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# 7 Poverty Risk and the Integration of Long-Term Care in Healthcare Policy in Germany and China During the COVID-19 Pandemic

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**Abstract:** This chapter compares how the German and Chinese healthcare systems differed in their impact on poverty risk among low-income people during the COVID-19 pandemic. It examines how long-term care policy in these two countries can support the population from such risk during pandemics, arguing that the interplay of healthcare and long-term care policy with regard to eligibility for and access to benefits is crucial to protect low-income individuals from the risk of falling into poverty.

## Emergence of Poverty Risk During the COVID-19 Pandemic

In many countries, social welfare policies were enhanced in the fight against the effects of the COVID-19 pandemic, particularly in the area of healthcare. The healthcare policy response to the COVID-19 crisis elicited significant discussions globally. A critical issue in this debate has been to identify how to limit low-income people's exposure to the risk of poverty, focusing on healthcare insurance and medical costs. The resources accessible to people in meeting their healthcare needs have been better defined during the crisis (e.g., Zhu et al. 2020), and the lack of access to care has been linked to people exhausting their personal resources to face medical expenses. During the pandemic, in areas where low-income people could barely obtain medical services, they faced the risk of poverty, or "hypothetical poverty." Comparisons can be useful to understand this relationship. This chapter reviews how Germany, a conservative European welfare state, and China, an Asian welfare state, have differed in their response to COVID-19 through institutional regulations aimed at preventing poverty risk among low-income population groups. The chapter contributes to this book on decentering the study of Europe by providing a comparative study between a country in Europe and a country outside of Europe and establishing a dialogue. The new insights illuminate the ways in which social welfare policy impacted poverty risk among low-income groups during the COVID-19 crisis.

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In an attempt to prevent the exposure to poverty risk of low-income population groups during the COVID-19 pandemic, China and Germany strengthened their public healthcare policy schemes to better cover medical-related costs, albeit with limitations. The Chinese public healthcare system is based primarily on universal design with targeted programs in local areas. Territories in different provinces may deviate from these programs, resulting in cross-regional variations that lead to differing coverage of self-paid medical cost across social groups. In China, additional benefits were added to healthcare coverage to include specific COVID-19-related expenses. As the first country experiencing the widespread breakout of COVID-19, China achieved early positive outcomes in its fight against the pandemic, including a cure rate of 94.3 percent nationally by early August 2020, with 70 percent of those recovering from the disease over 80 years of age (The State Council Information Office of China 2020). However, although the Chinese healthcare system, with its special COVID-19 policy schemes, covered all pandemic-related medical costs for seriously infected patients, it covered only 67 percent of medical expenses for those “not seriously infected” or only “possibly infected,” resulting in poverty risk for low-income individuals in particular. We argue that it is China’s lack of a long-term care (LTC) system to address healthcare needs in the context of COVID-19 infections that led to poverty risk for the Chinese low-income population.

In contrast, the German healthcare system is characterized by the coexistence of a public statutory health insurance (SHI) and a private healthcare insurance (PHI) system, where both inpatient and outpatient care are covered for every diagnostic group and for a broad array of preventive services. The German public SHI system, mostly publicly funded, offers universal health insurance coverage without upfront payments, a comprehensive bundle of benefits with comparably low cost-sharing requirements, and good access to care benefits. Compared to its European neighbors, Germany enjoyed positive outcomes in its response to the COVID-19 crisis in 2020. However, unlike in China, in Germany the healthcare policy did not include special schemes to specifically cover COVID-19-related costs. Instead, the German policy treated COVID-19 medical treatment costs as it would those related to other diseases. The German long-term care (LTC) insurance system was administered as usual during the COVID-19 crisis, covering the care needs of the population. We argue that the German healthcare system and its LTC schemes were operated normally in response to the COVID-19 pandemic.

