

Examination and Improvement of China's Medical Assistance System — Based on 964 Local Legislative Texts

Zhang Liang¹, Sun Shuyun²

¹School of Law, Shanxi University, Taiyuan, China

²School of Law, Shanxi University of Finance and Economics, Taiyuan, China

Email address:

zhangfamen93@126.com (Zhang Liang)

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Abstract: Since medical assistance is a livelihood security system for the poor to obtain basic medical services, the construction and improvement of medical assistance system is an important component of social security and livelihood security of a country or region. This paper has selected 41 provinces and cities to investigate the effective local legislation of medical assistance since the current legal construction of medical assistance in China is basically led by local legislation. The total number of valid samples is 964 local legislative texts. This paper examines the local legislative model of medical assistance in China, local legislation hierarchy and legislative subjects, medical assistance handling service mechanism, Medical assistance fund raising, medical assistance objects and identification, methods of medical assistance, standards of medical assistance, and other aspects through samples analysis. It can be seen that under the administrative pattern of "multi-ministry co-governance", the local legislation of medical assistance is fragmented and has a low legislative level. At the same time, there are problems in various regions, for example extensive handling service mechanism, unclear financing responsibility, missing scope of aid objects, single aid method and great difference in aid standards. Then it summarizes the problems existing in local legislation and analyzes the hidden legal principles, while the unified medical assistance regulations should be formulated under the centralized and unified management system of the National Healthcare Security Administration, so as to improve the handling service mechanism, clarify the financing responsibility, undertake comprehensive standards to identify the recipients of assistance, and determine the scientific methods and standards of assistance.

Keywords: Medical Assistance, Local Legislative Text, National Healthcare Security Administration, Medical Assistance Regulations

1. Introduction

Medical assistance is a subsistence guarantee system for the poor to obtain basic medical services. Since China's reform and opening up, with the development of the market economy and society, exploring the establishment of medical assistance system to prevent the occurrence of illness-induced poverty and returning to poverty due to illness has become a key project for people's livelihood at all levels of government. From 1990, when Shanghai Municipal Government promulgated the first special legislation on medical assistance, "Shanghai Municipal Emergency Medical Assistance for Urban Poor Citizens", to February 2020, when the State Council of the CPC Central Committee issued the "Opinions

on Deepening the Reform of the Healthcare Security System", proposing a "sound unified and standardized medical assistance system", experimental legislation has been explored in various places for 30 years. In August 2020, the General Office of the CPC Central Committee and the General Office of the State Council proposed to "improve the medical assistance system" in the "Opinions on Reforming and Improving the Social Assistance System", and in September of the same year, the Ministry of Civil Affairs and the Ministry of Finance issued the "Social Assistance Law (Draft for Public Comments)", which made programmatic, principled and benchmark provisions for medical assistance. Meanwhile, in February 2020, the CPC Central Committee and the State Council pointed out in the "Opinions on Deepening the Reform of the Healthcare Security System"

that medical assistance would be incorporated into the entire healthcare security system for construction, and Article 19 of the "Healthcare Security Law (Draft for Public Comments)" issued by the National Healthcare Security Administration in June 2021 provides for a sound, unified and standardized medical assistance system. Obviously, as an essential part of the construction of social assistance and healthcare security legislation, medical assistance is indispensable. In recent years, academic research has focused on whether and how to unify legislation on medical assistance, whereas few studies have been conducted on the construction of medical assistance system from the perspective of various local legislative texts in China. This paper compares and contrasts the current local legislation on medical assistance in China, and compares the structural elements of the medical assistance system, in an attempt to identify the problems of local legislation and system construction and analyze the underlying jurisprudence, and provide basic information and intellectual support for unified medical assistance legislation under the centralized management system of the National Healthcare Security Administration¹.

2. Research Methods

This paper adopts a sample analysis method. The keywords "medical assistance" and "social assistance" were searched in the Chinese laws and regulations information database and other platforms, and 964 valid local legislative texts in 41 provinces and cities for medical assistance were obtained as of December 31, 2022. The sampling area covers 22 provinces, 5 autonomous regions, and 4 municipalities directly under the central government of China with another 10 prefecture-level cities, namely Chengdu, Dalian, Guangzhou, Hangzhou, Lanzhou, Qingdao, Xiamen, Taiyuan, Yichang, and Zhenjiang. Horizontally, these 41 provinces and cities basically cover the eastern, central, and western regions of China, which is relatively extensive; vertically, from provinces, autonomous regions, and municipalities directly under the central government to prefecture-level cities, it is basically possible to take into account the macroscopic and targeted nature of local legislative norms in the sample. At the same time, following the medical assistance doctrine, combined with the

"Provisional Measures for Social Assistance (2014)" and other relevant legal norms, the medical assistance local legislative documents selected in this paper cover three types of medical assistance system texts, namely, conventional medical assistance, medical assistance for major and critical diseases and disease emergency assistance.

