Internal Migration and 'Rural/Urban' Households in China: Implications for Health care

Chen Chuanbo¹, Henry Lucas², Gerald Bloom² and Ding Shijun³

¹ School of Agricultural Economics and Rural Development, Renmin University, Beijing, China
² Institute of Development Studies, UK
³ School of Agricultural Economics, Huazhong Agricultural University, Wuhan, China
Acknowledgements

The authors acknowledge the scientific support extended by colleagues in the project ‘Protecting the rural poor against the economic consequences of major illness: a challenge for Asian transitional economies (POVILL)’, funded by a four year grant from the European Union Commission under FP6.

Ten institutions were involved in this three country project: Center for Advanced Study, Cambodia; China Health Economics Institute; Institute of Social Development, Beijing Normal University, China; Institute of Development Studies, UK; Karolinska Institute, Sweden; National Institute of Public Health, Cambodia; National Institute of Public Health, Lao PDR; Prince Leopold Institute of Tropical Medicine, Belgium; West China Center of Medical Sciences, Sichuan University, China; and Zhongnan University of Economics and Law, China.

Support was also provided by colleagues from 'Future Health Systems: Innovations for equity', a research programme consortium funded by the UK Department for International Development (Grant # H050474), The consortium includes researchers from China Health Economics Institute; ICDDR,B, Bangladesh; Indian Institute of Health Management Research; Institute of Development Studies, UK; Institute of Public Health, Makerere University, Uganda; Johns Hopkins University Bloomberg School of Public Health, USA; and University of Ibadan College of Medicine, Faculty of Public Health, Nigeria.

www.povill.com
www.futurehealthsystems.org

June 2010
Introduction
Limitations on family size and increases in life expectancy have resulted in a steady ageing of the rural Chinese population (Hesketh et al, 2005). This has been exacerbated by the outmigration in search of employment of predominantly younger adults. Around 140 million Chinese, some 10% of the population, are classified as members of the “floating” population, the great majority of these being rural-urban migrants (Song and Appleton, 2008). A substantial proportion of rural households, especially in poor areas, now have one or more registered members living for much of the year in an urban area.

While these migrants often only return home for the spring festival, they typically remain intimately linked to their rural household which may include their spouse, parents and children. Their remittances may often be the main source of household income and they provide a potentially very important financial safety net against the risk of crop failure, ill-health or other shock to rural household livelihoods. When they do return home they will often bring a variety of household goods, food stocks and medicines. The importance of their contribution will typically allow them to play a full role in household economic decision making.

However, their physical absence may greatly increase the burdens assumed by those who remain behind in terms of both productive and reproductive activities. This may be most serious for the elderly in households where all the younger adults migrate, possibly leaving young children in their care. Such burdens tend to increase both the susceptibility to ill-health and its impact on household livelihoods. The rural elderly may have to continue to work in spite of relatively serious health problems, simply because there is no one in the household who can take their place. They similarly have no one to provide home-based care or assist them in accessing formal health services when they experience ill-health. Chronic illness of those in the older age groups has become the leading cause of death and disability in rural China (Shi et al, 2008. Wang et al, 2007).

The migrants may also have difficulty in obtaining care because their registration status means that they have no right of access to most urban health services. Those who are seriously ill and thus unable to work may have no choice but to return home. This leads to the phenomenon

---

4 We derive the term ‘reproductive burdens’ from the literature on social reproduction (Young 1981). It refers to the functions of households in the following areas: capacity to produce and rear children; day-to-day maintenance of households through care of children and other dependents such as the elderly and/or ill, food processing and cooking, cleaning, etc.; and maintenance of household viability inter-generationally.
sometimes described in China as ‘rural areas export good health and re-import ill-health’. Given the decentralization of responsibility for health financing, the cost of caring for these returnees will be borne either by their family and friends or by the rural county government. Recent reforms have seen the introduction of the New Community Medical System (NCMS) a rural health insurance scheme that is heavily subsidised by central government in poor rural areas. However, relatively low reimbursement rates, and an exclusive focus on impatient care, have limited the assistance that it can provide to the households described above (Yip and Hsiao, 2009).

