Construction of a Multi-level Medical Security Policy System for Poverty Alleviation in the Post-poverty Era

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Abstract. The establishment of a multi-level medical security policy system have a more important impact on poverty alleviation in the post-poverty era. This study uses the third-party assessment survey data from Hubei and Jiangxi provinces and the 2018 National Sixth National Health Service Statistical Survey Report. From the perspective of disease risk and medical burden, assess the risk of poverty due to illness and medical security needs of the poor, and sort out the transition path and policy system of medical security policies for difficult groups in the post-poverty era, and deeply analyze the implementation effect and existing problems of current medical security poverty alleviation policies. and on this basis, the construction of the multi-level medical security poverty alleviation policy system is expounded from the aspects of social medical insurance and medical assistance, public health prevention and commercial medical insurance.

1 Introduction

In 2020, China has successfully achieved the goal of eradicating absolute poverty and achieved a phased victory in the battle against poverty. A total of 10 million households who have been impoverished due to illness have achieved precise poverty alleviation, and the insured rate of registered impoverished households has remained stable at over 99.99%. However, in the era of post-poverty alleviation, the form of poverty has changed, showing the characteristics of relativization of poverty forms, individualization of poverty objects, and multi-dimensional content of poverty.[1] How to ensure the phased achievements of poverty alleviation and improve the current medical security system to ensure that people at risk of returning to poverty will not become poor or return to poverty due to illness have become the focus of post-poverty alleviation era.

However, as of the end of 2021, there are still 23.54 million people in difficulty who are still paying 2.78 billion urban and rural residents’ endowment insurance premium by the government, which means that a large part of the group still needs to rely on assistance policies to maintain their basic lives, and risk of returning to poverty due to illness still exists. There are still many problems in the existing medical security policy. First of all, urban and rural residents’ critical illness insurance has limited protection for major and serious diseases, and has shortcoming of insufficient “accuracy”. the scope of application is limited, and the protection for the poor and those at risk of poverty is insufficient.[2] Second, there is a huge gap between the medical security policy benefits of the poor and the non-poor, forming a "cliff effect".[3] The actual reimbursement rate of the non-poor groups participating in the basic medical insurance for urban and rural residents is up to 65%, while the reimbursement rate for poor who enjoy the assistance of the medical insurance policy is up to 90%.

Huge differences in welfare will affect the advancement of poverty alleviation work and the sense of antagonism and relative deprivation between groups. Thirdly, failure to establish an accurate and effective identification of rescue objects and an access and exit mechanism will result in low security efficiency and waste of funds. [4] Finally, the medical security system with basic medical insurance as the main body and critical illness insurance and medical assistance as supplements fails to form a good synergistic interaction. The single-level guarantee of basic medical insurance is not only difficult to meet the medical needs of people who have become impoverished or return to poverty due to illness, and it will put huge expenditure pressure on the medical insurance fund.

In that case, it is urgent to follow the requirements of the “Implementation Opinions on Expanding and Consolidating the Achievements of Medical Security and Poverty Alleviation to Effectively Connect to the Rural Revitalization Strategy”, stably consolidate the comprehensive protection of the basic medical insurance, critical illness insurance and medical assistance system, and continue to improve the multi-level medical security system.
2 Disease risk and medical burden of the poor

2.1 Data sources

This paper uses the field data collected from the third-party household survey questionnaires for targeted poverty alleviation in Shicheng County, Ganzhou City, Jiangxi Province in 2018, and Suzhou High-tech Zone and Dahongshan Scenic Area in Hubei Province in 2020. The survey data adopts multi-stage sampling, adopts PPS sampling in the sampling stage of county/district and administrative villages, and adopts random sampling method to select samples at the household and individual level to ensure the representativeness and fairness of the samples. The survey samples are located in Hubei Province in the central region of China and Jiangxi Province in the southern region, whose GDP is in the middle or upper level in the country, which has a strong national representativeness. And the third-party household questionnaire is designed around whether the respondents meet the objective criteria for poverty alleviation and whether they have the conditions for poverty alleviation subjectively. The questionnaire is divided into two parts. The first part is about the poverty-stricken households that have been registered. It refers to the poverty-stricken groups that analyze the causes of poverty of poor households, file and record their information and incorporate them into the national poverty alleviation information network system, and provide targeted policy assistance.[5] The questionnaire comprehensively investigates the basic situation of the poor households that have been registered in terms of the implementation of the policy of "two worries and three guarantees" (no worries about drinking water, food, compulsory education, housing and medical security) and the recognition of the respondents. The second part is for the non-registered poor households, that is, the farmers who have not been registered or incorporated. The income level of this group is slightly higher than that of the registered poor households, but they enjoy less policy assistance than the registered poor households.[6] The sample information used in this paper includes: 696 registered poor households, including 250 in Hubei Province and 446 in Jiangxi Province; 417 non-registered poor households, including 50 in Hubei Province and 367 in Jiangxi Province.

