible is Y1,500 for hospitalization with a reimbursement rate of 80 percent. The benefit cap is 4 times the previous year’s annual per capita salary. Since its inception, the hospitalization rate among migrants has been around 1-2 percent (Zhou 2009). To provide additional benefits to migrant workers, a drug card valued at Y20 per month is offered to

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\(^2\) Average city wage is Y3292.
migrants to offset pharmaceutical costs. This card can also be used for free physical exams at two designated hospitals, Jiangong hospital and Changning Zhongxin hospital.

Three elements stand out in the Shanghai model. First, it is a tailored social insurance program for migrants. With the exception of construction firms, where migrant workers are hired on a more temporary basis (less than 6 months employment), firms cannot forgo pension insurance for their migrant employees. Many have heralded this bundling of pension and medical insurances as public recognition of migrant labor’s contribution to the city’s development because the city is taking some responsibility for the migrants’ retirement. Also, as an insurance program designed specifically for migrants, contribution rates and the benefits package are adjusted to the income level, mobility, and medical needs of migrants. Second, informal sector migrants have access to this insurance plan. Individuals, as well as companies, can set up comprehensive insurance accounts, so migrants engaged in the informal sector can pay the required premium to have access to the insurance. Third, migrants receive tangible benefits such as pharmaceutical subsidies, physical exams, and a pension without any individual contribution.

At the same time, the Shanghai model has some serious flaws. First, as compared to expanding an existing program, the creation of a new program is harder for other cities to adopt. In Shanghai’s case, this insurance was originally outsourced to private insurance companies because the Municipal Social Security Bureau lacked the technical expertise to manage this insurance, and its UEMI was managed separately by the health insurance office under the Municipal Health Bureau. Second, since there are no linkages between UEMI and migrant comprehensive insurance hospitals and clinics have the added administrative burden of dealing with migrants’ claims. Third, though faring better than Beijing’s program, coverage is not ideal.
Of the 5 million working migrants, around 3 million are enrolled in this comprehensive insurance. Thus, 40 percent of migrants still do not have any medical insurance in Shanghai (Zhou 2009). While providing pension insurance is good, it increases the burden for firms by an additional Y138 per month per worker, and this potentially lowers the willingness of firms to participate in the insurance. Finally, from an ideological perspective, the comprehensive insurance program is flawed as it categorizes migrants as a separate group of urban citizens. This complete separation, from administration to program features, as well as from UEMI, emphasizes the fact that migrants are non-urban residents. Currently, there are no plans to allow migrants to switch between UEMI and comprehensive insurance. When migrants seek care at hospitals, their status as migrants is immediately evident by their comprehensive insurance cards, which are different than UEMI cards. Moreover, the current Shanghai hukou policy states that only people enrolled in UEMI for 7 years are eligible for a Shanghai hukou, which means that migrants enrolled in comprehensive insurance are not eligible to convert their hukou, signaling that migrants, at the least in the near future, will not become Shanghai citizens.

Common Limitations and Some Solutions

In addition to the shortcomings in each insurance scheme, they also share several limitations in providing good medical coverage for migrants. While it is a common flaw across the entire medical insurance system in China, the lack of linkages between rural and urban insurances and between localities is a huge barrier in providing medical coverage to migrants. At the same time, even with medical coverage, migrants’ income level and rising medical costs in cities still make them vulnerable to financial ruins caused by poor health. To combat these common failings, some solutions have been put forth by various local governments.
No Linkages Between NRCM and Migrant Medical Insurances

In both the Beijing and Shanghai models, they suffer from the same drawback of no linkages between migrant medical insurances and the NRCM. Even if migrants are covered under their NRMC, they cannot receive reimbursement for medical treatment in the city and vice versa. If enrollment NRCM is around 90 percent, we should expect most migrants to be covered under this insurance scheme as their hukou are in the countryside. A migrant with NRCM but without urban medical insurance does not receive any medical benefits at urban health centers. Similarly, a migrant with urban medical insurance but without NRCM does not receive any medical benefits at a rural hospital. To make it even more complicated, a Beijing migrant with insurance traveling to Shanghai would not enjoy medical benefits either.

