

Income Redistribution Mechanisms of the Basic Medical Insurance System in the Context of Common Prosperity



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Abstract: In the context of common prosperity, how the basic medical insurance system can effectively perform its income redistribution function and narrow income gaps has become an important issue in the field of social security. This paper systematically examines the income redistribution mechanisms of the basic medical insurance system, clarifies its conceptual foundations and core value principles, and analyzes its operating mechanisms from three dimensions: financing, benefit compensation, and management system. The findings show that, in terms of financing, the proportional contribution model has a stronger redistributive effect than the fixed-amount contribution model. However, the minimum and maximum contribution bases and the existence of individual accounts weaken the progressivity of the system. In terms of benefit compensation mechanisms, the deductible threshold, maximum reimbursement limit, reimbursement scope, and settlement methods jointly affect the actual reimbursement rate. Unreasonable benefit designs may constrain low-income groups' access to medical services and create implicit barriers to medical care access. Under liquidity constraints, the advance payment followed by reimbursement (APFBR) method exerts a significant deterrent effect on medical-care seeking behavior among low-income groups, thereby weakening the system's income redistribution function. In terms of the management system, institutional fragmentation and low pooling levels are key structural factors that constrain redistributive effectiveness. Based on this analysis, the paper proposes policy recommendations, including establishing a dynamic financing mechanism linked to income levels, implementing differentiated reimbursement policies for vulnerable groups, promoting institutional integration, and raising pooling levels. These recommendations provide theoretical insights and policy implications for strengthening the redistribution function of the basic medical insurance system and promoting common prosperity in the new era.

Keywords: Common Prosperity; Basic Medical Insurance System; Income Redistribution Mechanism

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1 Introduction

In contemporary society, common prosperity is an essential requirement of socialism and an important feature of Chinese modernization. Common prosperity refers to achieving the goal of shared prosperity for all and collective flourishing by ensuring every member of society can

share in the fruits of economic development through equitable distribution mechanisms. The report of the 20th National Congress of the Communist Party of China explicitly states that it is essential to "promote social fairness and justice" and "solidly advance common prosperity", with the

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aim of making "more tangible and substantive progress in realizing common prosperity for all people" by 2035. During the 2026 National People's Congress and Chinese People's Political Consultative Conference sessions, General Secretary Xi Jinping emphasized that improving basic public services and social security, as well as improving the public health system and building a high-quality and efficient medical service system, are important pathways toward common prosperity.

Social security practices around the world demonstrate that such systems play an important role in income redistribution [1, 2]. As a vital component of social security, the basic medical insurance system serves as a key mechanism for narrowing income gaps and promoting common prosperity [3, 4]. The basic medical insurance system provides adequate basic medical coverage for insured individuals, effectively alleviates the public's financial burden of medical care, and achieves income redistribution through the mutual assistance mechanism, thereby promoting social equity and justice [5].

Within a multi-tiered social security system, medical security is directly linked to public well-being and social stability. Consequently, its income redistribution mechanisms have become a sustained focus of academic inquiry. Existing research generally unfolds along two main lines: first, the systematic review and analysis of institutional mechanisms. Some earlier studies have analyzed the income redistribution mechanisms of China's medical insurance system [6], while others have systematically analyzed the redistributive effects of the medical security system from an institutional perspective [7]. Second, empirical studies have measured and evaluated the redistributive effects of the system. Some studies have empirically examined the influences of the medical insurance system on different income levels using provincial and national data [8-10]; others have investigated the equity of benefits under the basic medical insurance based on CHARLS microdata [5]. Overall, existing empirical research indicates a significant gap between the actual redistributive effects of China's basic medical insurance system and theoretical expectations: medical expenditures exhibit a significant negative redistributive effect that is widening, although medical insurance reimbursement can partially mitigate this, its effectiveness is limited [11]. Low reimbursement rates and inappropriate payment structure designs are the primary causes of adverse income redistribution [12]. The strength of income redistribution effects depends on the system's progressivity rather than merely its scale [13]. This finding

offers significant insights for optimizing the design of the basic medical insurance system. However, existing studies have predominantly focused on empirical measurement, while insufficient attention has been paid to the micro-level theoretical mechanisms of the system and to the integration of its three dimensions (financing, compensation, and management). Meanwhile, in the context of common prosperity, how to evaluate the impact of institutional design on the public's income redistribution mechanism from a normative perspective also remains to be further elucidated.

