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FISCAL DECENTRALISATION, CHINESE STYLE: GOOD FOR HEALTH OUTCOMES?

by

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PREFACE

Improving access to affordable health care is one of the main challenges facing policy makers in developing countries, and China is no exception. President, Hu Jintao, has proclaimed that policies should foster a "harmonious society", but the economic consequences of illness - in rural China in particular - pose a serious obstacle to reaching this objective. Medical costs undermine the health of millions of Chinese by forcing them to pay expenses out-of-pocket in the hope of future earnings, or to delay treatment or else to cancel it altogether. To cope with this immense challenge, the Chinese government has introduced various institutional innovations - most recently the "new rural type co-operative medical care" - while reforming the administration and governance of social programmes and investment. The Chinese experience is very interesting in that it stands apart from most other countries: while considerable fiscal decentralisation has been undertaken on the expenditure side, the revenue side has been recentralized since a major reform in 1994.

Decentralisation in all countries, but especially in developing ones, does not, necessarily, lead to reductions in poverty and/or inequality. It is thus one of the Development Centre's objectives to establish guidelines for decentralisation policies that do favour developmental outcomes. Hence this case study of China. The authors find that the system of transfers from the centre to the province and county, and from the richer provinces to the poorer ones, must itself function efficiently. Fiscal decentralisation needs to be accompanied by the provision of adequate human and physical resources. Their analysis also points to the importance of the local governments' own capacity for raising resources.

This case study is of great value beyond the specific Chinese context. It clearly emphasises the need for more internal policy coherence to achieve self-proclaimed targets. In its current work programme on "Work and Well-Being" the Development Centre looks precisely at identifying the institutional and regulatory frameworks that promote synergies between the employment and social protection agendas. More coherent and better integrated policies can better contribute to the fight against poverty and social exclusion.

Javier Santiso

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RÉSUMÉ

Ce papier analyse l'effet de la décentralisation fiscale sur la santé en Chine, à partir d'une analyse de panel avec des données de district recueilli au niveau national. Les auteurs trouvent que, sous certaines conditions, les districts aux systèmes plus décentralisés ont des taux de mortalité infantiles moins élevés que ceux où le gouvernement provincial reste la principale autorité. Les responsabilités pour les dépenses au niveau local doivent toutefois être accompagnées de capacités fiscales adéquates. Pour les gouvernements de districts à bas revenus, la capacité à investir dans des biens publics comme les services de santé, dépend principalement des transferts intergouvernementaux. Les analyses confirment l'argument selon lequel la décentralisation fiscale peut mener à une plus grande efficacité des biens publics, en soulignant les conditions nécessaires pour atteindre ce résultat.

Mots clefs: Santé ; financement des services de santé ; décentralisation fiscale ; Chine.

Classification JEL: H51; H72; H75; I18.

ABSTRACT

This paper analyses the effect of fiscal decentralisation on health outcomes in China using a panel data set with nationwide county-level data. We find that counties in more fiscally decentralised provinces have lower infant mortality rates than counties where the provincial government remains the main spending authority, if certain conditions are met. Spending responsibilities at the local level need to be matched with county governments' own fiscal capacity. For county governments that have only limited revenues, the ability to spend on local public goods such as health care depends crucially upon intergovernmental transfers. The findings of this paper, therefore, support the common assertion that fiscal decentralisation can lead to more efficient production of local public goods, while also highlighting the conditions required for this result to be obtained.

Key words: Health; Health-care finance; Fiscal decentralisation; China.

JEL Classification: H51; H72; H75; I18.

I. INTRODUCTION

Fiscal decentralisation has become a worldwide trend. The literature indicates that transferring authority and resources from central to local tiers of government brings allocative benefits for the provision of local public goods (Dethier, 1999; Bardhan, 2002). In particular, in developing countries where considerable attention is given to the achievement of the Millennium Development Goals, it is hoped that fiscal decentralisation can improve access to health care and other social services. How?