**Three major health-related transitions in China**

The 20th century was marked by three major transitions in China that had an impact on the health sector: a demographic transition to reduced levels of mortality and fertility; an epidemiological transition to reduced incidence of most infectious diseases; and an economic transition. China passed very rapidly through the demographic and epidemiological transitions. The total fertility rate declined from around 6 in 1949 to 1.5 in 1998 (Quisheng and Lee, 2006), partly due to the introduction of the ‘one-child’ policy (Gu et al, 2007). Over the period from the founding of the Peoples Republic in 1949 to the late 1990s, life expectancy doubled to 70 years and infant mortality fell from 300 per 1,000 births in 1950 to 31 per 1,000 births in 1999 (Cook & Dummer, 2004). The predominant cause of mortality shifted from infectious diseases and perinatal conditions to chronic diseases and injuries. By 2000, almost 83% of all deaths were due to non-communicable diseases (primarily cerebrovascular disease, ischemic heart disease, chronic obstructive pulmonary disease and cancers) (Mathers et al., 2006).

Over a similar period China also made the transition from a planned to a ‘socialist market’ economy. This transition impacted substantially on the health sector because primary responsibility for the financing of health care moved from the commune or enterprise to the individual. Between 1978 and 2002 the share of out-of-pocket payments in total health care expenditure grew from 20% to 60% (MoH, 2004). The position was substantially worse in rural areas where until recently government subsidies were very limited and the great majority of the population had no effective health insurance. Here the share of out-of-pocket payments approached 90% (Gao et al, 2002).

In this paper, the combined implications of these developments are considered based partly on existing migration studies and partly on data taken from the Poverty and Illness (POVILL) study (Lucas et al, 2008). The aim of this study was to understand the potentially complex impacts of major ill-health on household livelihoods for a reasonably large number of affected households in selected study areas in three countries, Cambodia, China and Laos. At an early stage in the design it was agreed that these households should be selected using a strict probability sampling approach such that it was possible to make valid statistical inferences to the overall study area populations. In China, the household survey was undertaken in two purposively selected counties in each of two provinces. In each area, a multistage cluster sampling procedure was adopted to select village communities, each consisting of around 100 households. All households in these communities were enumerated, giving a total sample of
some 12,000 households. The sample size was based on evidence from existing surveys that in any given year around 5% of households might be affected by the type of major illnesses addressed by the project\(^5\). This proved to be a considerable underestimate, mainly because of the age structure of the population as discussed below. In-depth studies, typically requiring 1-2 person days were undertaken by social scientists with a probability sample from this sub-group of households, which numbered around 600 in China.

**Implications for health care**

The POVILL data suggest that in rural areas the combined effect of the three transitions described above is a rapidly aging population that is struggling to meet its healthcare needs.

**Demographic change**

Among the more than 50,000 individuals sampled for the study, some 17% of the *registered* population were over the age of 60 years and almost 7% over 65. Just 16% were under 15. However, large scale migration to urban areas has transformed the age distribution of the *resident* population. A remarkable 90% of men and 70% of women between the ages of 20 and 35 were reported as living away from home for part of the year and 90% of these were away for six months or more. As a consequence, the population resident for more than 6 months of the previous year is dominated by those over 50 (47%) or under 15 (20%), and the proportion of those over 60 is 25%. The proportion in the 20-49 age group falls from 42.8% to just 27.2% (table 1 and figure 1).

<table>
<thead>
<tr>
<th></th>
<th>Total Population</th>
<th>Resident at least 6 months</th>
<th>Absent more than 6 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-14</td>
<td>15.9</td>
<td>20.2</td>
<td>7.6</td>
</tr>
<tr>
<td>15-19</td>
<td>9.2</td>
<td>5.9</td>
<td>15.5</td>
</tr>
<tr>
<td>20-39</td>
<td>29.9</td>
<td>12.8</td>
<td>63.4</td>
</tr>
<tr>
<td>40-49</td>
<td>12.8</td>
<td>14.4</td>
<td>9.6</td>
</tr>
<tr>
<td>50-59</td>
<td>15.3</td>
<td>21.5</td>
<td>3.1</td>
</tr>
<tr>
<td>60-69</td>
<td>10.2</td>
<td>15.1</td>
<td>0.7</td>
</tr>
<tr>
<td>70+</td>
<td>6.8</td>
<td>10.1</td>
<td>0.2</td>
</tr>
</tbody>
</table>