Studies on the impact of healthcare policy on poverty risk prevention have usually focused on understanding the players and processes involved in organizing and supplying health resources. For example, it has been shown that both the state and the family influence societal power structures, (re)distribution, and welfare outcomes (Razavi 2007; Sipilä et al. 2003; Xu 2019). Researchers have frequently assessed service provision, financing, and the regulation of social policy systems to analyze healthcare systems or LTC policy (Bureau et al. 2007; Wendt et al. 2009). However, few studies have systematically examined the extent to which healthcare and LTC systems have been integrated to prevent poverty risk among low-income groups. Furthermore, comparative knowledge is limited on the way healthcare and LTC systems interact to produce differentiated poverty risk levels among low-income groups during pandemic crises. Against this background, this chapter

introduces an analytical framework to examine how healthcare policy schemes influence poverty risk among low-income people, based on a comparison between German and China—two countries that, while anchored in different traditions, rely on a similar approach to social insurance. Governance in those two countries relies on different levels of responsibilities, which are complex, decentralized, and shared by governing bodies at the state and local levels—especially in Germany. In the Chinese healthcare system, provincial and municipal-level bodies compete for financial resources from the central government to pay for policy benefits (Chen and Yuan 2021). While, the healthcare and LTC systems are based on different eligibility criteria of benefit recipients in the two countries, experiences in both places have shown that sometimes poverty risk cannot be compensated for. By uncovering cross-national policy outcomes that aimed at alleviating poverty risk during the global pandemic crisis, this chapter points to the role of healthcare policy, in particular LTC policy, in preventing poverty for socially disadvantaged group.

We measure poverty based on the 1984 European Council decision that stated that, in an effort to combat poverty, “the poor shall be taken to mean persons, families and groups of persons whose resources (material, cultural and social) are so limited as to exclude them from the minimum acceptable way of life in the Member State in which they live” (EEC 1985, 24-25). For the purpose of this study, the “low income” category includes people who earn less than the average income or pension in the working population, yet earn more than those below the national or regional absolute poverty threshold.

## **Analyzing Poverty Risk in COVID-19 Healthcare Policy**

This study focuses on the degree to which two countries’ healthcare policies may have driven poverty risk among low-income people who could not meet their healthcare needs during the COVID-19 crisis. It assesses whether LTC policy was useful in filling the resource gap for low-income individuals by reviewing three dimensions of integrated care policy: 1) eligibility for access to care and insurance benefits; 2) monetary value of the benefits received; and 3) access to LTC benefits.

The first dimension pertains to access eligibility, which can be based on means or need and may be specified by whether health insurance is mandatory for all or voluntary. To measure eligibility, this study considers whether low-income people must be insured through public or private insurance and pay contributions; it also takes into account whether they receive benefits based on their contribution level and whether they voluntarily join the healthcare insurance scheme or must personally cover their medical costs if they do not. The second dimension pertains to whether healthcare benefits can theoretically cover medical needs and how much low-income individuals must pay upfront to access benefits, for example, in the form of co-payments or out-of-pocket contributions. The third dimension concerns the possibility that LTC policy might help mediate the risk that low-income people fall into poverty. In both countries, integrating LTC and healthcare policy enables low-income people to access LTC benefits when insured. In both countries, we examine laws, regulations, and institutional instruments such as the 2018

Social Insurance Law of the People's Republic of China, the 2019 National Healthcare Security Administration national policy, the 2020 Chinese National Medical Insurance Administration Regulations, the German Social Code Regulation (SGB V, SGB VII, SGB VI, SGB XI), and the Federal Association for Prevention and Health Promotion Regulations (Bundesvereinigung Prävention und Gesundheitsförderung) for the years 2019 and 2020. Furthermore, the way national policy protects people from the risk of poverty falls into two categories: "low poverty protection" and "high poverty protection." In the former, the interplay between the three dimensions of an integrated policy reveals that weakness in one dimension is not compensated by the other dimensions; thus low-income populations are exposed to poverty risk. For example, if the healthcare benefits received are not large enough to cover medical needs, patients may be exposed to poverty risk despite being eligible for LTC benefits. Hence, low-income people's poverty risk could be higher if they needed LTC due to prior unmet medical care needs.

The "high poverty protection" policy ensures all three dimensions are addressed separately to prevent poverty risk and that the interplay between the different dimensions does not expose low-income populations to the risk of becoming poor. For example, healthcare policy could provide generous access to benefits that are sufficient to cover the cost of medical care based on needs. Moreover, integrating healthcare benefits with LTC benefits could also support low-income populations that have seen their care needs unmet in the past.