China is a very interesting case study for testing whether fiscal decentralisation indeed leads to improved production of local public goods and services. With its large size and population, China is one of the most decentralised countries in the world in terms of the spending authority assigned to the local governments. The health sector, in turn, is particularly interesting for assessing the impact of fiscal decentralisation on public goods. This sector has been undergoing reform for over 30 years, with considerable changes in the provision and financing of health care services. The Chinese experience stands apart from that of other countries in that, while considerable fiscal decentralisation has been undertaken on the expenditure side, the revenue side has been recentralised since a major reform in 1994. Moreover, and contrary to other experiences in developing countries, there has been no political decentralisation: local government officials are accountable not to the local electorate but to higher-level government officials.

Most studies on the impact of fiscal decentralisation in China have used province-level data (e.g. Jin *et al*., 2005; Tochkov, 2007). Several of these studies point to increasing spending inequalities among Chinese provinces that translate into widening spatial inequalities in access to health care (OECD, 2006; Kanbur and Zhang, 2003). Jin and Zou (2005) examine the fiscal relationship between central and provincial governments in China. Using the relative importance of the provincial government on the revenue and expenditure sides as fiscal decentralisation indicators, they analyse the impacts of fiscal decentralisation on economic growth. In addition, Zhang (2006) analyses the influence of fiscal decentralisation on regional growth and inequality in China. He focuses on fiscal decentralisation below the province level by using county-level fiscal data.

In this paper, we employ panel-data analysis using county-level data to estimate the impact of fiscal decentralisation on health outcomes. In particular, this allows us to address developments within provinces. As intermediaries between central/provincial government and townships, counties are highly important to health-care provision and thereby influence health

outcomes. Two key questions guide our analysis. First, do more decentralised county governments perform better, as measured in terms of lower infant mortality rates, than counties in which the provincial government plays a larger role in the provision of public services? Second, what role do transfers between the layers of government play in explaining different health outcomes? In China, fiscal transfers, including several kinds of subsidies, from the central to local governments play an increasingly important role in dealing with the rising inequality between and within provinces.

The next section provides a short theoretical snapshot of fiscal decentralisation and health outcomes with reference to the Chinese context. Section 3 presents the data used and descriptive statistics, while section 4 presents the results of the empirical analysis. The last section presents preliminary policy implications and our conclusions.

II. A SIMPLE FRAMEWORK: FISCAL DECENTRALISATION AND HEALTH

The administrative structure of the health sector in China is presented in a stylised way in Figure 1. The "Government" column represents the vertical alignment from the central government to lower tiers of government. The same vertical alignment is shown for health-sector administrations. The rows show the linkages between the government and health administrations at each level of government: central, province and county.

The figure also indicates the direction of flows within the system. Public funds for health flow from the upper to the lower tiers of government, and from the upper to the lower tiers of the health administration system (vertical arrow). At each level of government, these funds flow from the government to health administrations (horizontal arrow).

Figure 1. **The Administrative and Fiscal Structure of the Health Sector**

Government	Health Administration	(Disease control and prevention)
Central	Ministry of Health	(China CDC*)
Province [Prefecture (*Diqu*)]	Provincial Health Bureau	(Provincial CDC)
County [Township]	County Health Bureau	(County CDC)