Source: POVILL household survey

---

\(^5\) The definition of a ‘major illness’ was based on the potential implications of the illness for household livelihoods. This was necessarily a subjective assessment made by the researchers following analysis of the household responses to the survey questionnaire.
The POVILL data indicate that more than two thirds of sampled households in 2006 had at least one member who had migrated to another part of China. Most of these tended be serial migrants, moving between cities and provinces in search of improved employment opportunities. Migration was typically motivated by a desire to improve their economic situation rather than out of necessity. Agricultural production on the family farm was usually sufficient to keep family members “full and warm” but provided little surplus income. Migration was intended to generate money for additional production or leisure goods, to pay education fees, meet health care costs, or fund household construction projects.

**Health status**

Rural areas are said to be exporting good health and re-importing ill-health. There are three main mechanisms. First, the ageing rural population age structure resulting from out-migration will inevitably lead to a higher prevalence of serious chronic disease. Figure 2 shows that the prevalence of self-reported serious illness in the POVILL data increased from about 6% at 18 years to 55% at 65 years. Note that chronic illness, not requiring inpatient care, represented by far the most important category of reported serious illness for the elderly, while inpatient care is strongly associated with serious illness among younger age-groups.
Figure 2: Prevalence of self-reported serious illness by age

Second, healthy individuals are more likely to migrate than the sick, increasing the proportion of those less healthy in the rural population and decreasing the proportion in urban areas. Third, ageing migrants and those who experience a serious or incapacitating disease or a condition requiring intensive care (including pregnancy) will often return to their rural home to claim entitlements provided by their residential status, to seek family and community support and to avoid the high medical and living costs in the cities (Chen, 2009, Zhang et al, 2007, Bai and He, 2002). As can be seen from figure 3 below, 26% and 24% of the 590 returning migrants interviewed in the in-depth component of POVILL reported that their return was due to ill-health and aging respectively.

Figure 3: Main reason for migrants to return home

Source: POVILL in-depth interviews
The net effect of the outmigration of the healthy and their return when affected by serious illness or injury is that the health status at all ages is worsened in rural areas. Figure 4 shows that the proportion of those of working age reported as having a serious illness over the previous year was on average some 15 percentage points greater for those resident for at least six months each year. Though this figure is probably exaggerated by the failure to report some serious illnesses of migrants, data from the in-depth interviews would suggest that this would not greatly affect the comparison.

Figure 4: Reported prevalence of serious illness

Source: POVILL household survey

Migrant flows in both directions thus tend to improve the relative health situation of urban areas, in terms of able-bodied workers per sick individual, and increase the proportion of the burden of ill-health which falls on rural areas. This raises serious concerns in terms of health policy given that, as discussed in the next section, these areas typically have both weaker health-care systems and much more limited economic resources.

The burden of ill-health

In terms of the impact of serious ill-health on household livelihoods, the international literature has tended to focus on the direct financial costs of care. The debate has typically focused on the concept of ‘catastrophic health expenditure’, usually estimated in terms of the ratio between heath care costs and total consumption expenditure less spending required to meet basic subsistence needs (Xu et al, 2003). However, such measures address only part of the overall burden of ill-health. In countries such as China, where for the reasons discussed above, small rural households typically face considerable labour constraints, the loss of a key worker or the need for such a worker to devote time to caring for a sick individual, may pose even more difficult problems than the cost of care (Lucas et al, 2009). Initial findings from the 2008
National Health Household Survey (figure 5) indicate that low productivity due to ill-health was seen by over 25% of the poor as the main cause of their poverty as compared to just under 10% who cited the cost of health care. Note that an additional 24% linked poverty to labour constraints.

Figure 5: Main reason for poverty status as reported by poor rural households

Data from the POVILL study provides further evidence of the impact of ill-health in terms of lost labour time. The direct losses, due to inability to work, were reported as 9 days for those in the age group 15-39, compared with 28 days in the 40-59 year band and 45 days for those 60-69. Focusing on those usually classified as in the labour force, aged 15-59, this amounts to a loss of just over 17 days each year per labour force member. In addition, a substantial labour input was required in terms of caring for those suffering from serious illness, especially for those over 60. Calculating on a similar basis, there were 11.6 days when care was required per labour force member. As the total labour time required for care was not estimated from the POVILL household survey, these two estimates cannot simply be added. However, they do suggest the overall magnitude of the human resource costs of serious ill-health.