3. Results

3.1. Basic Overview of Local Legislation on Medical Assistance in China

3.1.1. Local Legislative Model for Medical Assistance

Three legislative models are evident in the sample: the special legislative model, the embedded legislative model, and the decentralized legislative model. The first is the special legislation model, i.e., a separate legislation for medical assistance, which is more systematic and comprehensive than other legislation models. The second is the embedded legislation model, in which medical assistance is embedded in the social assistance system as one of the programs, but the criteria for medical assistance and the scope of payment, and other operational regulations remain unavailable. The third is the decentralized legislative model, i.e., medical assistance-related regulations are scattered in legislative documents such as the new rural cooperative medical care and urban and serious disease medical insurance for urban and rural residents. The decentralized legislative model can hardly structure the medical assistance system systematically and comprehensively and lacks a relatively complete content of medical assistance elements. The statistics of the number of legislative models and distribution regions in the sample are shown in Table 1, which shows that: firstly, the embedded legislative model occupies a larger proportion, and the special legislative model and the decentralized legislative model are relatively few; secondly, from the regional distribution, the eastern part, which has relatively superior economic resources and medical service resources, adopts more special legislative models (6/15), while the central, western and northeastern parts mainly adopt the embedded legislative model.

Table 1. Statistical Table of the Number of Medical Assistance Local Legislative Models and Distribution of Geographic Provinces and Municipalities in the Sample (Unit: Each).

	Special legislative model	Embedded legislative model	Decentralized legislative model	Total
Eastern China	6	7	2	15
Central China	2	5	1	8
Western China	4	8	2	14
Northeast China	1	2	1	4
Total	13	22	6	41

Note: The division of regions in this paper is based on the "Methodology for the Division of Eastern, Western, Central, and Northeastern Regions" (2011) by the National Bureau of Statistics of China.

3.1.2. Medical Assistance Local Legislation Hierarchy and Legislative Subjects

The sample presents three legislative hierarchies: local

regulations, local government rules, and local normative documents. The sample shows that there is only one local regulation, the "Regulations on Social Assistance in Zhejiang Province (2014)"; 148 local government rules, accounting for

about 3/20 of the total number of documents in the sample, such as the "Measures for the Implementation of Social Assistance in Beijing" (2018)¹; and 807 local normative documents account for the largest proportion, accounting for about 17/20 of the total number of documents in the sample, such as the "Measures for the Implementation of Urban and Rural Medical Assistance in Guangxi Zhuang Autonomous Region" (2012).

The subjects of local legislation of medical assistance in the sample are basically local governments above the county level. Among them, the legislative subjects of medical assistance regulated by normative documents show two patterns: the first is the single competent subject legislation, with a number of 427, of which 275 are laws with local government as the legislative subject and 152 are sectoral normative legislation, of which more than 9/10 are civil affairs department legislation, and the rest are finance department or health department legislation. The second is the multi-departmental joint legislation, numbering 529, with the four departments appearing most frequently in the order of Finance (369 times), Civil Affairs (365 times), Healthcare (231 times), and Human Resources and Social Security (160 times), with the most joint legislation by civil affairs and finance departments. In addition, it also includes public security organs, taxation organs, poverty alleviation departments, disability associations, and other departments. It can be seen that the subjects of local legislation on medical assistance are diversified, showing a "multi-departmental joint governance" pattern.

3.2. Comparison of Structural Elements System of Local Legislation on Medical Assistance in China

3.2.1. Medical Assistance Handling Service Mechanism

There are three types of medical assistance handling institutions in the sample. First, it is clear that the medical assistance handling institution directly relies on the medical insurance handling institution, and then connects with the basic medical insurance and medical insurance for major and critical diseases in the medical assistance settlement service, with about 4/5 regions adopting this type of handling institution. Secondly, the specific settings of medical assistance handling institutions are clarified. For regular medical assistance, for example, the "Guangzhou Municipal Medical Assistance Measures" (2019) provides for the establishment of "municipal medical assistance service centers" and "municipal and district social insurance handling institutions"; while for disease emergency aid, for example, the "Rules for the Implementation of Shanghai Disease Emergency Assistance System" (2017) stipulate that the Financial Management Center of the Municipal Health and Family Planning Commission shall serve as the handling and management institution. Third, there is no explicit mention of the medical assistance handling institutions, categorizing their authority and responsibility for specific matters under various competent departments. In general, the sample shows that the setup of the handling mechanism is confusing and fails to be unified. In addition, local legislation has few detailed provisions on the handling process and the list of powers and

responsibilities.