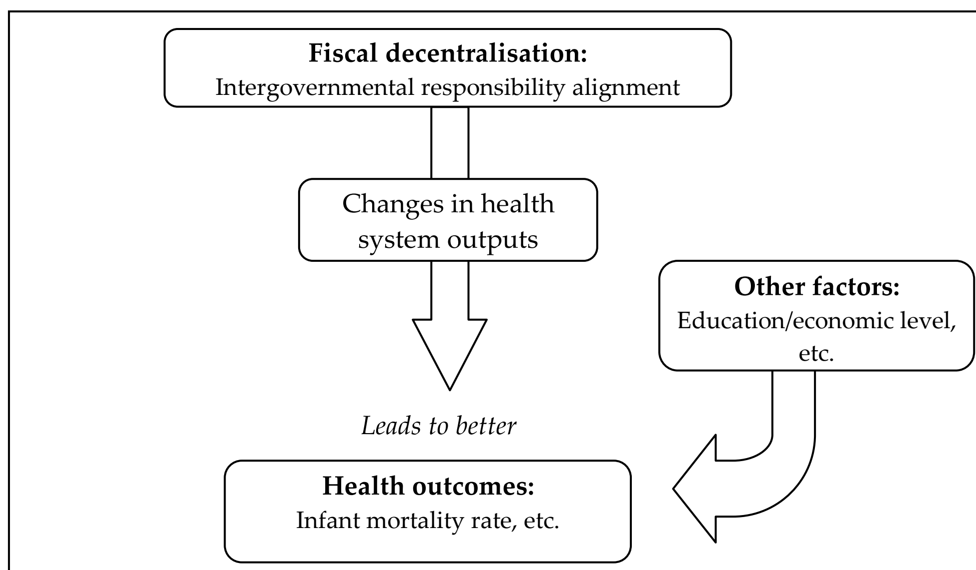
Note: * China CDC is formally the Chinese Centre for Disease Control and Prevention, which was created in 2002 (Peng *et al.*, 2003).
Source: Authors' compilation.

The central and provincial governments are responsible for broader policy and strategic design, as well as investment in major health infrastructure, whereas the counties have practical responsibility for implementing health programmes or services. Large provinces such as Hebei and Sichuan have more than 100 counties each. The fiscal or institutional capacity of the county government is critically important for the provision of appropriate health services, and ultimately for achieving better health outcomes among the local population.

Figure 2 presents a simple framework that links fiscal decentralisation to health outcomes. Following the conventional thinking on fiscal decentralisation and its relationship to the provision of a local public good, the following stylised chain of interaction can be established. Fiscal decentralisation assigns more financial responsibility for health service provision to lower

tiers of government – in the Chinese case, to the county level. This will bring about responsive service provision, as lower tiers of government can provide health care services more efficiently because they have better information on the needs of their citizens. Local government, with a "helping hand" (Shleifer and Vishny, 1998), will further invest in and develop the health system, which will lead in the medium- to long-run – in conjunction with other measures such as improved education – to improved health outcomes.

Figure 2. **The Linkage between Fiscal Decentralisation and Health**



This line of argument is subject to several caveats. First, local governments are not necessarily responsive to the needs of voters. In China, local government officials are generally not elected by universal suffrage, but they are elected by the Party, and hence may not be responsive to local needs and preferences. Local officials may be more interested in supporting local business development than in investing in provision of social services, notably low-cost primary health care. In fact, local governments may play the role of a "grabbing hand" by investing more in provision of more expensive tertiary health care (e.g. in hospitals) than in the further development of primary health care. Second, provision of health care services that have interjurisdictional spillover effects, such as immunisation, might suffer in a decentralised setting, as local governments have less incentive to provide such services. Third, designing a functioning intergovernmental fiscal transfer system that reconciles different revenue capacities is a challenge. Conditional transfers will reduce the expenditure management (decision-making) autonomy of local government, which would weaken the responsiveness of the public services it provides. In contrast, unconditional transfers would reduce the incentives for local government to manage funds efficiently (de Mello, 2000).

Hence, whether fiscal decentralisation leads to an improvement in health outcomes and whether fiscal transfers can play a smoothing role are questions that require empirical investigation.