Against this backdrop, this paper aims to explore the income redistribution mechanisms of the basic medical insurance system. The structure of the paper is as follows: first, it elaborates on the fundamental connotations and core value principles of income redistribution within the basic medical insurance system. Second, it provides a detailed discussion on the income redistribution mechanisms of the basic medical insurance system from three perspectives: financing mechanisms, benefit compensation mechanisms, and management systems. Third, based on the preceding analysis, it presents research conclusions and corresponding policy recommendations. This study contributes to clarifying the intrinsic logic of income redistribution within the basic medical insurance system, offering theoretical references for improving China's medical security system and advancing social equity and common prosperity, thereby holding significant practical implications.

2 Theoretical Framework

2.1 Basic Connotation

The income redistribution function of the basic medical insurance system stems from the probabilistic nature of disease risk and the design principles of the system [7]. First, every individual faces a potential risk of illness. However, the onset of disease and the effectiveness of treatment remain uncertain [14]. Specifically, the timing, type, and severity of disease onset are all uncertain, as are the treatment process and outcomes following disease onset, thereby resulting in uncertainty regarding the associated medical expenses. Medical insurance, based on the law of large numbers, can mitigate the non-systematic risks associated with illness. This is specifically manifested in the fact that it is impossible for insured individuals to fall ill at the same time; when some of them are ill, there will always be others who remain healthy. Therefore, medical insurance can

achieve risk sharing and mutual assistance, resulting in income redistribution from low-risk groups (the healthy population) to high-risk groups (the sick population) [6]. This is a fundamental institutional feature shared by all forms of medical insurance, including commercial medical insurance. Second, from an institutional design perspective, the basic medical insurance system adheres to the fundamental principle of combining rights and obligations: all insured individuals are required to fulfill their obligation to pay medical insurance premiums and, on this basis, legally enjoy medical insurance benefits. However, a notable discrepancy exists between premium payments and insurance benefits: typically, medical insurance premiums are correlated with income, whereas medical expenditures are not [15]. This means that high-income groups bear a relatively greater obligation to pay premiums. However, given their higher incidence of illness, low-income groups theoretically benefit from more comprehensive medical benefits, which helps alleviate their financial burdens of medical care [16]. Consequently, at the institutional design level, the basic medical insurance system serves a redistributive function whereby high-income groups subsidize low-income groups, thereby contributing to the reduction of income inequality. This embodies the fairness principle inherent in the basic medical insurance system and represents a key distinction between social medical insurance and commercial medical insurance.

2.2 Core Value Principles

Fairness and justice constitute the core value principles of the basic medical insurance system [17]. At its core, the system seeks to promote social equity through the redistribution of medical insurance resources. Income redistribution is an institutional feature of the basic medical insurance system, with social equity serving as one of its primary motivations [18]. Moreover, social equity significantly influences both the empirical measurement and normative evaluation of income redistribution [19]. From an evaluation perspective, this paper divides the evaluation criteria for income redistribution effects into two aspects. On the one hand, the "principle of infinite distributive justice" underlying income redistribution effects describes an ideal state that requires the basic medical insurance system to achieve as equitable distribution as possible. This can be used to evaluate the degree to which the system's policy objectives are met; on the other hand, the "principle of limited distributive justice" for income redistribution effects

serves as the baseline standard for assessing the basic medical insurance system when the "principle of infinite distributive justice" is constrained by practical realities and cannot be fully realized; it emphasizes moderate support for vulnerable groups such as low-income populations.

3 Income Redistribution

Mechanisms of the Basic Medical Insurance System

3.1 Financing Mechanism

In terms of financing, the basic medical insurance fund primarily originates from three categories: individuals, employers, and the government. The premium contribution models are divided into two types: proportional contribution model and fixed-amount contribution model (see Figure 1) [8, 9].

