Rural Medical Insurance and Health Equity for the Rural Elderly: Based on China Health and Retirement Longitudinal Study

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Abstract: As China's aging population gradually rises, the health issues of the elderly have attracted public attention. Improving health equity for the rural elderly is of great practical significance for implementing the Healthy China Strategy. The study leverages data obtained from the China Health and Retirement Longitudinal Study (CHARLS) in 2020 to integrate both the health level and the utilization of healthcare services into the research framework of health equity. Subsequently, this paper uses structural equation modeling to explore which factors affect the participation in rural medical insurance, whether rural medical insurance has a positive impact on the health equity of rural elderly people, and how rural medical insurance works through a path diagram. The result shows that rural medical insurance has a positive impact on the health equity of the elderly in terms of health level and medical and health service utilization level. However, factors such as age, living with partner, education level and income remain important, which affect the participation of rural medical insurance and thus health equity. The moderating effect of rural medical insurance is limited.

Keywords: Rural Medical Insurance; Health Equity; Utilization of Medical Services; Health Level; Structural Equation Modeling

DOI: 10.57237/j.wjeb.2026.01.001

1 Introduction

The health of the people is an important indicator of socialist modernization, and the Party and the state have always been attaching great importance to the right to life and people's health. In October 2015, the Fifth Plenary Session of the 18th CPC Central Committee first proposed the Healthy China initiative. In 2016, the Central Committee of the Communist Party of China and the State Council issued the Healthy China 2030 Planning Outline, which emphasizes that the construction of a Healthy China should adhere to the following principles, including health as a priority, reform and innovation, scientific development, fairness and justice. Among these, the principle of fairness and justice requires a focus on rural areas and grassroots levels, promoting the equalization of basic public health services and safeguarding the nature of public welfare for basic medical and health services.

As medical and health conditions are generally less developed in rural areas, promoting health equity among rural populations is particularly important for achieving

Funding: Chongqing Social Science Planning Doctoral Program (grant no. 2021BS082);
Key Discipline Graduate Research Innovation Project of Sichuan International Studies University (grant no. SISU2025XK069).

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Received: 8 February 2025; Accepted: 4 January 2026; Published Online: 14 January 2026 http://www.wjeconbus.com

the goals of Healthy China 2030. Moreover, although China achieved a comprehensive victory in the battle against poverty in 2020, lifting all rural poor populations out of poverty, yet poverty-related risk factors persist in rural areas. Poverty caused by illness remains a prominent issue. Therefore, enhancing health equity in rural areas also holds practical significance for consolidating the achievements of poverty alleviation [1].

In addition, China is facing an increasingly aging population. According to the Statistical Communiqué of the People's Republic of China on the 2023 National Economic and Social Development, released by the National Bureau of Statistics on February 29, 2024, population aged 60 and above had reached 296.97 million by the end of 2023, accounting for about one-fifth of the total population. The health of the elderly has become an issue of growing concern. Against the backdrop of population aging, promoting healthy aging is crucial for alleviating the immense social pressures brought about by this demographic shift [2].

In summary, focusing on health equity for the rural elderly, understanding the practical difficulties they face in accessing medical and health services, and identifying factors that influence health equity are significant for implementing the Healthy China strategy and consolidating achievements in poverty alleviation.

2 Literature Review

2.1 Health Equity

In recent years, academic research on health equity has been gradually increasing, and the public's desire to reduce health inequities through social policies has become increasingly strong. World Health Organization defines health equity as the elimination of avoidable and remediable differences in health among groups of people, whether socially, economically, demographically, or geographically defined [3]. Health inequity not only involves inequalities in the factors that affect health levels but also concerns disparities in timely access to medical care to ensure health, as well as other forms of inequality that infringe upon human rights. Some scholars argue that health equity refers to the absence of systematic differences in health among groups with varying degrees of social advantage or disadvantage. Health equity should not be simply equated with the overall level of health; instead, it focuses on whether disparities among different groups in health status and the utilization of healthcare services can be eliminated through social security mechanisms [4]. Health equity can be understood from two perspectives: one is equity in health outcomes, and the other is equity in access to healthcare services. This means that health equity encompasses not only fairness in the utilization of healthcare services but also fairness in health status itself [5]. Health equity is also defined as the rational distribution of health rights and responsibilities. The equitable distribution of health rights includes fairness in health resources, healthcare services, and health outcomes. In summary, the existing literature on health equity mainly discusses two key dimensions: the equity of healthcare service utilization and the equity of health outcomes [6].