III. MODELLING THE IMPACT OF FISCAL DECENTRALISATION ON HEALTH OUTCOMES: BASIC MODEL, DATA AND DESCRIPTIVE STATISTICS

III.1 Basic Model[1]

To assess empirically the question of whether and under which conditions Chinese-style fiscal federalism improves health outcomes, we apply a fixed-effects model to our panel data set. The basic model is as follows:

$$y_{it} = \alpha + \beta X_{it} + \gamma C_{it} + v_{it} \qquad (1),$$

where i denotes the province, t time, X fiscal decentralisation indicators, C the control variables and y the provincial infant mortality rate, while v is an error term. The following variables are used in the empirical analysis.

Dependent variable

The dependent variable in our model is "health outcomes", measured by provincial infant mortality rates per thousand live births (*IMR*).

Explanatory variables

1) Fiscal decentralisation indicators

For our quantitative examination of fiscal decentralisation below the province level, we use the following two indicators: vertical balance (*VB*) and the ratio of county expenditure to total provincial expenditure (*RCE*). These indicators are defined as follows:

Vertical balance (*VB*):

$$VB_j = \sum_i CE_{ij} \Big/ \sum_i COR_{ij} \qquad (2),$$

where j denotes the province and i the county, CE_{ij} is the expenditure of county (i) in province (j) and COR_{ij} is that county's own revenue. Hence, the numerator is counties'

[1] Descriptions of variables are summarised in Table A1 in the Appendix.

expenditure aggregated at the provincial level, and the denominator is counties' own revenue aggregated at the provincial level. Accordingly, *VBj* is the ratio of counties' aggregate expenditure to counties' aggregate own revenue in a given province (*j*).

If *VBj* is greater than one, counties' aggregate expenditure exceeds counties' aggregate own revenue in province (*j*). This indicates a fiscal gap at county level that has to be filled with intergovernmental transfers, including various kinds of subsidies[2]. If *VBj* is less than one, then revenues at county level are sufficient to pay for the assigned expenditures. Hence, the vertical balance is a good indicator of whether transfers from the provincial or central government are needed to meet the expenditure assignments of the counties.

Ratio of county expenditure to total provincial expenditure (*RCE*):

$$RCE_j = \sum_i CE_{ij} \Big/ TPE_j \quad (3),$$

where *TPEj* denotes total provincial expenditure, which consists of aggregate *CEij* in province (*j*) plus the expenditure of the provincial government (*j*)[3]. Thus, *RCEj* is always less than unity. It measures the ratio of counties' aggregate expenditure in province (*j*) to the total fiscal expenditure of province (*j*), and captures the relative importance of counties as public-service providers. This is an important indicator of the extent of fiscal decentralisation below the province level. As observed below, this ratio varies across provinces in China, which means that fiscal expenditure is more decentralised to the county level in some provinces than in others.

2) Socioeconomic characteristics

Social characteristics are measured by educational level and fertility rate at the province level. The provincial illiteracy rate (among the population aged 15 and over) is the percentage ratio of the number of illiterates to the total population aged 15 and over, which is used in our model as a proxy for the educational level. The fertility rate is measured by the provincial birth rate, which is the ratio of the number of births to the average population of the province.

The economic characteristics used are the economic level of the province and the size of the provincial government. Economic level is measured by provincial per capita GDP, and provincial government size is measured by the province's total fiscal expenditure relative to provincial GDP. The rural/urban ratio, which captures both social and economic characteristics of the province, is the ratio of the rural population to the urban population in the province.

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[2] It would have been interesting to disaggregate the "intergovernmental transfers" variable further into conditional and unconditional transfers, and on this basis to create another fiscal decentralisation variable. Unfortunately, these data were not available.

[3] *TPE* also includes the expenditure of the prefecture (*Diqu*), the administrative/governmental characteristics of which differ significantly between provinces.