Note that the days of care does not include time spent on the care of minor childhood illnesses, which might also impact on the labour time, especially in terms of infant children.
Table 2: Impact of ill-health: days required for care and labour time lost

<table>
<thead>
<tr>
<th>Age group</th>
<th>Days unable to work last year due to serious ill-health</th>
<th>Days requiring care last year due to serious ill health</th>
<th>Labour time lost per work force member (15-59)</th>
<th>Number of days care required per work force member (15-59)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-9</td>
<td>5.0</td>
<td>1.4</td>
<td></td>
<td>0.7</td>
</tr>
<tr>
<td>10-14</td>
<td>9.0</td>
<td>3.4</td>
<td>5.3</td>
<td>2.0</td>
</tr>
<tr>
<td>15-39</td>
<td>28.4</td>
<td>7.9</td>
<td>11.9</td>
<td>3.3</td>
</tr>
<tr>
<td>60-69</td>
<td>45.4</td>
<td>16.5</td>
<td></td>
<td>2.5</td>
</tr>
<tr>
<td>70+</td>
<td>48.3</td>
<td>29.3</td>
<td></td>
<td>3.0</td>
</tr>
<tr>
<td>Total</td>
<td>17.1</td>
<td>11.6</td>
<td></td>
<td>11.6</td>
</tr>
</tbody>
</table>

Source: POVILL household survey

Table 3 suggests the overall pattern of care giving for those with serious illness. The never-married, almost all in the younger age-groups, predominantly receive care from parents with some help from grandparents. In married couples, care is provided predominantly by the partner, with limited support from parents and children. Those living alone, predominantly the formerly married in older age-groups, receive care from their children, with a little help from grandchildren. Overall, partners of the seriously ill constitute around 58% of care givers, while parents make up almost 27%.

Table 3: Marital status of individuals with health problem and primary carers

<table>
<thead>
<tr>
<th>Care giver</th>
<th>Never married</th>
<th>Married</th>
<th>Living alone</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner</td>
<td>0.0</td>
<td>83.6</td>
<td>0.0</td>
<td>57.7</td>
</tr>
<tr>
<td>Parent</td>
<td>79.9</td>
<td>9.2</td>
<td>10.7</td>
<td>26.9</td>
</tr>
<tr>
<td>Children</td>
<td>0.0</td>
<td>6.3</td>
<td>85.7</td>
<td>8.3</td>
</tr>
<tr>
<td>Grandparents</td>
<td>15.1</td>
<td>0.0</td>
<td>0.0</td>
<td>4.0</td>
</tr>
<tr>
<td>Grandchildren</td>
<td>0.0</td>
<td>0.0</td>
<td>3.6</td>
<td>0.2</td>
</tr>
<tr>
<td>Sibling</td>
<td>5.0</td>
<td>1.0</td>
<td>0.0</td>
<td>2.0</td>
</tr>
<tr>
<td>Total</td>
<td>159</td>
<td>415</td>
<td>28</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: POVILL in-depth study

Cost of care
One major implication for the health sector of the transition to a ‘socialist market economy’ has been a move from work-unit based healthcare financing, via agricultural communes or state-owned enterprises, to a variety of insurance and quasi-insurance schemes. These are
four major types, corresponding to a division of the population into four groups: public sector staff, urban workers, other urban residents and rural residents.7

Public sector staff (including employees of government, political parties, NGO-like groups, public organizations, the army, the public health and education sectors, and research institutions) have been covered by the ‘public health service’ scheme since 1988. Official statistics provide limited information but a rough estimate seems to indicate that they include approximately 5% of the total population. For this group, health care expenses are essentially fully covered as part of government expenditures and funded out of taxation (Hougaard, Osterdal, Yu 2008)

Urban resident employees (staff in all kinds of formal enterprises in urban areas) are covered by the Basic Medical Insurance (BMI) scheme, which was established at the end of 1998 (State Council 2000). The scheme consists of a pooled fund for inpatient stays and individual medical savings accounts for outpatient visits. Basic medical insurance is financed by payroll taxes paid by employers (6%) and employees (2%). Some 160 million people, around 28% of the total urban population, were covered by the scheme in 2006.