Among these, the proportional contribution model refers to a system where the amount of medical insurance premiums is proportional to the insured individuals' income. Regarding the contribution mechanism itself, proportional contributions do not alter the relative income gaps among insured individuals. The Urban Employee Basic Medical Insurance (UEBMI) adopts a financing mechanism of "joint contributions by both employees and employers", falling under the proportional contribution model. For individual contributions, the contribution rate is 2% of the individual's salary, with the contribution base falling within a closed interval ranging from 60% to 300% of the local average social wage. Let the individual's salary be S , and the local average social wage be A ; then the specific calculation for the contribution base B is as follows:

$$B = \begin{cases} 0.6A & S < 0.6A \\ S & 0.6A \leq S \leq 3A \\ 3A & S > 3A \end{cases} \quad (1)$$

When an individual's salary falls within the closed interval of 60% to 300% of the social average wage, the contribution base is set at that level, and income gaps remain unchanged after individual contributions are made; when an individual's salary is below 60% of the average social wage, the minimum contribution base (0.6A) is applied, thereby placing a heavier contribution burden on low-income groups; when an individual's salary exceeds 300% of the

average social wage, the maximum contribution base(3A) is applied, resulting in a lighter contribution for high-income groups. This finding aligns with general theoretical principles in public finance theory regarding social medical insurance financing mechanisms. Although the financing ceiling restriction preserves the incentive for high-income individuals to participate in the insurance scheme, it effectively erodes the nominal progressivity of contributions, resulting in regressive effects on the financing side [20]. When the individual contribution rate remains unchanged, the establishment of both the minimum and maximum contribution bases undermines fairness. Moreover, since all individual contributions are deposited into individual accounts, they serve only to regulate individuals' income redistribution vertically over an individual's lifetime and do

not function as a mechanism for income redistribution among members of the same generation—individual accounts being, in essence, a form of mandatory savings rather than risk sharing. High-income groups accumulate more funds in their individual accounts due to higher contribution bases, whereas low-income groups experience the opposite. This situation further solidifies and even widens the gap in medical coverage among different income groups: high-income groups have accumulated substantial medical savings through individual accounts, whereas the size of the pooled fund remains constrained by the high proportion of funds transferred to individual accounts, thereby undermining the mutual assistance capacity and redistributive function of the basic medical insurance system.