## **Poverty Risk in Germany and China in the Context of COVID-19**

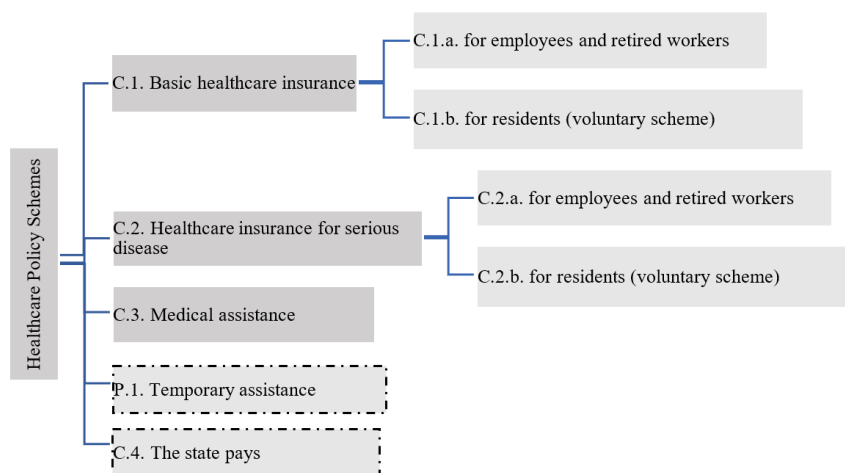
### ***Integrated Policy Dimension 1: Eligibility to Access Services and Benefits***

The Chinese healthcare system was designed by the central government as a universal policy system operating through targeted programs implemented at the local level (as shown in Figure 1). Sections C.1. to C.3. of the healthcare policy represents the central plan, while section P.1. covers targeted policy programs at the level of the provinces. The health needs of individuals with job security and social insurance contracts are covered through basic compulsory healthcare insurance for the employed (C.1.a.), which applies to approximately 17.3 percent of the population. It is highly probable that individuals with short-term or temporary employment are excluded from this insurance scheme (Ruan et al. 2024). However, individuals can access basic healthcare insurance after retirement (C.1.a. and C.1.b.), which concerns roughly 6.2 percent of the population (Yi 2021). The unemployed or self-employed seeking voluntary basic health insurance (C.1.b.) represent approximately 70 percent of the Chinese population.

In China, the basic health insurance scheme (C.1.) is contributory. Employers contribute about 75 percent of C.1.a. funds, and employees pay the remaining 25 percent, while non-employed individuals who are voluntarily insured under C.1.b. contribute 100

percent to this healthcare insurance scheme, or a fixed amount of approximately 285 RMB/year (€36/year) (Li et al. 2020). With nearly 95 percent coverage and a 65 percent reimbursement rate guaranteed in the provision of basic healthcare services, C.1. plays an important role in covering the population's medical needs. However, we argue that citizens with flexible jobs or low income—such as self-employed workers and those in small enterprises in secondary towns—could find themselves excluded from the basic healthcare insurance scheme. Our findings show that the Chinese healthcare system was adjusted to provide benefits that covered COVID-19-related medical needs, for example those of patients suddenly infected with COVID-19 and in need of medical care, including those in low-income categories. Under sections P.1 and C.4, people with COVID-19-related medical needs were better supported.

**Figure 1:** Policy framework of the Chinese healthcare system with coverage structure of COVID-19-related medical costs



Source: The authors based on State Council Information Office of China (2020) and Song et al. (2020).

Unlike its Chinese counterpart, the German healthcare system did not adapt to specifically address the COVID-19 pandemic and simply retained its pre-pandemic design. In its original form, the German system provides the population with universal coverage through a broad benefits package and low cost-sharing requirements. Healthcare benefits are generous, and costs are not considered a barrier to access. Disparities in accessing healthcare services across rural and urban areas are negligible, thanks to a past reform that promoted the development of healthcare services in rural areas. Consequently, not only do low-income individuals enjoy wide access to public healthcare but so do their families, resulting in lower levels of catastrophic healthcare expenditure in this group in Germany than in most other European countries (OECD 2020). Low-income people's

access to care is less restricted in Germany than it is in China. Moreover, the German system also ensures that all family members, even those with no income at all, are granted equal access to health services, and at no cost to them. Table 1 depicts the system of mandatory enrolment in healthcare insurance in Germany. In comparison, the Chinese healthcare system provided specific programs targeting COVID-19 medical related costs; however, these benefits were temporary, applied only to sick individuals, and did not cover family members. Hence, in China most low-income people were exposed to the risk of poverty during the pandemic, especially in cases where family members—such as very young or older individuals—were sick. It is clear that the German system provided more comprehensive access than the Chinese system, and German low-income families faced a lesser level of poverty risk than the Chinese population during the COVID-19 pandemic.