3.2.2. Medical Assistance Fund Raising

The local governments in the sample basically followed the provisions of the "Measures for the Administration of Urban and Rural Medical Assistance Funds" (2013) regarding fundraising. However, there are the following situations of funding responsibilities in various regions. The first is the principle provision, which does not specify the government at all levels and other funding responsibilities, and about 4/5 of the regions in the sample adopt this form. The second is to stipulate the proportion of funding responsibilities of governments at all levels, such as the "Opinion of the General Office of the People's Government of Taiyuan City on the Implementation of Further Improving the Medical Assistance System to Comprehensively Carry Out Medical Assistance for Major and Critical Diseases" (2016), which stipulates that municipal and county finances shall bear the burden in a graded ratio of 5:5 (6:4 in case of poor counties). The third is to stipulate the specific funding amount, such as the "Trial Measures for Urban and Rural Medical Assistance in Gansu Province" (2009), which stipulates that the financial subsidy funds of the people's governments at all levels shall be included in accordance with the standard of not less than 1 yuan per capita of the local urban and rural population each year. The fourth is to specify the method or formula for the allocation of funding responsibilities, such as Article 5 and Article 7 of the "Implementation Measures for the Management of Medical Assistance Subsidy Funds in Anhui Province" (2015), which stipulates the factor method allocation formula.

3.2.3. Medical Assistance Objects and Identification

The first is conventional medical assistance recipients and their identification. The identification of conventional medical assistance recipients in most regions in the sample is still based on economic conditions or even solely based on that, and some regions have supplemented and adjusted on this basis, with specific types including poor group type (17 regions)², supplementary poverty type (18 regions, still based on economic conditions identification) and adjusted poverty type (6 regions). The adjusted poverty type adopts a relatively comprehensive standard, which takes into account economic conditions, medical needs, household registration, and other identification factors, such as the "Interim Measures for Medical Assistance for the Poor in Guangdong Province" (2016), which is divided into income-based poor medical assistance recipients and expenditure-based poor medical assistance recipients.

The second is the special medical assistance recipients and their identification. For the recipients of major and critical disease assistance, in addition to meeting the above conditions for conventional medical assistance recipients, there are restrictions on the conditions of disease types. Only a small number of regions in the sample (about 1/8 of the total number of provinces and cities) have specified the types of major and critical diseases³, and the scope and number of the types of major and critical diseases specified in these regions vary,

such as Gansu expanding the types of serious and critical disease assistance to 50, and Yunnan including 22 types of diseases in the scope of medical assistance for major and critical diseases. In addition, the classification of emergency medical assistance recipients is basically the same everywhere, i.e., patients who are in need of emergency medical assistance in China but whose identity is not clear or who cannot afford to pay the corresponding expenses. For the identification of the above-mentioned conventional and special medical assistance recipients, only a few regions in the sample (about 1/20 of the total number of sample provinces and cities) made provisions for the establishment of dynamic detection and inquiry mechanisms for the relevant qualifications and asset information of the assistance recipients, such as the "Interim Measures for Inquiry of Financial Asset Information of Families Applying for Assistance in Jiangsu Province" (2017).

3.2.4. Methods of Medical Assistance

In the sample, the medical assistance methods are grouped into three categories according to the different stages of assistance: pre-medical assistance, medical assistance, and post-medical assistance, and most of them are combined with the assistance standards for principle and general regulations. Firstly, pre-medical assistance is a prepaid medical assistance system to subsidize the insurance of the assistance recipients. Secondly, the assistance during medical treatment is "to promote the connection between medical assistance and basic medical insurance and major medical insurance and to carry out 'one-stop' settlement service" [1], such as the " Guidelines

of Shanghai Municipal Civil Affairs Bureau on the 'One-stop' Service of Urban and Rural Medical Assistance in Shanghai" (2015). Finally, post-medical assistance is generally expressed as special assistance for some special recipients, for example, Article 7 of "Taiyuan Medical Assistance Measures (for Trial Implementation)" (2010) provides for fixed-amount assistance for specific persons. In general, all places use pre-medical assistance as the main form of assistance.

3.2.5. Standards of Medical Assistance

In the sample, there are following two modes of setting medical assistance standards. The first is the type dominated by assistance methods. That is, according to the types of subsidizing insurance, outpatient assistance and inpatient assistance, the assistance standards and levels are divided according to different assistance objects (assistance method + assistance object + assistance treatment), such as the "Notice of Yichang City on Further Strengthening Medical Assistance Work" (2016). The second is the type dominated by the assistance object. Crossing directly according to the assistance standard and assistance object (assistance object + assistance entitlement), the treatment gap is unified and reduced as much as possible for the arrangement under different types of diseases and assistance methods, such as the "Xiamen City Medical Assistance Measures" (2018). The setting of medical assistance treatment levels varies widely across the sample, lacking benchmarks and having a certain degree of territoriality, as shown in Table 2.

Table 2. Summary Table Comparing the Minimum and Maximum Amount of Medical Assistance in Different Places in the Sample.

		Deductible (Unit:10,000 yuan)			Cap Line (Unit:10,000 yuan)		
		Priority assistance recipients	Low-income assistance recipients	Other assistance recipients	Priority assistance recipients	Low-income assistance recipients	Other assistance recipients
Subsidized insurance and new rural cooperative medical system (NCMS)	Minimum amount				0.08	0.08	0.08
	Maximum amount						
Outpatient service	Minimum amount	0.04	0.03	0.03	0.042	0.02	0.02
	Maximum amount	0.1			0.6	0.6	0.6
Hospitalization	Minimum amount	0.5	3		1≤	1	1
	Maximum amount	1			18	18	15
Major and critical diseases	Minimum amount	1	1	3	1	1	1
	Maximum amount	3	3		15≥	15≥	15≥

Table 2. Continued.