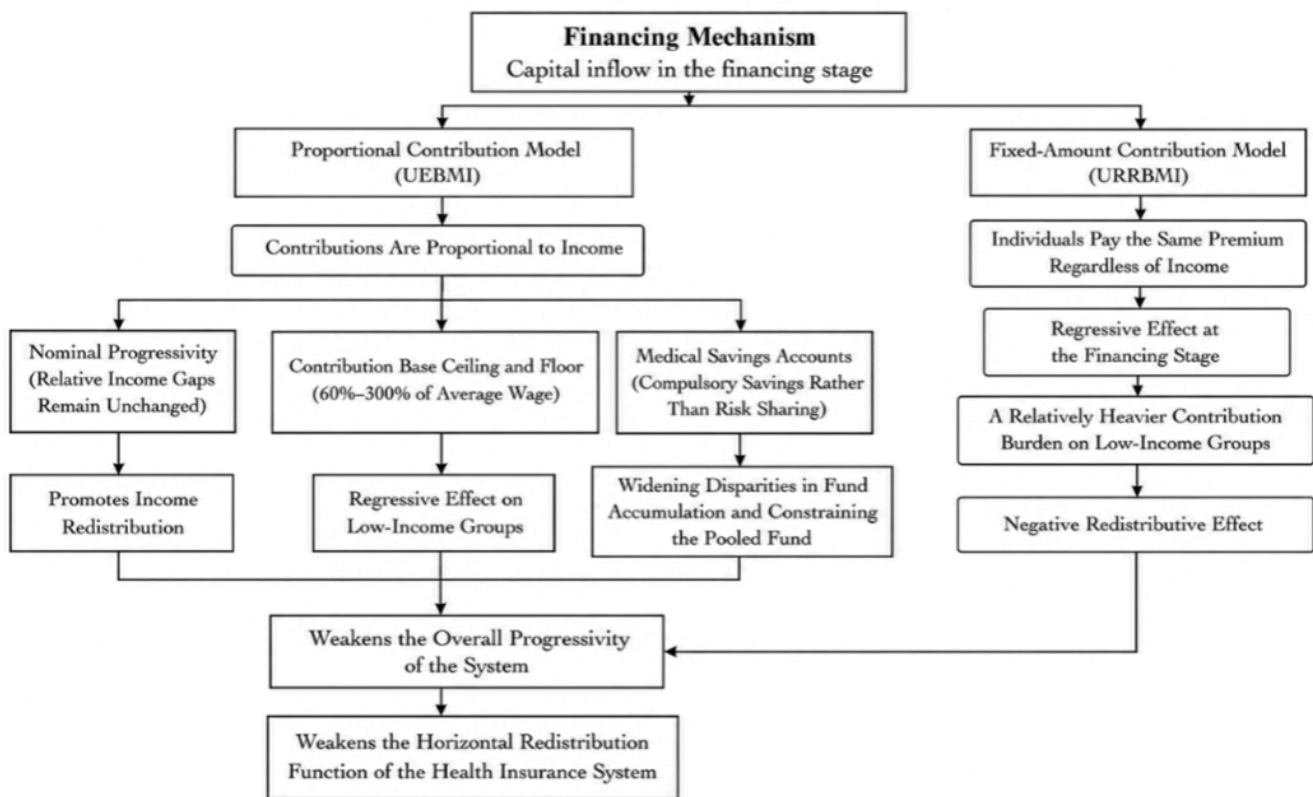


Figure 1 Analytical Framework of the Financing Mechanism

For employers, the contribution rate typically ranges between 6% and 8%, with three forms of contribution bases: first, using total employee wages as the base, where employer contributions are most strongly correlated with overall wage levels, resulting in the best income redistribution effect; second, using the local average social wage multiplied by the number of employees as the base, where employers with the same number of employees contribute

the same amount, regardless of overall wage levels, resulting in the poorest income redistribution effect; third, using the sum of employees' contribution wages as the base, which yields an intermediate income redistribution effect. According to the "Guidance on Establishing and Improving the Outpatient Mutual Assistance Security Mechanism for UEBMI" issued by the General Office of the State Council

in 2021, employer contributions shall no longer be allocated to individual accounts but shall be fully deposited into the pooled fund, while an outpatient mutual assistance mechanism is established simultaneously. This reform helps expand the scale of the pooled fund and enhance its redistributive function, thereby achieving a more effective redistribution outcome.

The fixed-amount contribution model refers to a system in which all individuals, regardless of income level, pay the same premium. Compared with high-income groups, low-income groups bear a heavier contribution burden, resulting in a regressive effect on medical insurance contributions and a negative income redistribution effect. The Urban Resident Basic Medical Insurance prior to integration, the New Rural Cooperative Medical Scheme, and the integrated Urban-Rural Resident Basic Medical Insurance (URRBMI) all implement a financing mechanism combining individual contributions with government subsidies, which belongs to the fixed-amount contribution model.

3.2 Benefit Compensation Mechanism

In terms of benefit compensation, the mechanisms influencing income redistribution primarily include benefit eligibility criteria, compensation policies, and medical insurance settlement methods (see Figure 2). Among these, meeting benefit eligibility criteria is a prerequisite for obtaining medical insurance reimbursement. Medical expenses incurred by insured individuals at designated medical institutions that fall within the scope of the "three directories": the Basic Medical Insurance Drug Directory, the Diagnostic and Treatment Item Directory, and the Medical Service Facilities Standards, as well as emergency and rescue medical costs, are eligible for reimbursement in accordance with regulations.