To bridge this gap in migrant medical insurance coverage, some rural counties are making efforts to link their insurance schemes to some city health systems. In 2006, Gushi county health bureau in Henan province signed service contracts at select hospitals in Beijing’s Fengtai district to allow migrant workers to obtain price discounts and partial reimbursement for services. A window was set up at these hospitals to register and collect contribution fees from migrant workers. Similarly, in April 2008, Sichuan and Henan health departments negotiated with their Beijing counterparts to set up migrant clinics in two designated hospitals, Yangfandian Hospital and Chaoyang No. 2 Hospital for Sichuan and Henan migrant workers (China CSR 2008). Similarly, in 2007, the Xi county government in Henan signed a contract with Shanghai’s Jiading Anguo Hospital to allow migrants from this locale to file for RCMS reimbursement at this hospital (Tang 2007). If migrants had not signed up for RCMS, they could do so at this hospital’s designated RCMS office that also handles claims. Since these contracts are done on an individual basis county by county, their overall impact is very limited.
Low Utilization Rate Due to Low Income and High Health Care Costs

Both the Beijing and Shanghai programs have low utilization by migrants. Low migrant income levels and rising health care costs prevent even those enrolled in this insurance from seeking care. Most Beijing migrants earn around Y800 per month, and the annual medical deductible is Y1300. Thus, depending on the type of treatments required, inpatient care can cost more than Y10,000, where his copayment is around 20 percent, which translates into Y2,000. Hence, an insured migrant would have to pay Y3,040 for an Y10,000 treatment, which is almost 1/3 of his annual income.

As mentioned earlier, communicable disease is a problem within migrant communities. Having medical coverage does not necessarily resolve this problem because migrants seek care at a lower rate and the medical system is focused on treatment and not prevention. From international experience, it is evident that communicable disease is best combated with prevention. Thus, to alleviate public health concerns Beijing and Shanghai have targeted health programs for migrants. In 2003, Beijing had vaccinated over 75 percent of its 4 million migrants against diseases such as measles and encephalitis. Since 2005, migrant children have been given 15 free vaccinations in Beijing. To date, the vaccination coverage rate among migrant children is over 85 percent (BPHIC 2008). Similarly, Shanghai has free vaccination programs for migrant children at local health clinics.

Additionally, since 2004, Shanghai has set up 24 delivery stations for migrant women to improve maternal and infant health among this population. These delivery centers are affiliated with neighborhood or district hospitals and charge only one-third of the price, and a vaginal delivery is capped at Y800. Three prenatal exams are capped at Y150 (Xia et al 2009). In the
beginning, no hospital wanted to participate because they could not cover their costs from these migrant women. As a result, the Municipal Health Bureau arranged a cost sharing agreement between the hospital, a charity fund, and government. To qualify for this maternal health benefit migrant women must provide temporary resident certificates and birth permission papers at designated delivery centers. While this program has been lauded as successful in lowering the maternal mortality rate and infant mortality among migrants, it is far from ideal. 24 stations is an inadequate number to cover the 1.2 million migrant women in Shanghai who are of childbearing age (Gao 2009).

**Policy Recommendations for Extending Coverage to Migrants**

Despite the shortcomings of the Beijing and Shanghai models, a number of policy recommendations can be drawn from their experiences. Regardless of their length of stay in cities, given their health risks, migrants should have some medical coverage in cities. A catastrophic insurance through the extension of UEMI with low deductible and tangible benefits is an effective way to cover this population. Efforts should be made to establish more linkages between the RCMS and UEMI. Additionally, targeted health programs are indispensible in improving the health outcomes of this population. Below is an elaboration of each policy recommendation.

*Extension of Local Urban Medical Insurance*

Drawing from the Beijing and Shanghai models, an extension of the local urban medical insurance rather than a special insurance program is an effective way to cover migrants. While a dedicated program can be tailored to the needs of migrants, administrative inefficiency, in addition to the exclusivity of such a program, makes it less attractive. By allowing migrants to
join UEMI through lower contribution rates, migrants are incorporated into a city’s social program as full citizens. This insurance should be open to all migrants who want to join and not just to those who are formally employed.