An urban resident scheme was started in 2007, targeting those not covered by the BMI, including, in particular, children and students. Coverage is intended to be available in all cities by the end of 2010. Local governments and participating urban residents will each provide 50% of the total fund.

For the rural population, the New Cooperative Medical System (NCMS) began in 2003. Rapid expansion resulted in coverage of 720 million agricultural households (86% of the total rural population) by the end of 2007. In the Western and Central regions of China, both central and local governments contributed ¥40 per year for each participant in that year, with the latter contributing an additional ¥20. In addition, a Medical Assistance (MA) program was set up for individuals identified as among the poorest, jointly funded by central and provincial governments, and implemented by the Ministry of Civil Affairs. In 2009 the Government announced a major new health policy and committed ¥800 billion additional funding for health over the next three years. This has led to increases in government contributions to NCMS and the creation of a new scheme to ensure that governments allocate ¥15 per person for public health services.

In reviewing the impact of NCMS, it is important to take into account the newness of the scheme and the timing of each study. Government contributions to NCMS have increased rapidly and the impact on household coping strategies is likely to have increased over time.

7 Under the ‘hukou’ population registration system, people are classified according to the geographical location of their household. Hukou-status may change in connection with job changes. For instance, if a student with rural hukou moves to a city university he/she will receive a temporary city hukou which may become permanent if they are employed in the city after graduation – but most rural migrants work in urban areas without a hukou change.
During the initial phases of scheme implementation, the newly establish NCMS management teams were afraid of running out of money before the end of the year and many schemes accrued surpluses (Zhang and Xie 2010). This affected levels of reimbursement. This has changed as scheme managers gained experience and higher levels of government became aware of the problem. Policy makers and local health managers have become increasingly aware of the problem of chronic disease and a number of schemes have experimented with providing coverage for some outpatient services. Despite the limitations of a study undertaken very early in the establishment of NCMS, the findings of the POVILL study identify several challenges that schemes still need to address.

The use of residence status to determine eligibility excludes some groups of the population from adequate cover. In particular, rural migrants employed in urban areas are typically not covered by the BMI. A recent study of 844 internal migrant households in Beijing (Chuanbo, 2010), found that 46% of migrants were not covered by any scheme, 41% had NCMS membership and 6% had commercial insurance (figure 5).

![Figure 5: Healthcare financing scheme coverage by migrants in Beijing](image)

Responsibility for financing and administering health care is decentralized. Provincial, county and city governments collect their own tax revenues, administer health care financing schemes and share responsibility for providing services. It is usual practice to arrange risk pooling for these health care financing schemes at city and county levels. Tax revenues primarily derive from income, turnover and sales taxes on local enterprises (Zhang 2006). Poorer counties typically have few such enterprises, leading to both low tax revenues and very limited employment opportunities for young workers, the more able of whom tend to migrate to urban areas.
In contrast, the richer cities typically have many small, medium and large enterprises, generating substantial tax income and attracting large numbers of migrant workers who make a major contribution to the local economy. However, they typically receive limited services from city governments, which are primarily concerned to provide benefits for their local ‘hukou’ people. Dependence upon local taxation thus paves the way for substantial inequalities, both between urban residents and migrants, and between rich urban and poor rural regions. For example, the total financial contribution per person in the NCMS in Shanghai in 2007 was around ¥450 compared with only ¥50 in most provinces in Central and Western China (Wu 2007). Figure 6 below illustrates the multiple disadvantages suffered by poor rural areas in terms of the demand for and supply of healthcare services.

The NCMS, which receives substantial subsidies from central government in poor counties, was intended to mitigate the rise in out-of-pocket payments and improve equity in the financing of, and access to, health care. However, the coverage provided was very limited in 2007, both in terms of both the service benefit package (Chen 2008) and the financial protection provided. Outpatient services were rarely covered, and then very inadequately. Inpatient service coverage often required patients to bear substantial costs, including co-payments, deductibles, additional fees, and payments for travel and subsistence. The medical assistance scheme for the poorest people often simply helped its participants enroll in the NCMS, providing

---

8 For example, in Dongguan, one of the most prosperous areas in Guangdong Province there are 1.79 million local ‘Hukou’ residents. They benefit substantially from local government expenditures while the migrant population, some 4.56 million people, receives very little.
substantial additional support only in a minority of cases. As a result, there were limited improvements in access to primary care for poor people, and financial protection against high health-care expenditure remained very restricted (Wagstaff 2007). The government has subsequently decided to integrate MA with NCMS.