The compensation policy primarily refers to a medical cost-sharing mechanism¹ composed of the deductible threshold², reimbursement ratio and the maximum reimbursement limit. The primary purpose of the deductible threshold is to curb moral hazard and control the unreasonable growth of medical costs. However, this cost-control tool has asymmetric impacts on different income groups:

for high-income groups, the deductible threshold hardly poses any barriers to accessing medical care; but for low-income groups facing strict budget constraints, the imposition of a deductible threshold may limit their access to necessary medical services, posing a risk of conditions deteriorating due to delayed or foregone treatment. For patients facing the risk of substantial medical expenses, the establishment of the maximum reimbursement limit reduces the benefits provided by basic medical insurance. In the absence of effective coordination and comprehensive coverage across multi-tiered medical security systems, this increases the risk of "falling into poverty due to illness, returning to poverty due to illness". Let overall medical expenses be M , medical expenses that fall within the reimbursement scope be $M_1 (M_1 \leq M)$, and the deductible threshold, reimbursement ratio, and maximum reimbursement limit be d , r , and c respectively. The formula for calculating the actual reimbursement rate r^* is as follows:

$$r^* = \begin{cases} 0 & M_1 \leq d \\ (M_1 - d)r / M & d < M_1 \leq c \\ (c - d)r / M & M_1 > c \end{cases} \quad (2)$$

The combined effects of the deductible threshold, the maximum reimbursement limit, and the reimbursement scope result in an actual reimbursement rate that is lower than the nominal reimbursement rate, which weakens the income redistribution effect of the basic medical insurance system.

The medical insurance settlement methods include direct settlement (DS) and advance payment followed by reimbursement (APFBR). Under the former, insured individuals only need to pay their out-of-pocket and self-paid expenses during medical treatment, while under the latter, insured individuals must first pay the full amount of medical expenses out of pocket and then submit a manual reimbursement claim in accordance with regulations after treatment is completed. Let the individual's income level be X . Under no borrowing constraints, the optimal medical expenditure for the insured is M^* , and the required "net"

1 The medical cost-sharing mechanism is designed to mitigate moral hazard among insured patients. Moral hazard refers to the overutilization of medical services as medical insurance reimbursement effectively lowers the price of medical service, thereby leading to unreasonable increases in medical expenses.

2 The deductible refers to the threshold for out-of-pocket payment

from the medical insurance fund. For medical expenses incurred by insured individuals at designated medical institutions within the scope of the "three directories", the insured must first cover costs below this deductible threshold, while the portion exceeding the threshold is reimbursed by the medical insurance fund according to specified regulations and proportional rates.

medical payment is $(1-r^*)M^*$; under borrowing constraints, the actual medical expenditure C of the insured is as follows:

$$C = \begin{cases} C_1 < C_2 & X < (1-r^*)M^* \\ C_2 < M^* & (1-r^*)M^* \leq X < M^* \text{ \& APFBR} \\ M^* & (1-r^*)M^* \leq X < M^* \text{ \& DS} \\ M^* & M^* \leq X \end{cases} \quad (3)$$

For insured individuals whose income falls within the interval $[(1-r^*)M^*, M^*)$, their actual medical expenditure equals their optimal medical expenditure under the DS method. However, under the APFBR method, these low-income groups are subject to binding liquidity constraints. Consequently, their actual medical expenditure is often lower than their optimal medical expenditures, creating a

suppressive effect on medical care utilization. Development economics theory indicates that in the absence of a well-developed financing lending market, health risk shocks often trigger an intertemporal poverty trap due to severe liquidity constraints [21]. Unreasonable benefit eligibility thresholds exclude a large number of low-income individuals from the scope of medical insurance coverage, while high-income groups face less liquidity constraints and become the primary beneficiaries of insurance payouts instead, thereby exacerbating the regressive redistribution tendency inherent in the basic medical insurance system [12]. As mentioned above, this is a classic example of "falling into poverty due to illness": low-income families are forced to abandon treatment or resort to low-quality medical services due to their inability to cover high medical expenses, leading to disease progression and ultimately falling into a vicious cycle of "disease-poverty-poorer treatment".