2.2 Health Status of Rural Elderly

The current prevalence of disability among the elderly exceeds 10% in various surveys, with the number of disabled elderly individuals reaching around 20 million [7]. With the accelerating aging of China's population and the increasing proportion of the very old, the probability of health deterioration among the elderly will continue to rise, leading to a significant increase in the number of elderly individuals with impaired health and functional disabilities [8]. A study using data from the 2018 CHARLS found that 27.53% of the rural elderly population in China had disabilities [9]. Overall, the health status of elderly individuals in rural areas is relatively poor and requires greater attention. Although rural healthcare conditions have improved in recent years and the gap between urban and rural medical services has been gradually narrowing, significant disparities in healthcare infrastructure and resources between rural and urban areas still exist [10]. In addition, researchers studying rural poverty reduction have found that, since rural residents primarily engage in physical labor and highly depend on good health, one effective approach to alleviating rural poverty is to improve the health status of impoverished farmers. This, in turn, supports a healthier agricultural labor force and contributes to rural economic development [11]. Therefore, the focus of the rural elderly as the research subject to investigate the impact and mechanisms of rural medical insurance on health equity holds significant practical importance. It can contribute to the further reforms of the rural healthcare insurance system and promote the sustainable

development of rural areas.

Studies have shown that the health status of middle-aged and elderly populations is influenced by individual factors such as gender, age, income, educational attainment, cohabitation with a partner, and family size. Specifically, women generally exhibit better health levels than men, married individuals tend to have higher average health levels, and people living in more developed regions typically enjoy better health than those in less developed areas. Among these factors, economic factors stand out as the most significant [12]. Moreover, a study pointed out that groups with higher socioeconomic status tend to utilize healthcare services more frequently [13]. When populations are categorized and compared by different criteria, the observed health inequities ultimately stem from disparities in socioeconomic status [5]. Based on the above theories, it is evident that individual, family, and societal factors all influence health status, with economic factors having a particularly significant impact. Therefore, in this study, these relevant factors are included as control variables to better isolate the effects under investigation.

2.3 Relationship Between Medical Insurance, Healthcare Utilization, and Health Level

There is no consensus in the literature regarding the relationship between medical insurance and healthcare utilization. It has been argued that through secondary distribution, the current medical insurance system in China reduces the economic costs of healthcare utilization for the elderly, thus alleviating their financial burden [14]. The medical insurance system promotes healthcare utilization among the elderly, improves their health status, and holds significant importance for advancing social equity [15]. Another study showed that differences in the elasticity of healthcare demand among residents of different economic status give rise to significant regional heterogeneity in the health performance of medical insurance systems. Consequently, the health protection effect of medical insurance tends to be more pronounced in less developed regions [16]. However, some scholars argue that while medical insurance reduces the financial burden of healthcare and increases utilization among the insured, it may exacerbate inequalities for those in extreme poverty who are unable to obtain insurance, thereby widening the gap in healthcare utilization between insured and uninsured populations [17]. Although the implementation of the New Rural Cooperative Medical Insurance (NRCMI) has improved the overall health status of minors in rural areas, the healthcare service consumption tends to rise with wealth, indicating that the wealth effect has been amplified by the NRCMI [18]. In studies on the relationship between medical insurance and health status, it is generally believed that social medical insurance improves access to medical resources through compensation or cost-sharing mechanisms, reduces the actual out-of-pocket costs for patients, and enhances residents' willingness and ability to purchase healthcare services, thereby leading to improved health status [19]. Moreover, research indicates that although different types of medical insurance vary in their effects on health incidence rates, they all significantly improve the health incidence rates among the elderly [20].

