



## Chapter 3

### The Trends of Government Input to Health Sector

After the introduction of the fiscal decentralization system in the early 1980's, local government has become more responsible for the input to the health sector; government recurrent budget for the health sector depends more upon the fiscal capacity of local government. However in recent years, the capacity of county government in poor regions become weakened. In some counties the local government is even unable to pay the salaries for the health workers regularly.

Government input to the health sector includes the government recurrent budget (GRB) from local government, capital investment (CPT) from government both at the local level and/or above. In addition, government funds are also given to those regions with high prevalence of special diseases such as endemic and parasitic diseases or acute prevailing diseases. In our data analysis, for technical reasons, we couldn't distinguish the latter two categories of government input, so in this thesis we only divided them into two groups, GRB (government recurrent budgets to health sector) and CPT (the rest of government input). GRB is usually provided by the local government for ordinary expenses for staff fees (staff salaries and subsidies, pensions, medical expenses for staff) and operational fees (for daily activities, such as public use, staff training, traveling, health promotion and education, building re-construction, small-scale equipment purchase, reagents etc.). Capital investment is usually used for large-scale equipment purchase, building construction, prevention and control for some special diseases etc. and is provided either by local government or by government at higher levels.

#### 3.1 Decline in Government Recurrent (GRB) Budget in Relation to GCP

Because we do not have the total health expenditure at county level, the ratio of GRB to GCP (general county production) is used here as one measurement to estimate the extent of government support to the health sector. Table 3.1 shows the recent trends of the ratio in each county. It could be

seen from this table that in general, all the ratios for those 5 counties showed declining trends. For example, JR county, Jiangsu Province, GRB accounted for about 0.4% of GCP in 1985, it declined to around 0.3% at the end of the 1980's and continued to decrease to 0.14 % in 1993. In Shanxi province, SY county allocated 1.4% of GNP to health sector in 1985, but it declined to 0.9% at the end of 1980's, and to less than 0.8% in 1993. In LP county, Guizhou province, though the ratio seemed higher than those found in other two provinces, the same trends were also found.

In general, the ratio of GRB to GCP in poorer regions seems higher than in richer province, reflecting the lower GCP and lower sufficiency in poor areas, but also presumably reflecting a smaller drop in relative funding.

Table 3.1 Proportion of Government Recurrent Budget to GCP in the 5 counties (1985-1993) (1/100)

Year	SY	QI	JR	DY	LP
1985	1.361	0.795	0.402	0.270	1.290
1986	0.985	0.855	0.329	0.318	1.032
1987	0.906	0.742	0.301	0.266	1.077
1988	0.887	0.698	0.308	0.260	0.720
1989	0.899	0.756	0.295	0.315	0.757
1990	0.877	0.776	0.247	0.348	1.156
1991	0.897	0.812	0.228	0.372	1.199
1992	0.861	0.809	0.409	0.160	1.327
1993	0.787	0.707	0.140	0.236	1.078

Note: SY = Shouyang County      Qi = Qi County  
 JR = Jurong County              DY = Danyang County  
 LP = Lipo County

### 3.2 Decline in Government Recurrent Budget (GRB) to Total Local Government Expenditure

The percentage of total local government expenditure is another important measurement which also reflects the extent of government financial support to the health sector. Like the ratio of GRB to GNP, a slight decreasing trend could also be found from the mid 1980s' for most of the counties. Thus, JR

county, Jiangsu province, compared to DY county, is much poorer. The proportion of local government budget allocated to the health sector kept decreasing, from 0.81% in 1985 to 0.34% in 1993. But in DY county, one of the top hundred most developed counties in China, this proportion did not change too much, ranging from 0.75 % to 0.63% during the whole period. (Table 3.2) For the two counties of Shanxi province, the proportion kept around 0.7%.

Table 3.2 Proportion of Government Recurrent  
to Total Government Expenditure in 5 Counties  
(1985-1993) (1/100)

Year	SY	QI	JR	DY	LP
1985	0.980	0.800	0.805	0.750	0.400
1986	0.651	0.727	0.579	0.722	...
1987	0.697	0.794	0.555	0.739	...
1988	0.635	0.722	0.683	0.743	...
1989	0.717	0.728	0.547	0.743	0.481
1990	0.763	0.788	0.845	0.653	0.717
1991	0.887	0.700	0.434	0.641	0.679
1992	0.828	0.759	0.367	0.663	0.704
1993	0.826	0.650	0.344	0.632	0.679

### 3.3 Ratio of Budget for Preventive Activities to GCP

The results from this survey show that the ratio of budget for preventive medicine varied from county to county ranging from 1 to 2 per thousand in Province of Shanxi and Guizhou provinces. In Jiangsu province (DY and JR county), the ratios were much lower than those in Shanxi and Guizhou provinces. In DY county, of 1000 Yuan GCP, only 0.2 Yuan were allocated to the preventive health sector in the mid-1980's and this dropped to 0.11 Yuan in 1993 (Table 3.3). In JR county in Jiangsu province, of 1000 Yuan GNP, 0.86 Yuan were allocated to the preventive health sector in 1985. It decreased to 0.37 Yuan in 1993.

It is important to notice that all the ratios showed the decreasing trends from 1985 to 1993, illustrating the reduced attention given by the local government to preventive health

activities, especially in Guizhou province which is considered as one of the poorest provinces in China. In LP county, one of the most poverty stricken counties in Guizhou province, 2.6 Yuan per thousand Yuan GNP was allocated to the preventive sector, but it dropped to 1.00 per thousand, in 1993 only 38% of that in 1985.

Table 3.3 Proportion of Preventive Budget Relative to GCP in 5 Counties (1985-1993) (1/100)

Year	SY	QI	JR	DY	LP
1985	0.079	0.127	0.086	0.021	0.260
1986	0.078	0.100	0.075	0.024	0.210
1987	0.062	0.112	0.066	0.019	0.138
1988	0.062	0.124	0.063	0.017	0.094
1989	0.063	0.124	0.056	0.019	0.143
1990	0.046	0.082	0.058	0.018	0.147
1991	0.046	0.093	0.049	0.018	0.190
1992	0.049	0.113	0.032	0.013	0.149
1993	0.052	0.080	0.037	0.011	0.100

For EPS and MCH, the government subsidy was their main income before economic reform. But after economic reform government decreased their recurrent budget year by year and the 'staff fee' increased year by year due to the living standard rise and the staff number increase in EPS and MCH. For survival, the managers of EPS and MCH found two ways: one was reducing the daily preventive activities. The other was providing some charged services to supplement the gap in government budget, such as out-patient service. The consequence was that the quality and quantity of preventive service decreased, for example, most of EPS provided immunization monthly before economic reform, but now some of EPS provide it every two months or three months. The result is the immunization coverage decreased and the morbidity of vaccine-preventive disease increase. Another phenomena was that morbidity of communicable disease had an increasing trend at beginning of 1990's. This trend never appeared after 1950's till 1990 even during the 'culture revolution' in the middle of 1960's. In

some provinces in southern China, schistosomiasis, which was announced as being eliminated recurred recently and the prevalence of Hepatitis A in Shanghai in Spring 1988 was an inevitable outcome of the functional change of EPS.

### 3.4 Conclusions

From the above analysis, we can get some conclusions on the trend of government input to the health sector.

1. The proportion of government health expenditure to GNP has decreased. It means that with increasing economic development, the government health investment has slowed disproportionately.
2. The ratio of government recurrent budget for health to total government expenditure has also followed a decreasing trend.
3. Especially for the preventive sector, the proportion of budget to GCP decreased dramatically. It means that government paid less and less attention to the preventive health sector.