		Assistance Ratio		
		Priority assistance recipients	Low-income assistance recipients	Other assistance recipients
Subsidized insurance and new rural cooperative medical system (NCMS)	Minimum amount	100%	50%	50%
	Maximum amount		100%	
Outpatient service	Minimum amount	50%	50%	50%
	Maximum amount	100%	80%	80%
Hospitalization	Minimum amount	80%	70%≤	30%
	Maximum amount	100%	90%	80%
Major and critical diseases	Minimum amount	50%	50%	30%
	Maximum amount	100%	85%	85%

Note: If there are differences in the types of assistance recipients in the sample, the author has categorized and classified the assistance recipients as poor groups in the tabulation as much as possible according to the division method prevailing throughout China. This table is the basic data, excluding the standards specified for special groups in a few regions (e.g., the standards for disease emergency assistance).

3.3. Problems of Local Legislation on Medical Assistance in China

3.3.1. Legislative Fragmented System Establishment

For one thing, there is the problem of divided legislation and fragmented systems. The embedded legislative model "cutting out medical assistance and incorporating it into social assistance legislation will certainly cut off the connection between medical assistance and medical insurance and medical and health system and simplify the complex issues"[2], which cannot get rid of the rough, vague and uneven legislation and lacks refined and operable legislative regulations that take into account the characteristics of the medical assistance system itself. At the same time, in the decentralized legislative model, there are mostly passive legislation based on realistic needs, with obvious emergency and instrumental characteristics [3], resulting in the specific systems of conventional medical assistance, medical assistance for major and critical diseases, and disease emergency assistance in a fragmented state, bringing difficulties and constraints to the integration of the medical security system under the jurisdiction of the National Healthcare Security Administration. Secondly, there is a lack of coordinated legislation. The situation of multiple legislative subjects and "multiple-departments joint governance" has led to a lack of coordination in the legislation and policy introduction under the medical assistance management system, and "insufficient coordination in unified management will further lead to difficulties in the formation of synergy in the management of social assistance services at the grassroots level"[4], which will lead to problems such as mutual shirking and inability to centralize accountability. In 2018, medical assistance was assigned to the National Healthcare Security Administration for direct coordination and management, while the fragmented pattern of legislation obviously cannot accommodate the construction and operation of a centralized and unified management system of the Healthcare Security Administration.

3.3.2. Low Legislation Hierarchy

The status quo of medical assistance legislation is mostly normative documents and fewer government regulations, which is due to the absence or imperfection of the high-level law. And the appropriate hierarchy of local legislation on medical assistance can be judged from the division of different matters of local legislation, that is, "matters involving the protection of the rights of special groups in society and other matters related to social security should be enacted by local regulations", while "the pioneering, experimental reform measures, can be addressed by laws, and if necessary, can also be prescribed by regulations" [5]. Therefore, in the absence of national unified legislation, in order to ensure its stability and enforceability, theoretically the legislative hierarchy should be no lower than government regulations for the construction of local legislation on the medical assistance system, especially the exploratory special legislation. However, the current medical assistance local legislation is mostly normative

documents, with a low hierarchy, which is flexible but not stable enough. The ineffectiveness of the laws and regulations makes it difficult to apply and implement special and targeted systems, which is not conducive to the maturation of a unified legal regulation system for medical assistance in China in the future.

3.3.3. Sloppy Mechanism for Handling Services

Firstly, the setup of the handling institution is confusing, and there are different setups in different regions in the sample, which is not only "not conducive to the convenience and unity of the handling process, but also leads to the reduction of the constraint and supervision ability for the medical service provider" [6], and it is difficult to create a unified and integrated public service platform for medical assistance. Secondly, the responsibilities of the handling institutions need to be refined and clarified, for example, there are no provisions on the subject, content, supervision and relief of the management of the assistance agreement. Although medical assistance is covered in the "List of Administrative and Law Enforcement Matters of the National Healthcare Security Administration" (2020), there is still no further refinement of the administrative content of the handling. And the "Circular of the National Healthcare Security Administration on the Issuance of the List of National Healthcare Security Handling Administrative Services" (2020) only mentions the approval of treatment payment for medical assistance recipients, and there are no provisions for other medical assistance handling services such as file building services and receiving reporting and complaint services. The absence of the high-level law has led to the lack of handling benchmarks, inconsistent norms, and sloppy processes in local legislation.