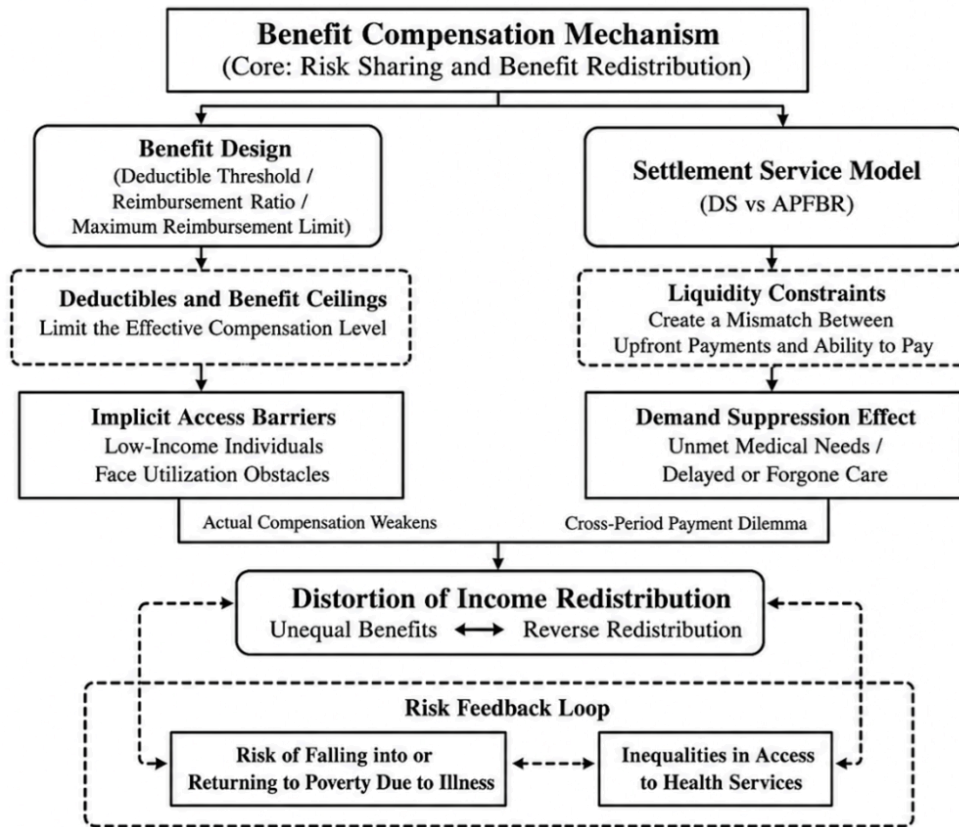


Figure 2 Analytical Framework of the Benefit Compensation Mechanism

3.3 Management System

In terms of the management system, the mechanisms influencing income redistribution have been classified into

two aspects: system design and pooling level (see Figure 3). System design encompasses a single-payer system and a multi-payer system. A single-payer system refers to all individuals participating in a unified basic medical insur-

ance scheme, enjoying the same medical benefits, with different income groups sharing a common risk pool for sufficient horizontal equity, thereby achieving favorable income redistribution outcomes. A multi-payer system refers to the basic medical insurance system comprising several distinct components. When assessing the income redistribution effectiveness of the entire system, it is essential to comprehensively consider the benefit gaps among these components: the greater the gap, the less effective the income redistribution mechanisms of the basic medical insurance system.

The pooling level refers to the tier and the scale of the covered population for medical insurance fund pooling. It is generally determined based on the corresponding administrative tier. In theory, raising the pooling level can enhance the equity of medical insurance benefits [22], improve risk-sharing capacity, reduce administrative costs,

and thereby enhance the effectiveness of income redistribution. The higher the pooling level, the stronger the cross-regional risk-sharing capacity, the smaller the gap in regional benefits, and the broader the scope of income redistribution. Prior to recent reforms, China's medical insurance pooling level was generally low, with most regions remaining at the county or city level, which limited the full realization of its income redistribution function [23]. In recent years, although China has fully implemented city-level pooling for basic medical insurance and is steadily advancing provincial-level pooling, there is still potential for further improvement in the current pooling level compared to the requirements for building a national unified market. Differences in the adequacy of medical insurance funds and benefit levels still exist between different pooling regions, which to some extent continues to limit the effectiveness of cross-regional income redistribution.