2.2 Diseases risk of the poor

Diseases, especially serious diseases rather than general diseases, are an important source of poverty. Among various poverty-causing factors, poverty due to illness (especially serious diseases) ranks first, and poverty due to illness and return to poverty account for more than 40% of the total number of registered poverty-stricken households.[7] This paper will measure the poor by using four indicators of the poverty group (including the registered poor households and the non-registered poor households) suffering from serious diseases and chronic diseases, hospitalization rate and the incidence of catastrophic health expenditures disease risk. Among them, catastrophic health expenditure refers to when a family's current health expenditure accounts for more than 40% of its ability to pay.[8] The disease risk of the poor group is assessed by comparing four main indicators of the registered poor households, the non-registered poor households and the national average.

2.2.1 The poor are at greater risk of major and chronic diseases

With the rapid development of China's economy and the acceleration of industrialization and urbanization, as well as changes in disease spectrum, chronic diseases have become the main health problems of Chinese residents. Furthermore, having a family member with chronic disease significantly increases the risk of catastrophic health expenditure in the family.[9] The sixth national health service statistical survey report shows that the prevalence of chronic diseases in rural areas is 35.2%. As shown in Table 1, the proportion of registered poor households in Jiangxi and Hubei provinces surveyed in this study suffering from chronic diseases is 40.37%, which is significantly higher than that of non-registered poor households in the same region and the national average. The registered poor households in this region have a higher risk of developing chronic diseases such as hypertension and diabetes. At the same time, the morbidity rate of major diseases among the registered poor households under the investigation is 15.80%, which is more likely to suffer from a major disease than the 12.55% prevalence rate of major diseases among the non-registered poor households in the same area during the same period.

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<th>The average level of poor households</th>
<th>National average</th>
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<tr>
<td>Major disease prevalence</td>
<td>14.22%</td>
<td>12.80%</td>
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<tr>
<td>Chronic disease prevalence</td>
<td>36.48%</td>
<td>35.2%</td>
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Note: Since the targeted poverty alleviation targets are rural residents, the relevant data on the national average is limited to rural areas. The data "12.80%" and "35.2%" come from the sixth national health service statistical survey report.

2.2.2 Poorer groups have higher hospitalization rates

The hospitalization rate is the ratio of the number of people with diseases who have been hospitalized in various medical and health institutions in the past year to the number of respondents. Hospitalization rates reflect the situation that people who have a disease and seek medical care over a period of time. The sixth national health service statistical report shows that the hospitalization rate of residents in rural areas is 14.7%, while the hospitalization rate of poor households in
Jiangxi and Hubei provinces in the survey sample is 22.70%, which is much higher than that of non-registered poor households and the national average. Among them, the most inpatients of the registered poor households suffer from chronic diseases such as cancer, cardiovascular and cerebrovascular diseases, and mental illness. Most of the non-registered poor households are hospitalized due to common major diseases such as heart disease, fracture and inflammation. From the types of hospitalized diseases, it can be seen that most of the diseases of the registered poor households are major diseases or acute diseases, and the number and scope of the diseases are larger than those of the non-registered poor households. The proportion of registered poor households suffering from major disease risk is relatively large, and they are in urgent need of medical services, so the hospitalization rate is higher.

![Hospitalization Rate Chart](image)

**Figure 1**: Statistics on the hospitalization rate of poor households in Jiangxi and Hubei provinces

2.2.3 The poor are at higher risk of catastrophic health expenditures, and there is a significant difference between the marginalized poor and the poorest groups.