3.3.4. Lack of Clarity in Funding Responsibilities

Current Chinese relevant regulations and policies, such as the "Measures for the Administration of Urban and Rural Medical Assistance Funds" (2013) and the "Circular of the General Office of the State Council on the Issuance of the Reform Program for the Division of Financial Affairs and Expenditure Responsibilities between the Central and Local Governments in the Field of Medical and Health Care" (2018), do not provide clear benchmarks for the funding responsibilities of the central and local governments at all levels of medical assistance, resulting in significant differences in the sharing ratios among local governments at all levels in the sample, making it difficult to ensure that the expenditure responsibilities of the assistance funds have statutory constraints and stable expectations [7]. If the funding responsibilities of governments at all levels are not clearly defined, confusing and non-uniform funding responsibility regulations around the country will remain, and it will be impossible to balance and coordinate the differences in the payment of basic medical assistance services between different regions, and the efficiency of the utilization of medical assistance funds will likewise be affected.

3.3.5. Inadequate Equity in Medical Assistance

Firstly, there is a lack of scope of recipients of medical assistance. The sample problem is that the identification of assistance recipients is mainly based on economic analysis to determine the assistance recipients as poor groups, but less or even ignore other identification conditions such as medical needs, resulting in marginal households and expenditure-oriented poor households not receiving due assistance; at the same time, there are few special provisions for dynamic information system detection and query, which easily leads to the solidification of assistance recipients. The scope of relief recipients is still divided into different types and lacks integration; the scope of "other relief recipients" is narrower (e.g. not including the medical assistance recipients for special major public events); there is no clear unified benchmark for the types of diseases for the assistance recipients of major and critical diseases.

Secondly, the medical assistance method is singular and there is little comprehensive assistance. On the whole, although the "Provisional Measures for Social Assistance" aim to establish comprehensive assistance throughout China, some relatively backward regions have only completed the subsidized participation in insurance and NCMS, and there are no further provisions for other ways of comprehensive assistance (such as assistance for the poor due to diseases and limited-time and fixed-rate assistance). With the gradual development and maturity of China's social security system, the demand for diversified medical services has increased, and there is an urgent need for "diversification and reasonable combination of assistance methods" to force the formation of comprehensive assistance methods [8].

Thirdly, the medical assistance standards present a non-equitable nature. On the one hand, the assistance standards vary greatly from place to place. Since the level of assistance standards is closely related to the local medical insurance system and minimum living standard security system, some regions have decentralized the standard-setting to the municipal or even county level, which further increases the degree of difference. On the other hand, some of the assistance standards are too restrictive, especially for the types of diseases, as shown by "arbitrarily expanding the list of disease restrictions, excluding many common diseases, frequently-occurring diseases and chronic diseases from the scope of assistance" [9]. Although medical assistance treatment should avoid pan-welfare and shift to "priority protection", it should also take into account a certain degree of fairness.

4. Discussions

4.1. China's Medical Assistance Management System Is Divided But Crossed, "Policy Governance" Fails to Change

Since the 1990s, when local governments explored experimental legislation, followed by pilot projects in rural and urban areas in 2003 and 2005, respectively, and until 2009,

when medical assistance was integrated into urban and rural areas in the context of the new medical reform, the positioning of medical assistance in China has led its management system to be divided but crossed. Firstly, the construction of medical assistance management system is confined to the fragmented establishment of medical insurance. Medical assistance is not only a special system of social assistance but also an important component of the medical security system. Medical assistance and medical insurance systems are complementary in nature, narrowing the difference between the medical security treatment of poor and disadvantaged groups and the general group, so medical assistance and medical insurance systems are more closely integrated. At the same time, the construction of the medical assistance management system is also largely influenced by the medical insurance management system. Combining the development of urban and rural medical insurance in China, it is evident that the design of the system was led by the original administrative authorities in charge of urban and rural areas, so the organizational system of urban and rural medical insurance always exist such problems as non-uniformity, conflicting decision-making directions and even fragmentation [10]. This has directly led to the difficulty of connecting medical assistance with the medical insurance system, further causing the management system and related mechanisms of medical assistance to rely on the embedded provisions of the social assistance system or scattered in different medical insurance management systems to be provided, forming a situation of divided medical assistance management system. Secondly, the management system of medical assistance is divided and crossed under the "multiple-department joint governance" principle. Medical assistance not only meets the basic survival needs of the poor and disadvantaged, but also helps to realize the fair value of medical services, narrow the gap between urban and rural medical resources distribution, and enhance the ability of the disadvantaged to eliminate poverty and prevent poverty, which makes the medical assistance system shoulder multiple social effects and involve many different social work fields. Therefore, the management of the comprehensive, complex and underpinning medical assistance system requires not only the administrative authority to be responsible for comprehensive coordination, but also multiple departments, such as finance, health, and poverty alleviation, to work together to promote it through administrative collaboration and information communication. However, for a long time, there are misunderstandings among various departments about the operation of the system, and the lack of coordination mechanisms and lists of powers and responsibilities has resulted in cross-authority or even vacuum⁴, making it difficult to coordinate legislation.