Since the establishment of the NRCMI in China in October 2002 and its integration with the Urban Resident Basic Medical Insurance (URBMI) in 2016 to form the Urban-Rural Resident Basic Medical Insurance (URRBMI), China has been committed to ensuring that rural residents have access to basic medical services, reducing their medical burden, and promoting health equity among farmers. In the academic research on rural medical insurance, scholars have either focused on the factors influencing it or the outcomes it affects. However, there is a lack of comprehensive discussion on the overall mechanism between rural medical insurance and health equity among the rural elderly. Therefore, this paper employs a structural equation model to explore the policy effects and specific mechanisms of rural medical insurance (referring to both NRCMI and URRBMI in this paper) on health equity among the rural elderly during its implementation process. Furthermore, the findings of this study can provide empirical evidence for further improving the basic medical insurance system, thereby promoting health equity among rural residents, preventing poverty caused by illness, and consolidating the achievements of poverty alleviation.

3 Empirical Research Design

3.1 Data Sources

The data used in this paper is sourced from the China Health and Retirement Longitudinal Study (CHARLS),

which primarily collects micro-level data on households and individuals aged 45 and above in China. Since this database provides detailed information on the health status of the elderly—including self-rated health, the number of chronic diseases, and tests measuring physical disabilities and depression—it allows for a comprehensive assessment of elderly health conditions. This aligns with the research focus on health equity among the rural elderly in this study. Therefore, the 2020 CHARLS database is utilized. The original sample consists of 19,395 individuals, and after research-objective-based data cleaning, a final sample of 5,371 individuals meeting the criteria was selected.

3.2 Variable Selection

The core explanatory variable in this paper is whether an individual participates in rural medical insurance (hereafter referred to as rural-medical-ins). Since the primary objective of this study is to examine whether rural medical insurance effectively promotes health equity among rural residents, a dummy variable is constructed to measure respondents' participation in rural medical insurance. If a respondent reports being enrolled in the NRCMS or URRBMI, the variable takes a value of 1; otherwise, it is set to 0. Given that individual characteristics, family structure, and socioeconomic status may influence both participation in rural medical insurance and health equity, this study includes control variables such as gender (hereafter referred to as male), age, cohabitation with a spouse (hereafter referred to as partner), number of children (hereafter referred to as child_alive_num), educational level (hereafter referred to as edu), and annual income e (hereafter referred to as income). Since this study focuses on health equity among the rural elderly, only individuals aged 60 and above with rural household registration are included in the research sample. Additionally, the variable "partner" is defined such that it takes a value of 1 if the respondent lives with their spouse and 0 otherwise. Edu is categorized into three levels: primary, secondary, and higher education. Individuals with primary school education or below are classified as having a primary level (coded as 1), those with junior high school, senior high school, or vocational school education are classified as having a secondary level (coded as 2), and those with a college degree or above are classified as having a higher level (coded as 3), with higher values indicating higher educational level. Furthermore, since some elderly individuals may have lost their ability to work, income for rural elderly individuals is defined to include wages or pensions, transfer payments, and financial support provided by their children.

Based on the literature, health equity encompasses both health status and the utilization of healthcare services. Therefore, this study sets two variables to represent health equity. The first variable is health status of rural elderly. Health status is generally assessed from both subjective and objective perspectives. In this study, subjective health status is measured using a Likert scale based on the question, "How would you rate your current health status?" The responses are coded as follows: "very good" = 1, "good" = 2, and so on, up to "very poor" = 5, with higher values indicating poorer self-rated health. For objective health status, two variables requiring medical judgment are used: number of chronic diseases (hereafter referred to as chrondis_num) and degree of physical disability (hereafter referred to as impair). Chrondis_num is calculated by summing the number of 'yes' responses to a series of questions asking whether the individual has specific chronic diseases. Similarly, impair is calculated by summing the responses to questions related to physical disability. In both cases, higher values indicate poorer health conditions. To comprehensively reflect the health status of rural elderly individuals, this study also incorporates mental health. The depression index (hereafter referred to as depression) is constructed by summing the responses to depression-related questions in the survey, with higher scores indicating more severe depressive symptoms and, consequently, poorer health status. The second variable is utilization of healthcare services. Given that the 2020 CHARLS questionnaire did not include direct questions on individual medical expenditure, this study employs the per capita medical expenditure (hereafter referred to as medical_expenditure)—derived by dividing the reported household medical expenses over the past year by the total number of household members—as one of the observable variables for assessing the utilization of healthcare services. Additionally, the frequency of healthcare service use is measured through two variables: "How many times have you visited a medical institution for outpatient care in the past month?" (hereafter referred to as outpatients) and "How many times have you been hospitalized in the past year?" (hereafter referred to as inpatients). Higher values for these variables indicate a greater level of healthcare service utilization among rural elderly individuals.