Internationally, the risk of catastrophic health expenditure is widely used as a reflection indicator of the risk of major diseases. By measuring the incidence and intensity of catastrophic health expenditures in low-income households under different threshold criteria,[10] The incidence of catastrophic health expenditures refers to the ratio of the number of households with catastrophic health expenditures to the total number of samples in the sample, and the intensity of occurrence refers to the degree of impact of catastrophic health expenditures on households' living standards. The results showed that the incidence and intensity of catastrophic health expenditures decreased as the threshold criteria increased. As shown in Figure 2, this study fixed the threshold standard at 40%, and calculated that the incidence of catastrophic health expenditures for the registered poor households and non-registered poor households in Jiangxi and Hubei provinces was 17.24% and 25.66%, respectively, both higher than the national average, indicating that both groups have a higher risk of catastrophic health spending.

It is worth noting that in the survey on the incidence of catastrophic health expenditures, the incidence of catastrophic health expenditures of non-registered poor households is 8 percentage points higher than that of registered poor households. This may be due to the fact that the impoverished marginal groups have received significantly less policy assistance than the extremely poor households because their economic income is slightly higher than that of the extremely poor households. For example, the medical insurance and hospitalization expenses enjoyed by the extremely poor households are purchased by the government, and the reimbursement rate for hospitalization is significantly higher than that of the impoverished marginal households. As a result, the impoverished marginal households have a higher hidden disease risk than the extremely poor households, and their ability to cope with diseases is weaker than that of the extremely poor households.
2.3 Medical burden of the poor

Compared with other groups, the poor are at higher risk of suffering from serious and chronic diseases, which means that this group needs to bear more cost of disease treatment and bear a huge economic burden in terms of medical expenditure. This study will analyze and explain the medical burden of the poor from out-of-pocket expenses and hospital reimbursement ratios.

2.3.1 More than one-fifth of the poor have less than 50% hospitalization reimbursement

As shown in Figure 3 and 4, no matter whether it is registered or non-registered, more than one-fifth of the poor households have a hospital reimbursement rate of less than 50%. Among them, the reimbursement ratio of the registered poor households over 90% only accounted for 9% of the survey respondents; Among the non-registered poor households, half of the people's hospital reimbursement rate is less than 50%, and no one has a reimbursement rate of more than 90%. The low rate of hospital reimbursement will affect the poor people's willingness to seek medical treatment and bring about a medical burden that exceeds their own financial capacity.

In the sixth national health service statistical report, the proportion of out-of-pocket hospitalization expenses for inpatients in rural areas was 47.2%. The proportion of out-of-pocket expenses of more than one-fifth of the registered and non-registered poor households surveyed far exceeds the national average. This shows that this group bears a considerable burden of medical expenditure.

2.3.2 Poor out-of-pocket medical expenditure are higher than the national average

Figure 3: Proportion of hospital reimbursement ratio of Non-registered poor households in Jiangxi and Hubei provinces

Figure 4: Proportion of hospital reimbursement ratio of registered poor households in Jiangxi and Hubei provinces
expenses, which is less than 3,600 yuan in the rural areas of the central and western regions, and 6,030 yuan in the eastern urban areas. As shown in Table 2, the per-time hospital out-of-pocket expenses of the surveyed poor households with registered and non-registered poor households were 9415.57 yuan and 49697.89 yuan respectively, far exceeding the national average level, indicating that the two groups in the study bear great pressure on medical burden. The difference between the extreme values of out-of-pocket expenses of the two groups is obvious, which reflects the difference in the proportion of medical insurance reimbursement for different diseases. At the same time, there is a significant difference between the median value of out-of-pocket expenses and the average value, indicating that some groups suffer from serious diseases, such as cancer, and the treatment costs are extremely high, which are unaffordable for ordinary families, and it is easy to cause the risk of becoming impoverished or returning to poverty due to illness.

| Table 2. Out-of-pocket hospitalization expenses of poor households in Jiangxi and Hubei provinces |
|---------------------------------|---------------------------------|
| Registered poor households     | Non-registered poor households |
| Maximum out-of-pocket cost      | 160000                          | 400000                          |
| Minimum out-of-pocket costs     | 0                               | 0                               |
| Median out-of-pocket costs      | 1000                            | 10000                           |
| Average out-of-pocket costs     | 9415.57                         | 49697.89                        |