**Table 1:** Low-income people’s eligibility for healthcare services

|                | Means-tested/ need-tested | Mandatory or voluntary          | Requirements to access benefits under the policy                                                                             | Can family member be included (pay extra or not?)                         |
|----------------|---------------------------|---------------------------------|------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|
| <b>Germany</b> | Need-tested               | Mandatory                       | Pay contribution; gain equal access to healthcare services.                                                                  | Yes, if beneficiary has children or non-working spouse. Do not pay extra. |
| <b>China</b>   | Need-tested               | Less mandatory + more voluntary | Pay contribution into the voluntary system: access to healthcare services depends on career description and social position. | No, family members pay separately when they need healthcare insurance.    |

Sources: The authors based on Schönbach (2018) and Liu (2021).

***Integrated Policy Dimension 2: Monetary Value of Benefits Received***

Healthcare policy in China allows for variations in the way health insurance is delivered across different provinces. The policy has been applied so that people receive different levels of healthcare benefits based on where they live. During the COVID-19 pandemic, a non-contributory temporary assistance scheme (P.1., Figure 1) under the authority of local governments supported low-income individuals who were unable to afford health insurance and find themselves exposed to poverty risk because they cannot pay for medical care (Chinese General Office of the State 2015). Thus, the P.1. scheme was meant to protect these citizens from shortages in medical resources in the face of the pandemic. This scheme was financed by local governments at the provincial level (Chinese State Council 2020), and the extent to which medical costs were covered depended on the level of economic development in the particular regions. Therefore, in relatively poor regions, P.1. often failed to protect low-income groups from poverty risk for lack of financial resources. In regions with higher socio-economical conditions, P.1. led to successes in protecting low-income groups from the risk of falling into poverty.

Furthermore, whether the state paid non-covered COVID-19-related medical expenses beyond the public healthcare coverage relates to poverty risk among low-income people in China. The Chinese healthcare system developed a “firefighter” policy scheme—C.4., or “the state pays”—to address COVID-19-related costs for people who were not insured under the original four schemes of the healthcare system. However, the overall policy structure did not appropriately serve low-income individuals without basic healthcare insurance, such as day laborers, since these individuals can only access the voluntary healthcare policy scheme.

In contrast, the German healthcare system is mostly publicly financed and thus does not require patients to make upfront payments; therefore, few people in Germany report unmet medical needs, even among low-income groups (Kalánková et al. 2021). A dense network of healthcare facilities and numerous nurses and physicians guarantee the high availability of services across the country (Potter 2019). Thus, financial safety nets and the comparatively low share of patients who incur out-of-pocket health expenses contribute to providing the population of Germany with strong financial protection.

In Germany, the general rules, rights, and values pertaining to healthcare are set out in national legislation—the German Social Code Book, or “SGB V”—and in the constitution, while services are executed at the state level or are delegated to corporatist bodies, such as private healthcare providers. The SGB V mandates that health insurance should “maintain, restore or improve health” (§1), to which end “care is to be provided that reflects needs, is uniform and aligned with the generally recognized state of medical knowledge” (§70). Although not stated as an explicit goal, the German constitution requires that people live in equivalent conditions throughout the country and be treated equally (i.e., in non-discriminatory fashion). Under these regulations, German healthcare policy offers relatively comprehensive protection for low-income populations, and the benefit package is need-oriented. To offset expenditures, citizens pay a relatively small share of costs—for example for doctor’s visits—in addition to their healthcare insurance contributions; but they gain from universal healthcare services. However, we found that citizens with pre-existing conditions were excluded from coverage and that this system could indeed be less welcoming to those with pre-existing or long-lasting health problems. Nevertheless, this limitation has not prevented COVID-19 patients from accessing medical services on the basis of medical need (see Table 2), even if the German healthcare system did not create new policy schemes to specifically address COVID-19 treatment, as China did.

In contrast to low-income people in Germany, Chinese low-income groups must pay high out-of-pocket medical costs even when they are covered under either public or private insurance. Differing significantly from the German scheme, China’s system requires that nearly 90 percent of outpatient service costs, whether incurred in hospitals or clinics, be covered by patients themselves. The Chinese healthcare system covers inpatient medical costs on the basis of a deductible threshold; costs under the threshold must be borne by the patient. Furthermore, out-of-pocket payments may be higher than estimated cost because the Chinese healthcare system only covers the cost of certain medicines, so that not all prescriptions fall under the policy. The list of medicines that are covered is renewed

every year based on new regulations, and the gap between medical needs and medical coverage remains.