3.3 Model Design

This study employs a Structural Equation Model (SEM) to explore whether rural medical insurance has a positive effect on health equity among the rural elderly in China. Additionally, the path diagram presented by SEM helps to identify the specific aspects of health equity that are influenced by rural medical insurance. A complete SEM consists of two parts: the measurement model and the structural model. The measurement model uses several observed variables to describe a latent variable that is difficult to measure directly, while the structural model illustrates the relationships between latent variables [21]. Based on the variable selection discussed earlier in this paper, variables such as male, age, partner, child_alive_num, edu, income, and rural-medical-ins are directly observable and thus do not require measurement through a measurement model. Only latent variables, such as "health status of rural elderly" and "utilization of healthcare services," cannot be directly observed. Therefore, there is no need to use the measurement equation to assess these variables. Accordingly, the structural equation model in this study is set up as follows:

$$\text{Measurement equation } y = \Lambda_y \eta + \varepsilon \quad (1)$$

$$\text{Structural equation } \eta = B\eta + \Gamma\zeta + \psi \quad (2)$$

Equation (1) is the measurement equation for the latent variable η_i. The observed variables y_i are used to measure the latent variables η_i, which represent health equity among the elderly in this study. Λ_{y_i} represents the regression matrix where the observed variable y_i is explained by the endogenous latent variable η_i, and ε_i represents the measurement error of the explained latent variable. The four observed variables—self-rated health (y_1), chrondis_num (y_2), impair (y_3), and depression (y_4)—are used to measure health status of rural elderly (η_1), which represents health equity. The two observed variables—outpatients (y_5), inpatients (y_6), and medical_expenditure (y_7)—are used to measure utilization of healthcare services (η_2), which also represents health equity.

Equation (2) represents the structural equation describing the relationships between the latent variables η_i. B_i is the regression coefficient of the latent variable η_i explained by another latent variable η_i, and Γ_i is the regression coefficient between the explanatory variable ζ_i and the explained latent variable η_i. ψ_i represents the error term where a latent variable is explained by another latent variable. In this study, the explanatory variable is rural-medical-ins, and the control variables include age, male, edu, partner, child_alive_num, and income.

In summary, the structural equation model established in this study requires the estimation of three parameters: Λ_y, which represents the factor loadings of the observed variables explained by the endogenous latent variables; B, which denotes the regression coefficients of the latent variables explained by other latent variables; and Γ, which refers to the regression coefficients between the explanatory variables and the explained latent variables.

4 Empirical Analysis

4.1 Descriptive Statistics

Table 1 provides the descriptive statistics of the variables. It offers some basic information about the elderly in rural areas. The gender distribution is relatively balanced, with males and females each making up approximately half of the sample. The average age of the elderly is around 68 years. Moreover, statistical data show that 79.63% of the elderly live with their spouses, indicating that most elderly individuals cohabit with their partners, providing mutual care; however, a small portion of them live alone. The average number of children per elderly individual is 2.993, meaning most families have two to three children. In terms of socio-economic status, only a small fraction of the elderly has a college education or higher, while over 80% have an education level of elementary school or below, indicating a generally low level of education among the rural elderly. The average annual income of rural elderly individuals is 8,475.26 yuan, with a large standard deviation. Half of the elderly earn less than 4,100 yuan annually, and fewer than 30% have an income greater than 10,000 yuan, highlighting the significant income disparity among the elderly. Furthermore, the vast majority of rural elderly individuals are covered by rural medical insurance.

Regarding the health status of the elderly in rural areas: nearly half of them rate their health as "average," while 21.54% of elderly individuals assess their health as "very good" or "good." Around 30% of the elderly consider their health to be "poor" or "very poor," indicating that elderly individuals perceive their health to be overall average. Additionally, the average number of chronic diseases among the elderly is 0.586, the level of physical

disability reaches 13.922, and the depression index is as high as 20.321. Overall, the physical health of the elderly is relatively poor, which requires attention.