In addition, there is no legal basis for local legislation on medical assistance in China, and the programmatic, principled, and framework "Provisional Measures for Social Assistance" is the only administrative regulation on which local legislation on medical assistance is based. Due to the inadequate basis of the higher law, most of the local legislation on medical assistance under the divided and crossed management system

is creative legislation or experimental legislation. From the point of view of the introduction process, the normative documents are used to experiment first, and the experience summary ascending to legislation becomes the prevailing practice all over the country. From the perspective of the implementation effect, under the divided and cross-management system of medical assistance, the main way and tool of medical assistance governance is to choose normative documents with high flexibility and contingency. Normative documents are the main carrier for administrative subjects to implement medical assistance policies in practice. Therefore, the promulgation of normative documents is essentially the "governance by policy". However, compared to local laws and regulations, the "policy governance" through the promulgation of normative documents lacks the stability, predictability, standardization, compulsion, and uniformity of the rule of law" [11].

4.2. China's Medical Assistance Handling Institution Is Not Separated from the Government Authority, and the Relationship with the Medical Security Handling Is Not Clarified

From the perspective of the social assistance system, the public sector is directly responsible for the management of social assistance handling in China [12]. However, due to the close relationship between medical assistance and medical insurance systems, some regions have set up medical assistance handling institutions in practice, which are jointly responsible for the management and services of medical security with medical security handling institutions. Similar to the medical security handling system, the system of medical assistance handling is also constrained by the "lack of separation" between the administrative authority and the handling institution, and the medical assistance handling institution, as the "handling agency" of the government, is "restricted" and "fragmented" by the administrative authority in terms of personnel power and financial power of the fund.

Firstly, in practice, the daily work and operation of the handling institutions are mostly managed by reference to the civil service law, resulting in the loss of independent staffing and personnel adjustment authority. Secondly, the handling institutions are not independently responsible for the operation of the funds allocated by the administrative authorities. In practice, the handling institutions have become the "executive agencies" of the government departments, and their financial management and payment are mostly subject to the government departments. Therefore, under the divided and crossed medical assistance management system, the institutional setup of the medical assistance handling institutions, which are not independent and affiliated with government departments, will be confused, vague, or even missing. At the same time, the long-standing division between medical assistance and medical insurance systems has led to the division of management and handling services, so that the relationship between medical assistance and medical insurance handling institutions has not been thoroughly clarified, and the "one-stop" settlement service, protocol

management mechanism, and the mechanism of medical assistance in different locations have not been uniformly established for a long time. Under the "large department system" environment after the establishment of the National Healthcare Security Administration, the handling services of medical assistance and medical insurance should be continuous and integrated, rather than simply merged. In the premise that the relationship between the two is not fully clarified, the medical assistance handling then presents problems such as unclear functions and inconsistent handling processes.

4.3. Misalignment of Authority and Financial Powers for Medical Assistance in China, Imbalance in Funding Responsibilities of Central and Local Governments

The unclear responsibility of governments at all levels for the financing of medical assistance funds is actually the result of the distorted arrangement of the responsibility for the distribution of public services in China's financial system. In terms of the government's financial input system, due to the lack of an effective transfer payment system, local governments have assumed the main responsibility for the development of medical and health care but lack the corresponding financial resources [13]. The serious lack of government input has led to a situation of misalignment between the governmental authority and the financial power of the grassroots government. In terms of authority, the grassroots government departments bear a large amount of basic healthcare expenditure, which should be largely borne or coordinated by the provincial or even central government departments; while in terms of financial power, the reform of the tax-sharing system implemented in 1994 has, to a certain extent, led to a gradual upward fiscal shift and an unequal actual tax burden all over the country. The limited transfer payment system has further weakened the financial expenditure and budgetary adjustment capacity of the grassroots government, thus creating a situation in which lower-level local governments assume responsibility for providing a large number of public services without allocating corresponding financial support [14]. According to some studies, the current situation of China's medical assistance financing responsibility is that the central government and county-level governments bear a larger share of the financing responsibility, while the provincial governments, which have a stronger financing capacity and less authority, put in a relatively insufficient proportion [15]. In terms of the relationship between authority and financial power, the division of authority is the basis for the division of financial power, while the division of financial power is the guarantee for the performance of authority. At present, China's medical assistance management system is divided and crossed, and there is a lack of clear definition of responsibilities and coordination mechanisms between central and local governments, between upper and lower levels of departments, and between various departments, and the uncertainty of the division of authority also affects the division and allocation of financial power.

4.4. Lack of Equity in Rights in the Construction of China's Medical Assistance System

As a special assistance of the social assistance system, medical assistance especially emphasizes the protection and preservation of disadvantaged groups [16]. The basis of medical assistance protection for the disadvantaged is to ensure the fairness of medical assistance rights. Theoretically, equity in rights usually contains three levels: equity in the starting point, equity in the process, and equity in the outcome. The lack of equity in medical assistance in the sample is precisely due to the lack of equity in the system design and related legislation.

