Increased Fiscal Autonomy: A Study on the Impact of Local Government Expenditure on Maternal and Child Welfare on Maternal and Infant Mortality in the United Kingdom

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1 Motivation and Research Question

The United Kingdom's pre-NHS healthcare landscape was defined by decentralized provision, where local authorities held primary responsibility for public health. This system created a profound postcode lottery, where the quality and availability of maternity services depended heavily on geographic location and local political will. This paper investigates whether increasing the fiscal autonomy of local governments through the 1929 Local Government Act—which replaced matching grants with a fixed sum Block Grant—had a causal impact on maternal and infant mortality. Specifically, this study asks if allowing local officials greater discretion in resource allocation led to improvements in early-life health outcomes by enabling more efficient, localized investments.

2 Contribution to Literature

This research sits at the intersection of public finance and health economics, contributing to three primary strands of literature.The paper contributes to the literature on fiscal federalism by empirically testing how the design of cost-sharing between central and local governments influences local incentive structures. This work complements research on safety nets, such as the impacts of U.S. Medicaid expansions on infant mortality, by offering a historical parallel to contemporary geographic disparities in access to care.

3 Data and Setting

The study utilizes a unique, hand-digitized panel dataset spanning 1923 to 1937, covering 83 UK County Boroughs. To capture the postcode lottery, I digitized historical Local Government Financial Statistics, which provide a granular breakdown of local and central government expenditure on specific public health services. Outcome data on maternal and infant mortality were sourced from the Annual Report of the Registrar General. This setting is particularly original as it captures the final era of decentralized healthcare in

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the UK before the 1948 transition to the National Health Service (NHS), allowing for an evaluation of a universal system in its formative, localized stage.

4 Methodology

To identify the causal impact of expenditure on health outcomes, the paper employs an Instrumental Variables (2SLS) strategy within a difference-in-differences (DD) framework. This approach overcomes the inherent endogeneity between healthcare spending and mortality—where areas with poor health may spend more out of necessity. The study exploits the transition from matching grants to the Block Grant in 1929. The identification utilizes an intensity measure—defined as a borough's total government grants in 1929 as a percentage of its total rateable property value—to capture the exogenous change in fiscal prioritisation. In the first stage, the paper estimates the effect of the Block Grant on the proportion of public health funds devoted to maternity and child welfare (MCW) services. In the second stage, this policy-induced shift in expenditure is used to estimate the impact on infant and maternal mortality.

5 Main Results

The analysis reveals three major findings. First, the introduction of the block grant led to an exogenous increase in the fiscal prioritization of MCW services; areas most impacted by the reform significantly increased the proportion of their health budgets devoted to maternity care. Second, this increased expenditure had a robust causal impact on reducing infant mortality. For boroughs classified as compliers, the introduction of increased autonomy reduced All Under 1 Year mortality by 2.48 standard deviations and All Under 4 Weeks mortality by 1.15 standard deviations. Third, in contrast to the infant outcomes, there is no significant impact on maternal mortality—including puerperal sepsis and childbirth-related deaths—though point estimates moved in the expected negative direction. This suggests that MCW services in this period were more effective at addressing infant-specific risks, such as neonatal hygiene and nutritional support, than clinical maternal complications.

6 Policy Implications

These findings provide a powerful empirical case for the importance of early-life health investments, demonstrating that even in a decentralized postcode lottery system, increasing local fiscal autonomy can yield massive returns if directed toward maternal and infant welfare. For modern policy makers, particularly in regions where maternal health disparities remain high, this research suggests that the design of fiscal transfers is as critical as the total volume of funding. By allowing for efficient resource allocation at the local level, governments can successfully mitigate the hereditary taint of poverty and improve the long-run starting line for the next generation.