*Tangible Benefits*

Since migrants are generally younger and healthier than their urban counterparts, they will naturally use the health system less frequently. As a result, both firms and migrants are less likely to see the benefits of insurance despite their importance in risk management. To induce buy-in from these two parties, tangible benefits such as free physical exams and drug cards should be part of the benefits package. Moreover, since migrants are more likely to utilize outpatient care than inpatient care in cities, outpatient services at designated primary health centers should be included in their insurance. Local insurance funds should be able to handle this payout because current reimbursement claims made by migrants are only 1-2 percent of total contributions (Xia et al 2009).

*Lower Deductible for Migrants*

In both cases, the Beijing and Shanghai medical insurance systems ignore the fact that migrants are usually the poorest of the urban poor. While the Beijing model is more egalitarian in inpatient benefits, a migrant, being less well-off than his urban counterpart, will experience more financial burden from the same copayment. The annual deductible of ¥1300-¥1500 is close to half of a migrant’s monthly wage. Instead of enjoying the same benefits as local residents, migrants should enjoy a lower deductible given their income status. While common health benefits is a step towards giving migrants the appropriate social rights, without the
appropriate measures to resolve the underlying social inequalities such as income and *hukou* status, the system is far from fair.

*Links Between NRCM and Urban Migrant Insurances*

The lack of linkages between the NRCM and UEMI is a major hurdle for migrant health. The cost differences between rural and urban health facilities and the premium differences between the NRCM and UEMI make linkages between these two insurances very difficult, but these two insurance systems need to be connected. While reimbursement rates may vary between locales, a reimbursement system needs to be set up so that migrants can use their medical insurance. For example, a NRCM can set a 40 percent reimbursement rate at urban hospitals compared to 60 percent at local rural hospitals, and a UEMI can set a 50 percent reimbursement rate at rural hospitals compared to 60 percent at local urban hospitals. Either way, migrants should be able to receive benefits as insured members.

*Targeted Public Health Programs for Migrants*

In addition to medical insurances, a city would need to have targeted public health programs for migrants. Given migrants’ low income and mobile nature, a catastrophic insurance would cover their risk in major illnesses and protect them from financial ruins; however, their public health needs should be addressed as well. They are an at-risk group for communicable diseases. Thus, urban governments need to have special public health education programs, vaccination campaigns, and other low-cost health programs that would alleviate their medical concerns. Moreover, given their income status, urban governments should have subsidized clinics for certain medical needs such as low cost maternity wards.

**Conclusion**
As countries continue to undergo urbanization, urban governments face enormous pressures to provide public goods and design social programs for its new population. Besides the lack of housing and education which are the banes of urban slums, the lack of health care is detrimental not only to the individual but also to a city’s economic development as poor health affects human capital development and increases income inequality in cities. As a result, it is important to provide a minimum level of medical coverage to prevent further impoverishment caused by illness among this population. Drawing from the Chinese experience, we can see that providing catastrophic medical insurance is an effective way to cover a mobile and poor population in urban areas. From this initial stage, the catastrophic insurance can be scaled up to include inpatient services and drug benefits as a city’s finances improve. This insurance can also be expanded to include different groups in urban society.

Given China’s experience, it is important to note that insurance for the poor should be government run. While the private sector can be involved in managing these programs, much like the Shanghai model, the government should ultimately be responsible for these programs. Moreover, these insurance programs should require compulsory participation from enterprises as firms’ incentives are tied to lowering production costs and increasing profits, and not increasing labor costs. Additionally, it is not enough to just have insurance coverage; urban governments have to invest additional resources in public health and special programs to alleviate migrant medical problems in order to bridge the gap between the insured and uninsured, and also to meet the medical needs of all migrants.

Moreover, since social programs, including medical insurance, are a way by which urban governments are allocating social rights to different groups in society, special attention needs to be paid to the structure of these programs in guaranteeing universal rights to urban citizens. From
Beijing and Shanghai’s experiences, we see that a more inclusive model can help to ensure an urbanization process where migrants are socialized into urban citizenship rather than kept separate as outsiders in their host cities.
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