Firstly, it fails to guarantee the equity of the starting point of the right to medical assistance. In terms of the scope of the subject of the right to medical assistance, it should include all the disadvantaged groups in need of medical assistance (assistance recipients). However, the disadvantaged group mentioned here is not exactly the same as the poor group in the sense of economics, but also includes the poor group in terms of rights, which is "the group that cannot enjoy the normal civil rights or the basic rights are not guaranteed by the institutions in the country due to the exclusion of social laws, institutions, policies, etc." [17]. Therefore, the disadvantaged groups of medical assistance should include both the disadvantaged groups of economic poverty and the disadvantaged groups of rights poverty. Otherwise, most of the regions in the sample only cover the income-based poor, while the expenditure-based poor and the disadvantaged who are in need of medical assistance under special conditions but are not legally and institutionally guaranteed are not given the right to medical assistance. In this regard, the equity in the identification of medical assistance recipients in the sample also needs to be improved. Formal equity requires non-discriminatory medical assistance, while substantive equity places higher requirements on the identification of assistance recipients, such as timely adjustment of the scope of assistance recipients through a dynamic identification mechanism and the introduction of multiple identification indicators to improve the accuracy of identification, otherwise, problems such as unfocused assistance or failure to provide assistance for those in need may arise.

Secondly, it fails to guarantee equity in the process of the right of medical assistance. The equity of the process means to adopt a certain way or means to protect and maintain the rights based on the equity of the starting point. In the case of the medical assistance system, the essence of the equity of the process is that the method of assistance should be fair. The method of medical assistance is also known as the method of payment of medical assistance. Usually, the payment of social assistance includes three forms: monetary payment, material payment, and welfare services [18]. In order to guarantee the realization of rights, theoretically, the method of assistance or payment of medical assistance should also include the above-mentioned forms, especially material payment and welfare services, which directly provide basic medicine, examination, primary health care services, etc. to medical

assistance recipients. However, medical assistance in most of the regions in the sample is limited to subsidized participation in insurance in monetary payments, and its ability and effectiveness are still limited in the face of obstacles such as the deductible and co-payment ratio of the health insurance system, which makes it difficult to achieve equity in rights through a single form of assistance.

Lastly, it fails to guarantee equity in the outcome of the right to medical assistance. The equity of outcome also requires that the setting of medical assistance standards should uphold the principle of equity. In order to mitigate or suppress injustice, the standard of medical assistance treatment should usually be protected with appropriate bias. In addition to allocating funds to different recipients, the government should also consider the provision of the necessary material share in the fair allocation of medical assistance standards, as well as the "reasonable arrangement of benefits and equal provision of public services"[19]. It is obvious that the assistance standards in most of the regions in the sample not only vary widely and unevenly, but also fail to take into account the basic medical needs of the right subjects themselves, and the relevant restrictions or preferences also lack the measurement of the principle of equity.

5. Conclusions

Since medical assistance plays an irreplaceable underpinning role in the medical security system, local governments in China have been exploring legislation in a "progressive" manner under the guidance of central policies and legislative regulations, initially forming national and local medical assistance institutional frameworks and legal systems, and gradually enhancing the underpinning function of local medical assistance. However, it is clear from the sample that China's medical assistance is managed and administered by multiple departments, such as civil affairs, finance, health, and human resources and social security, with multiple policy objectives, and the cross-management system and local countermeasures selection have determined that the local legislation on medical assistance presents multiple legislative models and institutional fragmentation. Essentially, China's medical assistance has long been embedded in a gradual, phased and transitional economic and social macro system during the transition period, and has been hampered by administrative governance, public finance and other institutional contradictions, while failing to fully grasp the fair connotation of the right to medical assistance in the process of system construction, which have led to the current dilemma of local legislation on medical assistance.

6. Recommendations

In summary, in order to break the contradiction between the multi-departmental fragmented management system and the structured system of medical assistance, it is necessary to promote a unified special medical assistance legislation in China under the future "Social Assistance Law" and "

Healthcare Security Law", and the State Council should formulate "Medical Assistance Regulations" to provide a clear basis and benchmark guidance for the local legislation of medical assistance.

6.1. Clarify the Positioning and Responsibilities of Medical Assistance Competent Authorities and Handling Institutions

First, the legislation stipulates that the responsibility of medical assistance management is explicitly placed in the National Healthcare Security Administration, so as to improve the overall role of local healthcare security departments on local medical assistance, get rid of the situation of inaccurate positioning of subjects, unclear authority and responsibility, and low integration under the divided and crossed management system, and ensure the compatible convergence of various internal medical assistance systems. Secondly, the responsibilities of civil affairs, finance, healthcare, human resources and social security, and other departments related to medical assistance should be refined, while legislating to clarify the medical assistance joint meeting system, which identifies the contents that need to be coordinated across departments. Thirdly, the settings and responsibilities of medical assistance handling institutions should be clarified. At present, medical assistance has been operated as a part of the medical security governance system in practice. Therefore, it can be unified with the basic medical insurance handling institutions, and at the same time, the list of medical assistance handling business and powers are specified, and the cohesive mechanism between medical assistance handling and medical insurance handling is refined.