Competition between providers may contribute to unnecessary expenditures. Rural patients often inappropriately seek (or are persuaded to seek) inpatient care. The following example is taken from the POVILL in-depth study:

In 2006, a 29-year-old woman suffering from leukemia, had blood transfusions in the county hospital for 4 days every two weeks, paying ¥2,000 each time and being reimbursed just ¥248. After three transfusions, her husband persuaded the doctor to give permission for blood to be purchased for transfusion at home. Four transfusions were undertaken by a village doctor, at a cost of ¥440 each time.

Table 4 is based on responses from the 9,097 surveyed households in the 3 counties with NCMS that were included in the POVILL study. It shows that NCMS and MA reimbursements were reported as accounting for only some 2-4% of total household healthcare expenditure, with the remainder being met by out-of-pocket payments.

Table 4: Proportion of household healthcare costs met by NCMS and MA

<table>
<thead>
<tr>
<th>County</th>
<th>Average Expenditure (¥)</th>
<th>Average Inpatient Expenditure (¥)</th>
<th>NCMS Reimbursement Per capita (¥)</th>
<th>MFA Reimbursement Per capita (¥)</th>
<th>Out-of-pocket percentage of total expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hongan</td>
<td>2,372</td>
<td>915</td>
<td>93</td>
<td>1.6</td>
<td>96.0</td>
</tr>
<tr>
<td>Langzhong</td>
<td>4,081</td>
<td>1,301</td>
<td>53</td>
<td>1.8</td>
<td>98.7</td>
</tr>
<tr>
<td>Fushun</td>
<td>2,652</td>
<td>837</td>
<td>91</td>
<td>1.3</td>
<td>96.5</td>
</tr>
</tbody>
</table>

The above table should be interpreted with care. Healthcare expenditures are those reported by households and may be exaggerated. None of the NCMS schemes provided reimbursement for outpatient care which, given the relatively limited number of reported inpatient episodes, accounted for the largest proportion of health care costs. Note that much of this expenditure, as indicated by figure 2, related to ongoing treatments for chronic illness. Such treatments can be similar to those for inpatient treatments as indicated in figure 7, which compares the median cost of an inpatient episode to the annual cost of outpatient treatment for those at the 75th cost percentile for a number of common chronic illnesses.
The NCMS has been strongly focused on providing some relief for people facing high cost inpatient care via a risk pooling fund. It is payments from this fund that are reflected in the above table. These may be of substantial value to the limited number of beneficiaries but will obviously not reduce payments by the great majority who do not use inpatient care. There is a second component – the household account – which is essentially a prepayment scheme for primary healthcare, usually provided by a village doctor, and involves no cost/risk sharing or subsidy. Draw downs from this account are often added to risk fund reimbursements in published materials on NCMS. However, while this component is of considerable importance from a political and social perspective, its role as a social security mechanism is questionable (Yip and Hsiao, 2009).

**Discussion**

The findings of the POVILL study, and in particular the in-depth discussions with some 600 households affected by serious illness, strongly suggest that major economic and social changes have taken place in the poorer rural counties of China over recent decades that have led to radical shifts in the composition and behaviour of rural households. Before 1984, all members of a traditional Chinese rural household worked and lived together as part of a highly cohesive community. But the economic transition and associated high levels of internal migration has led to what might be termed ‘rural/urban’ households, retaining a rural base but with ‘satellite’ outposts in urban areas. Some members, the elderly, the very young and to a lesser extent women, remain in the rural home. Other members live for a large part of each year in urban areas, most often singly but sometimes with their spouse.