Regarding the level of healthcare service utilization, the average number of outpatient visits in the past month is 0.489, meaning elderly individuals visit outpatient services approximately once every two months. The average number of hospitalizations in the past year is 0.391, and the average medical expenditure over the past year amounts to 4,621.46 yuan, with a large standard deviation. These data suggest that the economic cost of seeking outpatient and inpatient healthcare services is relatively high for the elderly, indicating a significant financial burden of accessing medical care. Additionally, the large standard deviation reflects considerable internal disparities in healthcare service utilization among rural elderly individuals, which may indicate inequities. These factors may, to some extent, reduce the level of healthcare service utilization among the elderly, which is detrimental to health equity for rural elderly individuals.

Table 1 Descriptive Statistics of Variables

Variable Name	n	Mean	SD	Min	Max
age	5371	67.653	5.826	60	97
male	5371	0.488	0.500	0	1
partner	5371	0.796	0.403	0	1
edu	5371	1.186	0.393	1	3
income	5371	8475.262	11992.407	0	212022
child_alive_num	5371	2.993	1.345	0	10
rural-medical-ins	5371	0.944	0.229	0	1
self-rated health	5371	3.055	1.043	1	5
chrondis_num	5371	0.586	0.933	0	9
impair	5371	13.922	3.913	12	46
depression	5371	20.321	6.372	10	40
outpatients	5371	0.489	1.396	0	30
inpatients	5371	0.391	1.145	0	36
medical_expenditure	5371	4621.46	13879.779	0	250000

4.2 Analysis of Empirical Results of Structural Equation Modeling

4.2.1 Analysis of Influencing Factors

This study investigates whether participation in rural medical insurance can promote health equity among the rural elderly, controlling factors such as gender, age, cohabitation with a spouse, number of children, educational level, and annual income. Since some of these control variables do not meet the assumption of independent and identically distributed data, the study employs the Maximum Likelihood Robust Estimator (MLR) for parameter estimation to better fit the model. The standardized root mean square residual (SRMR) of the structural model is 0.042, which is below the recommended threshold of 0.05, indicating a good model fit according to the requirements of structural equation modeling. Detailed empirical results are presented in Table 2.

The statistical results from Table 2 show that the regression coefficient of age for the participation of rural elderly in rural medical insurance is -0.092 ($p < 0.01$), indicating a negative correlation between age and participation in rural medical insurance. In other words, as the age of the elderly increases, they are less likely to participate in rural medical insurance, which may be due to the loss of income sources with increasing age, making it difficult for them to afford insurance premiums. In addition, cohabitation with a spouse also affects the participation of rural elderly in rural medical insurance, with a regression coefficient of 0.068 ($p < 0.01$), indicating a positive correlation between living with a spouse and participation in rural medical insurance. Moreover, the regression coefficient of educational attainment for the participation of rural elderly in rural medical insurance is 0.019 ($p < 0.1$), showing a positive correlation, meaning that the higher the education level of rural elderly individuals, the more likely they are to participate in rural medical insurance. The regression coefficient of annual income for the participation of rural elderly in rural medical insurance is 0.027 ($p < 0.01$), indicating that elderly

individuals with higher income and better economic conditions are more likely to participate in rural medical insurance, while those with lower income and poorer economic conditions may be unable to participate due to financial constraints. The regression coefficient of participation in rural medical insurance for the utilization of healthcare services is 0.052 ($p < 0.01$), indicating that participation in rural medical insurance can promote the utilization of healthcare services among the rural elderly, which is beneficial for health equity. In addition, the regression coefficient of participation in rural medical insurance for the health status of the rural elderly is -0.032 ($p < 0.1$). Since the latent variable "health status of rural elderly" in the measurement model is measured by observed variables such as "self-rated health," "chrondis_num," "impair," and "depression," where higher values indicate poorer health, a negative regression coefficient suggests that participation in rural medical insurance is conducive to promoting better physical health among the rural elderly, thereby enhancing health equity. Furthermore, the regression coefficient of health status for the utilization of healthcare services is 0.637 ($p < 0.01$), indicating a positive correlation between health status and the utilization of healthcare services, meaning that the worse the health condition of the elderly, the more likely they are to seek outpatient or inpatient medical treatment.