6.2. Clearly Classifying the Responsibilities of Central and Local Governments for Medical Assistance Funding

The first is to legislate to clarify the funding responsibilities between the central and local government departments at all levels. The central government can assume greater management and expenditure responsibilities in the area of general healthcare security, while provincial governments can assume relatively greater management and expenditure responsibilities in the area of general healthcare security [20]. Therefore, as the National Healthcare Security Administration promotes provincial integration, the system should be designed to increase the expenditure responsibilities of provincial governments and further balance regional differences in provincial funding, establish a clear financial sharing mechanism between provincial and sub-provincial governments, reduce the pressure on grassroots funding, and balance the rights of the grassroots in terms of affairs and finance. The second is to revise and refine some provisions of the "Measures for the Administration of Urban and Rural Medical Assistance Funds" and "Interim Measures for the Administration of Disease Emergency Relief Funds", and try to unify them with the "Medical Assistance Regulations" to form a legal regulatory system for the financing of medical assistance funds.

6.3. Establishing a Medical Assistance Target Identification Mechanism with Comprehensive Criteria

The first is to establish a timely and accurate identification mechanism for medical assistance recipients, and to set up comprehensive identification criteria (such as family income and property, consumption expenditure, medical service needs under special circumstances, etc.) and a comprehensive identification screening process to change the identification based solely on economic conditions. At the same time, the healthcare security department will take the lead in establishing a docking mechanism, dynamic monitoring and inquiry mechanism with the civil affairs department for poverty identification. The second is to clarify the scope of medical assistance through legislation. The assistance recipients will be divided into three categories: income-based poverty assistance recipients (including members of the minimum subsistence guarantee, special hardship supporters, low-income relief recipients, etc.) with economic conditions as the main identification basis, expenditure-based poverty assistance recipients (mainly referring to patients with serious illnesses in families suffering from poverty due to illness) with medical needs as the main identification basis, and other assistance recipients (including disease emergency assistance recipients, medical assistance recipients of special major public events, and other persons with special difficulties as stipulated by the people's governments at or above the county level)⁵. At the same time, the legislation enumerates the types of diseases that are the target of serious disease assistance as the benchmark range, and local governments use this as the basis for implementation or reference.

6.4. Improving the Comprehensive Medical Assistance Approach and Enhancing Medical Assistance Standards

The first is to improve the comprehensive medical assistance methods. From the internal point of view, it is necessary to try to add or incorporate special assistance methods on the basis of subsidized insurance, such as limited-time and fixed-rate assistance for expenditure-type poor families, assistance for people in need in case of public health emergencies or specific infectious diseases, and emergency assistance for unidentified vagrants. Externally, other systems of the medical security system (such as basic medical insurance, medical insurance for serious diseases, etc.) are provided for separately through the assistance methods, changing the primary single assistance to comprehensive and multiple assistances. The diversified development of the assistance method promotes the relevant systems to complement each other and has achieved the best comprehensive effect [21]. The second is to raise the standard of medical assistance fairly. In the first place, the treatment standards that take into account the needs of medical assistance are gradually explored, such as trying to gradually transition from assistance by type of disease to the high cost of serious illness assistance standards. Secondly, it is to refine different assistance standards according to different assistance

methods. Thirdly, on this basis, the scope, types of diseases, standards, and other legal benchmarks of different assistance systems are clarified to avoid excessive differences between different places.

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1 In 2018, China's 13th National People's Congress resolved the State Council to set up a "National Healthcare Security Administration" to establish a centralized and unified management system for medical insurance and integrate medical assistance managed by multiple departments such as civil affairs, finance, health and poverty alleviation.

2 The classification of the poor group type is the same as the classification in the "Circular of the General Office of the State Council Transmitting the Opinions of the Ministry of Civil Affairs and Other Departments on Further Improving the Medical Assistance System and Comprehensively Carrying Out Medical Assistance for Major and Critical Diseases" (2015), both of which equate medical assistance recipients to the poor group based mainly on economic conditions, including key assistance recipients (members of the family with a minimum living allowance and special hardship supporting person), low-income assistance recipients and other assistance recipients. For patients whose medical needs are the main consideration, such as those who suffer from poverty due to illness, the relevant national norms only propose in principle to explore assistance.

3 The scope of major and critical diseases is not clearly stipulated in the relevant legislative norms. In the "Circular of the General Office of the State Council Transmitting the Opinions of the Ministry of Civil Affairs and Other Departments

on Further Improving the Medical Assistance System and Comprehensively Carrying Out Medical Assistance for Major and Critical Diseases" (2015), it is only stipulated that "the scope of medical assistance for major and critical diseases should be appropriately expanded".

4 For example, as an important part of the medical assistance system, disease emergency assistance should have been managed by the healthcare security department after the institutional reform. However, in practice, some regions have different management, some are under the management of the health department, some are under the management of the civil affairs department, etc.; the special fund for disease emergency assistance also lacks special account management.

5 "Other persons with special difficulties as stipulated by the people's governments at or above the county level" may include non-local household migrant workers, non-local household school students, people who have done righteous deeds, people with opportunistic HIV infection, etc.