In summary, in China, low-income groups face higher poverty risk because they are required to pay out-of-pocket for certain diseases. However, this conclusion does not apply to COVID-19-related medical costs, which have been mostly covered by the state, except in the case of low-income individuals without any basic health insurance. We present a summary comparison of the benefits in China and Germany in Table 2.

**Table 2:** Benefits that low-income individuals can access

|                | Extent to which healthcare policy benefits cover medical needs                                                 | Level of individual compensation to receive benefits                                                                                                 | Co-payment or out-of-pocket costs                                                                                                                                                                                |
|----------------|----------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Germany</b> | Need-based;<br>Comprehensive medical needs can be fulfilled.<br>Patient rights are well-protected and noticed. | Smaller contribution to doctor visit fee;<br>Compensate the gap between pre-existing medical costs and contribution to private healthcare insurance. | Individuals must pay €10 per quarter for doctor's visits. They do not pay if they do not visit the doctor that quarter. The deductible depends on the private insurance plan to which the individual subscribes. |
| <b>China</b>   | Need-based;<br>60%-85% of medical costs are covered<br>Patient rights are protected but unnoticed.             | 15%—40% of medical costs (i.e., the portion of costs uninsured by social healthcare insurance).                                                      | Relatively high out-of-pocket payments into the system; patients pay significant portion of medical costs.                                                                                                       |

Sources: The authors based on Grossmann et al. (2023); Schönbach (2018); Yip et al. (2019); The State Council Information Office of China (2020); and Liu (2021).

Offering broad coverage under the public healthcare insurance scheme, the German system remains more comprehensive than the Chinese system with regard to benefits. Furthermore, in Germany, family members who are not part of the job market, such as non-working spouses, are also insured under the public healthcare insurance scheme, which enhances the prevention of poverty risk. In contrast, in China, low-income groups must pay at least 15 percent of medical costs in addition to out-of-pocket expenses for dependent family members requiring medical services, regardless of their healthcare insurance contribution. Moreover, the extent to which this group may access healthcare insurance benefits is open for debate. Observers are often under the impression that the Chinese policy protects people against absolute poverty by offering nearly free medical care. Our findings support that, in reality, low-income groups are not poor enough to benefit from the free healthcare benefits package. Instead, these groups experience income insecurity and medical resource scarcity, and they are exposed to relatively higher poverty risk than they would be under the German system.

### ***Integrated Policy Dimension 3: Access to LTC benefit***

Given the proven long-lasting health consequences of COVID-19—particularly for older individuals and those with pre-existing conditions such as diabetes and high blood pressure—we analyze how long-term care insurance (LTCI) compensates low-income patients' LTC needs resulting from a COVID-19 infection after initial medical treatment. We argue that acute medical and LTC needs should both be considered together during pandemics, since they are often linked and indistinguishable. It is therefore useful to understand how healthcare systems have integrated LTC in both countries to best cover healthcare needs resulting from the COVID-19 pandemic.

Our findings are that the German LTCI system compensates people for their LTC needs. In principle, the German LTCI covers everyone insured under it. Moreover, it is compulsory for privately insured people to be covered by private LTCI (§1 sent. 2). Therefore, up to 99 percent of the people residing in Germany are covered under public or private LTCI (Kickbusch et al. 2017), essentially making the LTCI a universal system (Theobald and Ozanne 2016). Moreover, employers and employees contribute equally into the system, although the state pays contributions for low-income individuals; and non-employed individuals can be co-insured through the main earner of the household of which they are part. Hence, at the policy level, the German healthcare system and its LTCI are well integrated and need-tested. As a result, low-income people can access generous LTC and medical services when they have mixed (i.e., short-term medical and LTC) needs resulting from the COVID-19 pandemic.