In the measurement model of this study, the estimated coefficients for the observed variables—self-rated health, chrondis_num, impair, and depression—which measure the latent variable of health status of rural elderly are all positive and significant at $p < 0.01$. Additionally, the observed variables for measuring the utilization of healthcare services, including outpatients, inpatients, and medical_expenditure, are also significantly positive at the $p < 0.01$ level. Therefore, this indicates that the selected observed variables for measuring these two latent variables are reasonably chosen.

Table 2 Empirical Results (n=5371)

	Relationship between Variables	Coefficient	SD	z	p
Measurement Equation	male→rural-medical-ins	0.019	0.014	1.36	0.173
	age→rural-medical-ins	-0.092	0.018	-5.03	0.000***
	partner→rural-medical-ins	0.068	0.017	4.01	0.000***
	child_alive_num→rural-medical-ins	0.006	0.017	0.35	0.729
	edu→rural-medical-ins	0.019	0.011	1.66	0.097*
	income→rural-medical-ins	0.027	0.010	2.59	0.010**
	rural-medical-ins→utilization of healthcare services	0.052	0.019	2.66	0.008***
	rural-medical-ins→health status of rural elderly	-0.032	0.019	-1.70	0.090*
Structural Equation	health status of rural elderly→utilization of healthcare services	0.637	0.043	14.77	0.000***
	self-rated health→health status of rural elderly	0.645	0.016	39.50	0.000***
	chrondis_num→health status of rural elderly	0.373	0.018	20.18	0.000***
	impair→health status of rural elderly	0.521	0.017	30.74	0.000***
	depression→health status of rural elderly	0.454	0.017	27.31	0.000***
	outpatients→utilization of healthcare services	0.360	0.030	12.12	0.000***
	inpatients→utilization of healthcare services	0.463	0.052	8.89	0.000***
	medical_expenditure→utilization of healthcare services	0.306	0.033	6.28	0.000***

Note: Significance levels are denoted as follows: * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$.

4.2.2 Analysis of the Mechanism of Influence

As can be seen from Figure 1, there is a negative correlation between age and participation in rural medical insurance. In contrast, cohabitation with a spouse, education level, and income all have significant positive effects on participation in rural medical insurance. Participation in rural medical insurance positively impacts health equity among rural elderly. This effect is mainly achieved through influencing the utilization of healthcare services and the health status of rural elderly. Moreover, health status can also affect healthcare service utilization. Since higher health status indicates worse physical condition, the utilization of healthcare services increases as health deteriorates. Since participation in rural medical insurance benefits elderly health and improves health status, the increase in healthcare service utilization is not due to health status changes. Instead, it is because rural medical

insurance reimburses part of medical expenses, thereby easing the financial burden on elderly individuals when using healthcare services. This, in turn, promotes higher healthcare service utilization.