III.2 Data

To construct the two fiscal decentralisation indicators, we use county governments' fiscal expenditure, county governments' own revenue[4] and total fiscal expenditure at the province level. The source of the county data is *Prefecture and County Level Public Finance Statistics* (*Quanguo Di Shi Xian Caizheng Tongji Ziliao*). The provincial data are from the *Finance Yearbook of China and the China Statistical Yearbook*. Provincial infant mortality rates were supplied by the *Beijing Centre for Disease Prevention and Control*[5]. The provincial illiteracy rate for the population aged 15 and over is calculated from the *China Population Statistics Yearbook*. Provincial per capita GDP is from the *China Compendium of Statistics*, which also serves as the basis for calculating the provincial birth rate and provincial rural/urban ratio.

Problems of data availability limit the implications that can be drawn from our analysis. For instance, it would have been very useful to include "health expenditure at county level" as a further explanatory factor and to use variables other than infant mortality rates as proxies for health outcomes. It is to be hoped that the Chinese government's increased interest in health issues will lead to improved data quality and availability, allowing for studies that are not constrained by the limitations of the existing data.

III.3 Descriptive Analysis

This paper employs the fiscal decentralisation indicators defined above to capture fiscal decentralisation below the province level in China. We use panel data covering 26 provinces over a seven-year period (1995-2001) for our quantitative analysis[6].

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[4] We include tax refunds in counties' own revenue because the fiscal characteristics of tax refunds in the Chinese sense define them this way rather than as transfers. See OECD (2006) for details of the fiscal system.

[5] The data set is available from the authors upon request.

[6] Our data set does not include Tibet, Beijing, Tianjin and Shanghai because of their exceptional nature. County expenditure in Tibet depends greatly on resources received from the upper tiers of government. The vertical balance (seven-year average) of Tibet is 5.7, which means that Tibet's county expenditure is almost six times as much as its own revenue. This level is exceptionally high compared with other provinces. Regarding Beijing, Tianjin and Shanghai, their county expenditure ratio (seven-year, three-province average) is 8.3 per cent, which is very low compared with other provinces. As these are large province-level municipalities, they may differ from other provinces in terms of administration or fiscal treatment. Hence, we exclude these three provinces as well as Tibet from our data set. Since 1997, Chongqing has also been one of the large province-level municipalities. Thus, we do not include Chongqing in our data set from 1997 to 2001. Before 1997, Chongqing was considered a district of Sichuan province, and our data set for 1995 and 1996 reflects this situation.

Table 1. **Descriptive Statistics of Major Variables**

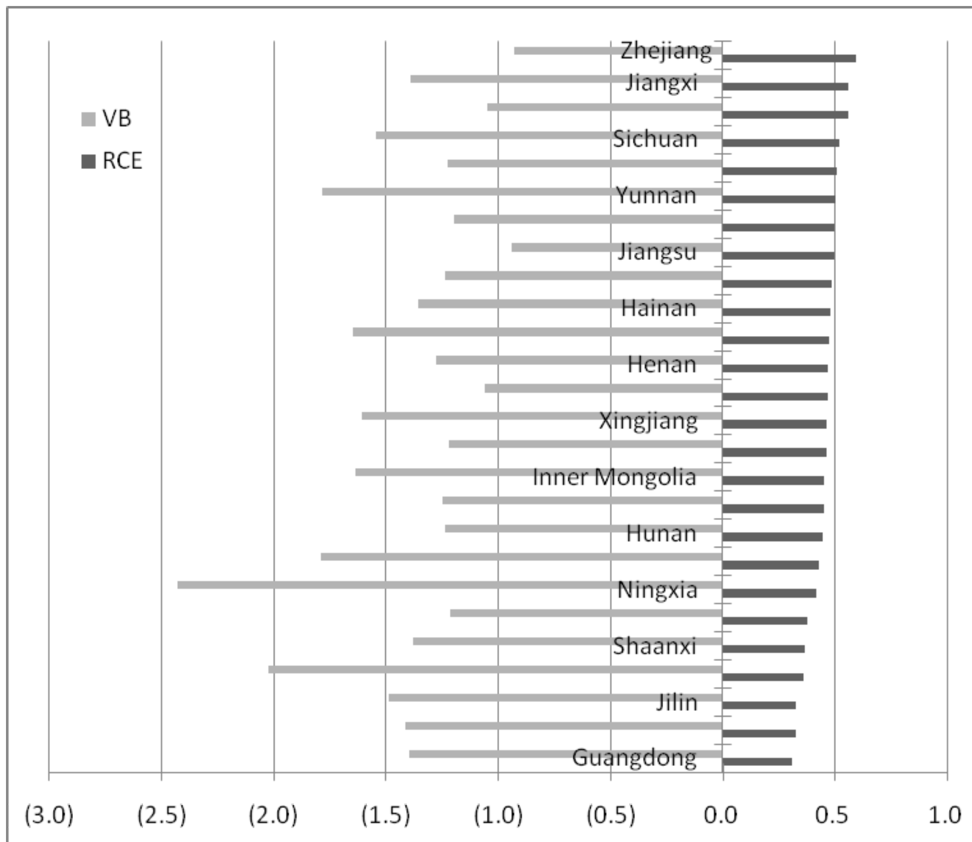
	Obs.	Mean	Std. Dev.	Min.	Max.
IMR	182	21.96	9.34	8.99	50.28
VB	182	1.36	0.37	0.77	2.59
RCE	182	0.45	0.08	1.21	0.61
Economic level	182	6 031.7	2 705.3	1 853.0	14 655.0
Rural/urban ratio	182	2.44	1.20	0.23	6.24
Birth rate	182	15.29	8.25	7.70	115.00
Illiteracy rate	182	16.75	8.16	5.07	51.45