In general, most household members probably retain, at least initially, the concept of the rural base as their ‘real’ home. Some may well return to that home when, because of sickness, age or economic downturn, they are no longer able to earn higher incomes in urban employment and need the official, community or family support that is only available in the rural base.
They may also return if parents or other relatives become less able to manage the family holding or need health and personal care, or simply to resume contact with their children and other family members. On the other hand, some of those who have migrated may come to see the city as the place which offers the greater opportunities for themselves and their growing children, who may join them to seek secondary education. Eventually they may persuade their ageing parents and other relatives to re-unite the nuclear or even extended family unit in the urban area. Many hope that the children will gain an education that enables them to secure well-paid employment and obtain permanent registration in a city.

These combined rural/urban households have provided a very efficient arrangement for generating livelihoods, taking care of children and building up household assets relevant to a relatively rapid transition from rural to urban residence and employment, such as housing, social networks and education. The willingness of two generations to combine their efforts and make major sacrifices in terms of living apart and in difficult conditions has made important contributions to China’s rapid economic development and to the great improvement in the incomes of many rural (and formerly rural) households. However, these transitional rural/urban households are very vulnerable to a number of potential shocks (figure 7). If a member of the older generation falls ill, not only will they need money for medical care and, perhaps, support with daily activities, but they may also need to withdraw their support for the care of the grandchildren. In that case one or both of the migrant generation may need to return home and lose their opportunity to earn money in urban employment and finance education for their children. Similarly, when a member of the middle generation falls seriously ill the family may need to revert to a fully rural livelihood. This clearly places enormous pressures on households that suffer this kind of misfortune. There is also a longer term risk of the emergence of households who become trapped in the countryside and are largely excluded from the benefits of economic development. The design of interventions that reduce the risk of both eventualities provides major challenges for policy makers.

Figure 7: New forms of household in China
National policy has long been established on locality-based schemes that depend on household registration (hukou), which is not easily transferable from rural to urban areas. The NCMS is still financed and administered by county governments, with substantial subsidies from higher levels of government. Many schemes reimburse some medical costs of migrants. However, the need to pay the costs of care in expensive urban hospitals is putting serious strains on these schemes. Poor rural counties have very limited resources to support this kind of coverage. This raises important questions about whether the localities where they work should contribute towards insuring against medical costs and other risks associated with their migrant status.

The ageing of the population and the growing burden of chronic illness is creating new challenges. Children have a limited capacity to care for ageing parents in these mixed rural/urban households. The rural health care system needs to give much more attention to the prevention of chronic disease and to the provision of low cost treatment. It also needs to establish mechanisms for supporting elderly people during an episode of acute illness or when they become disabled. This may involve a change in the services that township health centres provide and the organization of village-level community services. Measures are also needed to help older people who are looking after young grandchildren. Many rural localities have already established nurseries. These could be complemented by arrangements to care for children when they fall ill and to look after them when the person caring for them is unwell.

The focus on treatment costs for serious acute illness episodes is understandable in terms of the operation of support schemes. For example, many are designed solely to provide financial assistance in meeting hospital inpatient care costs (STEP Programme, 2005). From the point of view of scheme management this has considerable advantages: illnesses resulting in inpatient episodes are a tiny proportion of the total, which limits the number of transactions undertaken by the scheme; each episode can be considered as an isolated event taking place over a fixed period; and there will typically be detailed documentation on diagnosis, treatment, outcome and costs, allowing rigorous financial monitoring of expenditures and at least the possibility of effectively regulating the quality of services provided (Lucas et al. 2008). However, the government needs to find ways to reduce the incentives for people to seek inpatient care and to support people in finding low cost treatment for chronic illness.

The creation of demand side schemes, such as NCMS and MA are important first steps towards the creation of a health system that responds to the needs of rural residents for access to effective and affordable care and for protection against the major financial consequences of major illness in the family. However, much more needs to be done to design schemes that address the major health-related needs of transitional rural/urban households with large numbers of ageing family members. This is the challenge for the next few years.
References


Liang Quisheng and Che-Fu Lee, 2006, Fertility and Population Policy, in Chiung-Fang Chang; Che-Fu Lee; Sherry L. McKibben; Dudley L. Poston; Carol S. Walther (eds.), Fertility, Family Planning, and Population Policy in China, Routledge.


Zhang Huan and Xie Liwei (2010) “The Implementation of China’s New Cooperative Medical Scheme: A Two-County Case Study” unpublished report on POVILL study, School of Development and Public Policy of the Beijing Normal University, Beijing