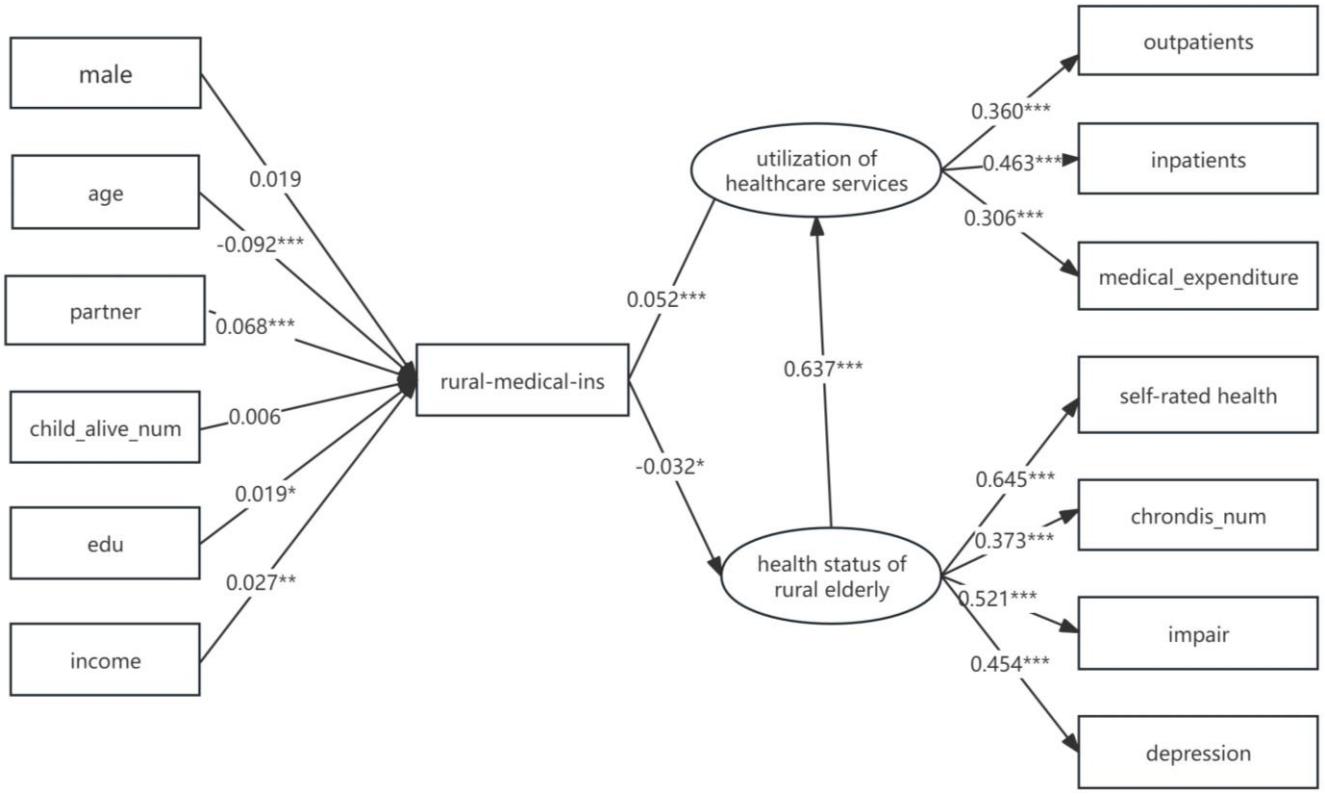

Figure 1 Structural Model Diagram of Factors Influencing Health Equity among Rural Elderly

5 Conclusions and Recommendations

5.1 Conclusions

This paper uses structural equation modeling to examine the impact of rural medical insurance on health equity among rural elderly and explore the mechanisms behind. The study finds that although rural medical insurance has a positive impact on promoting health equity among rural elderly by reducing their economic burden of using healthcare services and improving the utilization and health levels, factors such as age, cohabitation with a spouse, educational level, and annual income still affect participation in rural medical insurance, which in turn influences health equity. The moderating effect of rural medical insurance is subject to limitations.

The primary goal of the basic medical insurance system is to redistribute medical expenses through reimbursements, reducing inequalities in the utilization of healthcare services caused by economic disparities and promoting health equity. As the focus of medical insurance reform gradually shifts from achieving universal coverage to addressing issues of insufficient and imbalanced healthcare security, disparities in healthcare utilization among the elderly are gradually being reduced, and the fairness in healthcare service utilization is progressively being improved. Yet, rural medical insurance has not addressed inequalities in healthcare utilization and health levels caused by avoidable and remediable factors such as cohabitation with a spouse, educational level, and annual income. Overall, the policy effectiveness of rural medical insurance in promoting health equity among the elderly is relatively limited.

5.2 Recommendations

For the medical insurance system to achieve the goal of promoting health equity for residents and addressing issues of insufficiency and imbalance in healthcare security, this paper proposes the following suggestions: First, appropriately lower the reimbursement threshold for medi-

cal insurance to effectively reduce the medical burden on low-income groups. Second, low educational levels are one of the factors hindering re-employment of younger rural elderly. The government should vigorously develop grassroots education for the rural elderly, actively organize knowledge lectures and skill-training sessions tailored to the elderly group, and help younger elderly individuals who are willing to work but unable to find employment, thereby increasing their income. In addition, low educational levels also affect elderly participation in rural medical insurance. By promoting grassroots education for rural elderly and increasing popular science education on rural medical insurance, the government can help elderly people better understand rural medical insurance and encourage active participation. Finally, the government should collaborate with insurance companies to build new types of elderly communities that offer integrated care services, providing both healthcare and daily assistance, ensuring that even those elderly individuals who live alone can receive timely care when they fall ill. Through joint efforts from various sectors of society, we can continuously improve the utilization of healthcare services and the health levels of rural elderly, promoting health equity among rural elderly people.

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