In comparison, the Chinese LTC system has shown weaknesses in the way it is fragmented and less generous in its LTC coverage. In response, the central government has targeted LTC needs in low-income groups and has attempted to establish a dependent LTCI since 2016, which is especially relevant in the context of COVID-19. As a result, approximately 49 cities in China had established pilot LTCI plans by 2020. However, LTCI remains very selective and fragmented, with stark regional disparities. Participation in the pilot LTCI plans has been only voluntary, and people are not eager to contribute because they believe they have enough coverage as is. The key issue in China is that the concept of LTC remains only vaguely defined, and the policy has been designed to target only older adults with disabilities. Moreover, although in principle, everyone covered by health insurance is included in the LTCI scheme, both remain merely voluntary. Statistics reveal that up to 23 percent of older adults—most of whom have a disability or chronic disease—were insured under the Chinese LTCI (Chinese Ministry of Civil Servant 2019) until the COVID-19 pandemic outbreak. Although people were initially not required to contribute to the LTCI system, after a few of years of implementation, a small fee became mandatory as part of people's regular health insurance. Moreover, the state pays the share of low-income people's contributions only if they are already covered under the state's health insurance. To date, there is no evidence that the Chinese LTCI has covered LTC needs resulting from COVID-19 infection in low-income groups. In fact, even in LTCI pilot cities, only a small number of older low-income people have received LTC services

based on severe long-term disability (Cai et al. 2021; Chen and Fang 2021). The Chinese long-term insurance scheme has been unable to support this population's needs for care.

Our findings support that in the German system, healthcare and LTCI were better integrated than in the Chinese system during the COVID-19 pandemic. First, coverage is mandatory in Germany, thus providing good access to care and affording patients free choice of provider and short waiting times. This is partly due to Germany's effective infrastructure, a dense network of ambulatory care physicians and hospitals, and a quantitatively high level of service provision. The routine medical and LTC needs of low-income individuals are largely covered by healthcare and LTCI schemes regardless of people's level of income insecurity in Germany. In contrast, these schemes are only voluntary in China. Second, the German healthcare system and LTCI offer benefits separately based on clear eligibility criteria when there are mixed needs; the two systems in effect compensate for each other. However, in China, from the perspective of service provision, these two systems operate separately, sharing only their source of financing. Third, both the healthcare system and LTCI have strong and separate independent financing sources in Germany. Within the German social insurance system, funding for LTCI is established through contributions. Spending on public LTCI funds amounted to €42.95 billion in 2019, with €25.8 billion spent on home care. Moreover, the public LTCI funds paid out €2.1 billion for pension entitlements to 928,000 working-age family members who cared for relatives in poor health. The relationship between expenditures in cash payments and in-kind services was 70:30 in 2019, and the ratio of cash payments to recipients and in-kind services was 84:16 (Health Ministry 2020). The LTCI funds directly pay state-approved care providers, and the costs of diverse services are predetermined to ensure consistent expenditure across providers and regions (Theobald and Ozanne 2016). In China, LTCI financing comes through the healthcare insurance fund rather than contributions (Li et al. 2020). LTCI payments to municipally approved care services are predetermined in principle, but approval for funding for services in a given year depends partly on the surplus in the healthcare insurance fund in the previous year. Nevertheless, less than 30 percent of the employees' healthcare insurance fund surplus and less than 10 percent of the resident healthcare insurance contribution can be transferred to the LTCI fund (Liu 2021). Fourth, the German system covers family members of potential recipients, which protects low-income individuals from poverty risk. It is possible to conclude that in China, medical care and LTCI are weakly integrated and fail to address the mixed needs of the low-income population. Consequently, low-income people might overuse medical resources for their LTC needs to compensate for the expenses that they are unable to cover for general medical care. During a pandemic outbreak, when medical resources are overall limited, such as during the COVID-19 crisis, poverty risk is heightened for low-income patients when they are unable to access additional medical resources and services.

## **Relationship between Healthcare Policy and Poverty Risk Among Low-income People in Germany and China During the COVID-19 Pandemic**

We have demonstrated that the interplay between healthcare and LTC policy results in differentiated poverty risk outcomes based on the way they support access for low-income people's access to benefits. Low-income people with access to comparatively limited healthcare benefit packages or LTC benefits are exposed to high poverty risk. This risk increases the more access to care is limited. Therefore, a more robust LTC policy could alleviate poverty risk for low-income people. However, this fix also depends on the amount of healthcare benefits available and whether the benefit packages are generous enough to help low-income people, in particular during crises such as the COVID-19 pandemic. Compared to the German policy, the Chinese healthcare policy generally covers less than 85 percent of low-income people's medical needs. Moreover, these people have limited access to public LTC resources when they have mixed healthcare needs (Chinese Health Ministry 2020). The Chinese LTCI has shown to be weak in its coverage of LTC needs resulting from COVID-19 infections. Furthermore, a systematic LTCI policy system does not exist in China; only fragmented LTCI pilot plans have operated in some cities. Finally, when low-income people face mixed medical and LTC needs, they are only eligible for limited LTC benefits, which could lead to high poverty risk. Our findings support that low-income people's poverty risk varies depending on what the focus of the policies are and show that integrating different policy dimensions is important to protect low-income people from poverty risk.