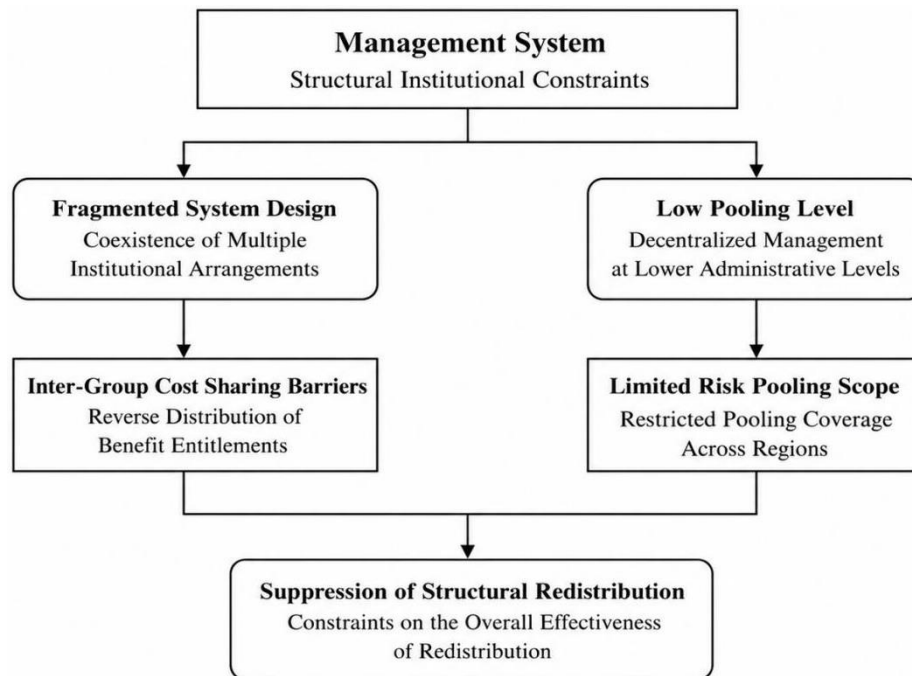


Figure 3 Analytical Framework of the Management System

4 Research Conclusions and Policy Implications

Currently, China has entered a new phase of steadily advancing common prosperity. Improving the income redistribution mechanisms of the basic medical insurance system is a crucial measure for achieving the goal of common prosperity. Based on a theoretical perspective of common

prosperity, this paper systematically elucidates the theoretical logic, core value, and operational mechanisms of income redistribution within the basic medical insurance system, focusing on three dimensions: financing, benefit compensation, and management systems. The main conclusions are as follows: first, through risk-sharing and mutual assistance mechanisms, the basic medical insurance system theoretically achieves income redistribution from low-risk groups to high-risk groups and from high-income groups to

low-income groups, possessing the potential to promote social equity and narrow income gaps. Second, within the financing mechanism, the proportional contribution model exhibits a stronger income redistribution effect compared to the fixed-amount contribution model, but the setting of minimum and maximum contribution bases and the existence of individual accounts weaken the system's progressivity. Third, within the benefit compensation mechanism, the deductible, maximum reimbursement limit, reimbursement scope, and settlement methods collectively influence the actual reimbursement rate. Unreasonable institutional design may further constrain low-income groups' access to medical services, thereby weakening the income redistribution effect. Fourth, within the management system, significant gaps in medical insurance benefits across different institutions and low pooling levels are key structural factors that constrain the income redistribution effects of the basic medical insurance system.