2.3.3 The medical and health expenditure of the poor accounts for too much of their income

The proportion of the medical and health expenditure of the poor to the income can reflect the medical burden pressure of this group to a certain extent. As shown in Figure 5, in the survey of the proportion of out-of-pocket expenses for hospitalization of registered and non-registered poor households in the total household income, it was found that more than half of the interviewed non-registered poor households received medical care Expenditures exceed more than 90% of total household income, and only a few non-registered poor households account for less than 50% of total household income. In 2018, the proportion of medical and health expenditures in rural areas in China accounted for 30.55% of income. The medical expenses of the surveyed subjects account for a large proportion of their income, far exceeding the national average level, and the medical burden they bear far exceeds their own economic capacity, which affects their normal living standards and makes them at great risk of becoming impoverished due to illness. Although some registered poor households enjoy the government's medical security policy, and the high medical reimbursement ratio greatly reduces their out-of-pocket expenses, they still bear huge pressure on medical and health expenditures due to their limited economic income.

![Figure 5: Proportion of medical expenditure of poor households in Jiangxi and Hubei provinces to total household income](https://doi.org/10.1051/shsconf/202315401011)
3 The content and main problems of medical security poverty alleviation policy

3.1 China’s current medical security policy system for poverty alleviation

After achieving the phased goal of eliminating absolute poverty, expanding and consolidating the achievements of poverty alleviation and effectively connecting the rural revitalization strategy have become the top priorities in the post-poverty era. The existing policy system aims to achieve comprehensive and normalized protection by optimizing and adjusting the medical security poverty alleviation policy, improving the long-term mechanism to prevent poverty and returning to poverty due to illness, and improving the triple system of basic medical insurance, serious illness insurance and medical assistance for urban and rural residents.

3.1.1 Strengthen the guarantee function of basic medical insurance for urban and rural residents

In the "Implementation Opinions of the National Medical Security Administration, the Ministry of Civil Affairs, the Ministry of Finance, the National Health and Health Commission, the State Administration of Taxation, the National Rural Revitalization Bureau of the Banking and Insurance Regulatory Commission, and the National Rural Revitalization Bureau on Expanding and Consolidating the Achievements of Medical Security and Poverty Alleviation to Effectively Connect to the Rural Revitalization Strategy", it is mentioned that it is necessary to improve the basic medical insurance system for urban and rural residents, consolidate the level of hospitalization benefits, and the proportion of hospitalization expenses within the county's policy scope is generally stable at around 70%. Compared with the 30 yuan per capita financial subsidy standard for urban and rural residents' medical insurance in the 2019 medical insurance policy, the hospital reimbursement ratio has been increased. At the same time, the government will continue to standardize the outpatient chronic disease protection policy, and optimize the outpatient drug protection mechanism for chronic diseases such as hypertension and diabetes.

3.1.2 Consolidate and improve the protection capability of serious illness insurance

In the "Notice of the National Medical Insurance Administration, the Ministry of Finance, and the State Administration of Taxation on Doing a Good Job in Basic Medical Insurance for Urban and Rural Residents in 2021", it is pointed out that the threshold for participating in serious illness insurance for rural residents is lowered and unified to the half of the per capita disposable income of local residents in the previous year. The proportion of payment within the policy scope has been increased from 50% in 2019 to 60%. At the same time, on the basis of comprehensively implementing the policies of the inclusive treatment of major illness insurance, the poverty-stricken personnel, minimum living officers, and poverty-stricken returnees were implemented by 50%, reimbursement ratio increased by 5 percentage points, and the tilt guarantee policies that gradually canceled the top line.

3.1.3 Clarify the guarantee standard of the medical assistance system

In the document of the "General Office of the State Council on improving the medical insurance and rescue system" of the General Office of the State Council in 2021, it is mentioned that Reasonably stipulate the level of rescue and annual assistance, and do category assistance well. Compared with the previous medical assistance policies, the principle of the scope of rescue costs is clear: within the last year's rescue limit, the proportion of the proportion of rescue for the individual inpatient medical expenses within the policy scope is not less than 70%. At the same time, when the proportion of low-income population rescue in rural areas is slightly lower than the subject of the minimum guarantee, if the personal medical burden is still heavy after the triple system is paid, a certain tilt assistance is given.