Our findings further indicate that neither adequate access to healthcare nor sufficient benefit amounts are enough by themselves to protect low-income people from poverty risk in China; this insufficiency is also rooted in the fact that the healthcare and LTCI systems do not complement each other well for people with mixed medical needs, unlike in Germany. This was especially pertinent during the pandemic, although the German system does not offer specific coverage in the case of a global public health crisis. Furthermore, we assessed that in welfare states, there is an attempt to decrease the risk of poverty faced by low-income people through institutional regulations that control eligibility levels and focus on policy integration based on needs.

This study introduces a new analytical framework for examining how different healthcare policies contribute to or prevent poverty risk for low-income people during health crises such as the historical COVID-19 pandemic. Our comparative analysis of regulations in China and Germany allows for an assessment of healthcare and LTC policies in welfare states. Previous studies have assumed that social policy in welfare states plays an important role in promoting social equality and in providing access to healthcare resources. This chapter underlines that the failure to systematically consider both the way in which different dimensions of healthcare policy interact and the level of integration of healthcare systems with long-term care policies is significant in addressing poverty risk for low-income people during health crises or pandemics.

Comparing Germany and China is pertinent because both countries share a similar social insurance regulation system but have experienced different policy outcomes in the fight against COVID-19. In addressing post-pandemic needs, China can learn from Germany's effective integration of policy dimensions—especially when it comes to long-term care—to protect people from poverty risk. Conversely, Germany (and other countries) can learn from China's integration of a temporary healthcare scheme within the structure of its social insurance system in the face of acute public health issues, such as a pandemic. In both countries, low-income people's poverty risk was markedly correlated to the receipt of social welfare benefits during the pandemic, because these people bore sudden increases in care needs and medical expenses. Hence, a generous healthcare system in which LTCI is integrated can have a significant impact on preventing poverty risk for those socially disadvantaged group. Future investigations should further compare a range of policy dimensions across different countries, in and outside of Europe, and identify other approaches in the prevention of social inequalities that vulnerable groups may face during pandemics.

## References

- Bureau, Viola Desideria, Hildegard Theobald, and Robert H. Blank. 2007. *Governing Home Care: A Cross-National Comparison*. Edward Elgar Publishing.
- Cai, Wenjia, Chi Zhang, Hoi Ping Suen, et al. 2021. "The 2020 China report of the Lancet Countdown on health and climate change." *The Lancet Public Health* 6 (1): e64-e81. [https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667\(20\)30256-5/fulltext](https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(20)30256-5/fulltext)
- Chen, Weidong, and Xiaohui Yuan. 2021. "Financial Inclusion in China: An Overview." *Frontiers of Business Research in China* 15: 1–21.
- Chen, Yi., and Hanming. Fang. 2021. "The Long-Term Consequences of China's 'Later, Longer, Fewer' Campaign in Old Age." *Journal of Development Economics* 151: 102664.
- Chinese General Office of the State. 2015. "中国国务院办公厅关于进一步完善医疗救助制度、全面开展重特大疾病医疗救助工作意见的通知,国办发(2015)30号" [Improving the Medical Assistance System and Comprehensively Launching Medical Help for People with Serious Diseases].
- Chinese Ministry of Civil Servant. 2019. "民政部: 关于进一步扩大养老服务供给促进养老服务消费的实施意见" [Guidelines to Expanding Old Age Services and Promoting Old Age Consumption in China].
- Chinese State Council. 2020. "中国国务院关于开展城镇居民基本医疗保险试点的指导意见" [Decision on Establishing a Basic Medical Insurance System for Urban Employees].
- EEC (European Economic Community). 1985. Council Decision of 19 December 1984 on Specific Community Action to Combat Poverty. *Official Journal of the European Communities*, no. L: 24–25.