The above findings provide a theoretical basis for the positive role played by the basic medical insurance system in alleviating poverty and regulating income distribution. Based on these findings, the following policy recommendations are proposed:

First, a flexible financing mechanism linked to income levels should be established to enhance the progressivity and fairness of medical insurance contributions. The income redistribution effect of the proportional contribution model is superior to that of the fixed-amount model, whereas the setting of minimum and maximum contribution bases undermines the system's progressivity. The fixed-amount contribution model results in regressive contributions to the basic medical insurance for urban and rural residents. To this end, reforms should be advanced in the following areas. First, for URRBMI, we should explore the establishment of a flexible financing mechanism linked to household disposable income, conduct pilot programs for income-tiered contributions in regions with necessary conditions, and establish a differentiated contribution mechanism based on income levels. Second, dynamically adjust the upper and lower limits of the contribution base, moderately lowering the minimum contribution base to alleviate the contribution burden on low-income groups. At the same time, the degree to which high-income groups benefit from the maximum contribution base should be reasonably controlled to prevent them from unduly benefiting from the relief provided by the contribution cap. Third, the implementation of outpatient mutual assistance reforms should be accelerated and deepened, urging localities to duly allocate

employer contributions to the pooled fund as required, expanding the coverage of outpatient pooled funds, and allocating more funds to mutual assistance to enhance horizontal redistribution function from high-income groups to low-income groups. Furthermore, the government should strengthen the preferential allocation of fiscal subsidies toward low-income groups. In addition to general national fiscal subsidies, participation of disadvantaged groups can also be ensured through the medical assistance program, which provides differentiated premium subsidies based on beneficiaries' circumstances, such as offering full coverage for individuals in extreme poverty, fixed-amount subsidies for those receiving minimum living allowances, and support for individuals under monitoring for the prevention of a return to poverty.

Second, it is necessary to optimize the design of benefit compensation policies to effectively improve the actual level of protection for low-income groups. The combined effect of deductibles, maximum reimbursement limit, and reimbursement scope result in actual reimbursement rates that are significantly lower than nominal rates, creating implicit barriers to access for low-income groups. At the same time, the APFBR method further exacerbates the constraints that liquidity constraints place on low-income groups' medical-seeking behavior. To this end, efforts should focus on the following areas. First, implement differentiated reimbursement policies for vulnerable groups such as minimum living allowance recipients, extremely poor individuals, and registered poor populations, including appropriately lowering deductibles and raising maximum reimbursement limit, while accelerating the effective integration of basic medical insurance, critical illness insurance, and medical assistance to fully leverage the role of the multi-tiered medical security system and strengthen the safety-net function provided by medical assistance. Second, dynamically adjust the "three directories" of basic medical insurance to include more clinically essential, clinically effective, and reasonably priced drugs and medical procedures within the reimbursement scope, thereby reducing patients' out-of-pocket payments. Third, fully implement and optimize "one-stop" DS services, further expand the coverage of DS for out-of-area medical care, effectively resolve the APFBR issue that still exists in certain scenarios, break the liquidity constraints faced by low-income groups who are unable to access reasonable medical services due to payment limitations, and strengthen the development of medical insurance information systems.

Third, it is necessary to accelerate the integration of

basic medical insurance systems and elevate the pooling level to narrow the benefit gaps between different schemes. Institutional fragmentation under the multi-payer system has led to significant medical insurance benefit gaps among different groups of insured individuals, with benefits that are disproportionately concentrated among high-income groups, thereby undermining the overall income redistribution effect of the system. To this end, reforms should be advanced in the following areas. First, further improve the unified management mechanism for the medical insurance reimbursement catalog, and in line with economic development, gradually narrow the benefit gaps between URRBMI and UEBMI, thereby promoting the basic medical insurance system toward substantive equity. Second, steadily raise the pooling level of medical insurance funds, on the basis of fully implementing city-level pooling, accelerate the advancement of provincial-level pooling and gradually transition toward national pooling, thereby expanding the size of the risk pool and enhancing the fund's risk-sharing capacity and redistributive adjustment functions. Finally, establish a dynamic benchmarking and convergence mechanism for benefit levels across different schemes. Using the actual benefit levels of low-income insured groups as the core indicator, regularly assess gaps across different schemes and target pathways for convergence, thereby gradually narrowing benefit gaps across different insured groups.

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