3.2 The problem of medical security poverty alleviation policy

3.2.1 With basic medical insurance as the main body, the coverage of critical illness insurance and medical assistance is limited

The current medical security policy is based on the basic medical insurance for urban and rural residents, supplemented by serious illness insurance, and the medical assistance system as the bottom line. However, in policy practice, the three types of systems are not closely linked, rely too much on the basic medical insurance system, and fail to form a good coordination and complement with each other. The current critical illness insurance and medical assistance systems are insufficient in the accuracy, dynamics, guarantee strength and coverage of the assistance target determination mechanism, and the inability to accurately and dynamically identify and determine the assistance target will make the population at risk of disease in need of assistance unable to receive corresponding medical treatment and security. At the same time, the lack of protection for serious illness insurance and medical assistance, and the limited coverage of diseases, make these two medical insurance systems fail to supplement and improve basic medical insurance, and the targeted assistance groups face increased pressure from disease risks and medical burdens. This makes it impossible for groups with major diseases and some chronic diseases to obtain corresponding medical insurance, resulting in a huge medical burden and the risk of returning to poverty.
3.2.2 Primary medical service capacity is limited and residents’ health management is lacking

In 2018, the National Health and Medical Commission issued the "Working Plan for the Signing and Service of Chronic Disease Family Doctors for the Poor Population" to provide health support for the poor. Both the registered and non-registered poor households in the two provinces surveyed have contracted family doctors to provide services. However, during the survey, it was found that the contracted family doctors had no other corresponding health management services except for regular door-to-door routine blood pressure checks. In addition, the contracted family doctors are generally performed concurrently by doctors from the village health center, and usually two to three doctors are responsible for the health management of the whole village. In 2019, there were 1.56 people in township health centers per 1,000 rural population, far below the national average of 2.59.[11] Doctors are under a lot of work pressure, and the health services they can provide are limited. The shortage of primary medical resources makes family doctor services often "signed but not contracted". Insufficient investment in primary medical resources makes groups suffering from major diseases and some chronic diseases have to choose Grade-A tertiary hospitals with higher treatment costs for treatment, increasing the burden of medical expenditures.

3.2.3 Over-reliance on disease treatment and insufficient disease prevention

"Prevention is the most effective health strategy." Health-targeted poverty alleviation has achieved positive results in increasing disease prevention and control and health promotion in poor areas, but it still fails to break out of the "disease-focused" framework. The current medical security policy pays more attention to the assistance and corresponding protection after the occurrence of the disease, and the investment in the prevention of the disease is insufficient. A large part of the reason is that disease prevention is an invisible indicator, and its benefits cannot be directly measured, resulting in insufficient investment in disease prevention when medical funds and resources are given priority to treatment and rehabilitation.[12] The lack of health awareness among residents and the limited capacity of contracted services provided by family doctors also hinder the development of disease prevention work. The poor have insufficient concept and investment in disease prevention, and the corresponding disease prevention and protection measures are limited, which makes the risk of disease increase for the poor, and they fall into a cycle of poverty and return to poverty due to illness.

3.2.4 Low and middle-income families have insufficient medical security capabilities and are at high risk of returning to poverty due to illness

Except for the registered poor households who enjoy the medical insurance purchased by the government and a high proportion of hospital reimbursement, other people whose economic income is slightly higher than the poverty line but still at risk of returning to poverty all purchase basic medical insurance for urban and rural residents by themselves. This group of people has limited expenditure on medical insurance, and other commercial insurance has a high threshold for participation and high premiums, which makes this group of people have to rely only on basic medical insurance for urban and rural residents to protect their own health. And their responses and capacity for disease risk are limited. The lack of the corresponding universal medical insurance makes it impossible for the medicines outside the essential medicine list to be reimbursed accordingly, and the economic burden increases, which increases the risk of low- and middle-income families falling into poverty and returning to poverty due to illness.

4 Construction of multi-level medical security poverty alleviation policy system

Improving the multi-level medical security poverty alleviation policy system is an important measure to improve the medical security public service system and expand the coverage and security capabilities of medical insurance policies in the post-poverty era. This paper will explain the construction of the multi-level medical security poverty alleviation policy system from the aspects of social medical insurance and medical assistance, public health prevention and commercial medical insurance.