- Grossmann, Beate, Uwe Prümel-Philippson, and Inke Ruhe. 2023. "Die settingbezogene Gesundheitsförderung und Prävention im Spannungsfeld von digitalem Fortschritt und wertebasierter Orientierung–aus Sicht der Bundesvereinigung Prävention und Gesundheitsförderung..." In *Settingbezogene Gesundheitsförderung und Prävention in der digitalen Transformation*. Nomos Verlagsgesellschaft mbH & Co. KG.
- Kalánková, Dominika, Minna Stolt, P. Anne Scott, Evridiki Papastavrou, and Riitta Suhonen. 2021. "Unmet Care Needs of Older People: A Scoping Review." *Nursing Ethics* 28 (2): 149–78. <https://doi.org/10.1177/0969733020948112>.
- Kickbusch, Ilona, Christian Franz, Anna Holzscheiter, et al. 2017. "Germany's expanding role in global health." *The Lancet* 390 (10097): 898–912. [https://doi.org/10.1016/s0140-6736\(17\)31460-5](https://doi.org/10.1016/s0140-6736(17)31460-5).
- Li, Yazi, Chunji Lu, and Yang Liu. 2020. "Medical insurance information systems in China: mixed methods study." *JMIR Medical Informatics* 8 (9): e18780. <https://doi.org/10.2196/18780>
- Liu, Jia. 2021. "Health security and public health emergency management in China." In *Human security in China: A post-pandemic state*. Springer Singapore.
- OECD (Organisation for Economic Co-operation and Development). 2020. *OECD Health Statistics 2020: Definitions, Sources and Methods*. <https://www.oecd.org/health/health-data.htm>.
- Potter, Teddie. 2019. "Planetary health: The next frontier in nursing education." *Creative Nursing* 25 (3): 201–7. <https://doi.org/10.1891/1078-4535.25.3.201>.
- Razavi, Shahra. 2007. *The Political and Social Economy of Care in a Development Context: Conceptual Issues, Research Questions and Policy Options*. United Nations Research Institute for Social Development.
- Ruan, Peiheng, Shuai Wang, and Feng Yun. 2024. "Social insurance law and corporate performance in China." *International Review of Economics & Finance* 94: 103374. <https://doi.org/10.1016/j.iref.2024.103374>.
- Schönbach, Karl H. 2018. *Gesundheitsrecht SGB V/SGB XI*. 2. Auflage. Nomos Verlagsgesellschaft MbH & Co.
- Sipilä, Jorma, Anneli Anttonen, and John Baldock. 2003. "The importance of social care." In *The young, the old and the state: Social care systems in five industrial nations*, edited by Anneli Anttonen, John Baldock, and Jorma Sipilä. Edward Elgar Publishing.
- Song, Suimin, Chunling Ma, Shujin Li, and Bin Cong. 2020. "Developing Medical Examiner Offices in China: Necessity and Administration Mode." *Strategic Study of Chinese Academy of Engineering* 22 (4): 154–60. <https://doi.org/10.15302/J-SSCAE-2020.04.022>
- The State Council Information Office of China. 2020. *Fighting Covid-19 China in Action*. Chinese People's Press.
- Theobald, Hildegard, and Elizabeth Ozanne. 2016. "Multilevel governance and its effects on long-term care support." In *Long-Term Care Reforms in OECD Countries*, edited by Cristiano Gori, Jose-Luiz Fernandez, and Raphael Wittenberg. Policy Press.
- Wendt, Claus, Lorraine Frisina, and Heinz Rothgang. 2009. "Healthcare system types: A conceptual framework for comparison." *Social Policy & Administration* 43 (1): 70–90.

- Xu, Jia. 2019. *Integrated research on ageing policy and poverty risk in European welfare states*. Chinese Commerce and Trade Press.
- Yi, Baokang. 2021. "An overview of the Chinese healthcare system." *Hepatobiliary Surgery and Nutrition* 10 (1): 93–5. <https://doi.org/10.21037/hbsn-2021-3>.
- Yip, Winnie, Hongqiao Fu, Angela T. Chen, et al. 2019. "10 years of health-care reform in China: progress and gaps in Universal Health Coverage." *The Lancet* 394 ( 10204): 1192–1204. [https://doi.org/10.1016/s0140-6736\(19\)32136-1](https://doi.org/10.1016/s0140-6736(19)32136-1).
- Zhu, Na, Dingyu Zhang, Wenling Wang, et al. 2020. "A novel coronavirus from patients with pneumonia in China, 2019." *The New England Journal of Medicine* 382 (8): 727–33.