4.1 Improve the ability of serious illness insurance and medical assistance to protect the poor

The current medical insurance system is a triple insurance with basic medical insurance as the main body, serious illness insurance as the supplement and medical assistance as the bottom line. However, in the process of implementation, due to the limited medical resources, the demand for medical insurance is far greater than the supply of medical resources, which makes the basic medical insurance with the widest coverage far exceed the medical burden within the scope of its ability. However, serious illness insurance and medical assistance did not form a good coordination and support for the supplement of basic medical insurance. To strengthen the hierarchy of the triple medical insurance system, it is necessary to clarify the scope of responsibility between the triple insurance and the allocated medical resources. Serious illness insurance is defined as a supplement to basic medical insurance in the nature of the system, and insurance is still its essential attribute. The medical assistance needs to strengthen its underlying guarantee function, and the coverage and level of assistance can be gradually expanded according to the assistance capacity of the medical fund, so that the list of medical assistance drugs has increased compared with the list of essential
drugs. At the same time, strengthen the transmission of information between various departments, carry out dynamic monitoring of the population at risk of returning to poverty, conduct dynamic review of the medical security benefits they enjoy, and establish a corresponding exit mechanism while improving the access standards.

4.2 Improve primary health service capacity and medical resource input

Due to the limited allocation of medical resources and large regional differences, primary health institutions have limited treatment levels and health management capabilities. Certain policy preferences can be given in areas where medical resources are scarce, and subsidies can be provided in terms of reimbursement ratios and outpatient drugs. The first is to improve the medical resource allocation system, and to improve the situation that the allocation of medical resources in various regions is too large, the waste of resources and the blind expansion of medical institutions. The second is to implement regional linkage assistance. Hospitals with better medical level in the region drive primary health institutions to provide training, telemedicine guidance or drug support. While improving the treatment level of primary health institutions, it also relieves the pressure of Grade-A tertiary hospitals for medical treatment.

4.3 Building a health pattern for prevention

Build a health pattern that changes from "treatment-centered" to "prevention-centered". The first is to improve and popularize the system of contracting family doctors to improve the embarrassing situation of "signing but not contracting". To reasonably plan the contract ratio between family doctors and residents, so that each contracted family can enjoy corresponding health services. On the basis of conventional health service projects, personalized health management services can be developed, which can increase medical revenue to ease the strain on medical spending. The second is to strengthen public health funding, investing in publicity and education, infrastructure and living environment governance, enhancing public health awareness and improving living environment, realizing the prevention of chronic diseases and common diseases and personal health management to reduce the risk of disease.

4.4 Develop Inclusive Commercial Medical Insurance

In addition to the basic medical insurance for urban and rural residents, most of the current medical insurance is commercial medical insurance. Benefiting commercial medical insurance, because of its low entry threshold, low cost, and wide coverage of diseases, can make up for the vacancy in the medical insurance needs of low- and middle-income families or marginalized groups, and it is also beneficial to other groups of people. It’s a supplement to health insurance to meet high-level medical insurance needs. For example, the "Dongguan Jiafu" launched by the Dongguan Municipal Medical Security Bureau in cooperation with China Life and other insurance companies does not limit other restrictions such as past medical history and age. Paying a premium of 168 yuan a year can enjoy a medical insurance of up to 3.3 million yuan. This kind of inclusive medical insurance launched through cooperation with other insurance companies under the guidance of the government is also a supplement to the multi-level medical security policy system, filling the gap between the previous basic medical insurance and ordinary commercial insurance, allowing low- and middle-income families increase ability to resist disease risk. Inclusive commercial insurance costs are jointly borne by government subsidies and personal payments, and can be purchased by the government for extremely difficult groups. At the same time, according to the statistics of the annual insurance fund balance, the scope of covered diseases and the reimbursement ratio are dynamically adjusted.

5 Conclusion

This paper uses the third-party assessment survey data from Hubei and Jiangxi provinces and the 2018 National Sixth National Health Service Statistical Survey Report. Through statistics on the prevalence of serious diseases and chronic diseases, hospitalization rate, hospital reimbursement ratio, and catastrophic health incidence rate among the registered and non-registered poor households in Jiangxi and Hubei provinces, and compared with the national average level. The study found that the poor still have certain disease risks and medical burdens in the post-poverty era, making this group always at risk of returning to poverty due to illness. The paper analyzes the current medical policies for the poor, and finds that there are problems such as insufficient coverage of critical illness insurance and medical assistance, and less investment in disease prevention and health management. Finally, from the aspects of social medical insurance and medical assistance, public health prevention and commercial medical insurance, this paper expounds the construction of a multi-level medical security policy system for poverty alleviation by improving the ability of serious illness insurance and medical assistance, building a health pattern for prevention and developing inclusive commercial medical insurance to reduce the risk of poor groups returning to poverty due to illness.

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