Table 1 reports descriptive statistics of our panel data set. The infant mortality rate (IMR) varies across provinces and over the period covered. The lowest IMR (8.9) is for Zhejiang province in 2001, and the highest (50.2) for Qinghai province in 1996. The lowest figure is much better than in other Asian countries (for example, the IMR of the Philippines was 30.0 in 2000), while the highest (50.2) is worse than those of other Asian countries (for example, Indonesia's IMR was 48.0 in 1995). Socioeconomic characteristics also differ across provinces and over time. It is now well known that there are significant economic differences between provinces in China. In addition, our observations indicate that social characteristics, such as educational level, differ across provinces and over the period considered. Table 1 shows that both *VB* and *RCE* differ between provinces. As these are our most interesting variables, further details on them are reported below.

Figure 3 presents the *VB* and *RCE* of 26 provinces in 2000. *VB* is greater than one in most of the provinces, which means that counties depend on intergovernmental fiscal transfers to carry out their responsibilities. We confirm that the degree of *VB* varies across provinces. In addition, we find no particular trend relating *VB* to *RCE*. The proportion of county expenditure covered by intergovernmental transfers is high in some provinces, but *RCE* (the relative expenditure importance of counties to province) is not necessarily high in these provinces. The province-county fiscal relationship differs from one province to another in China[7]. For instance, Figure 3 shows that Zhejiang has the highest *RCE* among the provinces, which means that county expenditures are high relative to total provincial expenditure; however, Zhejiang's *VB* is not very high compared with other provinces. The *RCE* of Guangdong is the lowest among the provinces, but Guangdong's *VB* is higher than that of Zhejiang. This suggests that counties in some provinces might have a relatively high fiscal capacity, whereas counties in other provinces might have insufficient fiscal capacity to meet their responsibilities.

[7] Note that differences in the depth of fiscal decentralisation below the province level (the province-county relationship) do not necessarily relate to the economic level or the geographical patterns of the provinces (OECD, 2006). The value of RCE could reflect differences in the fiscal administrative system below the province level. Basically, there are three tiers of government from the province level down: province, prefecture and county. In some provinces, the provincial government is directly linked to the county governments, while in others the prefecture governments play an intermediary role between province and county. A higher RCE value might measure a difference in the administrative structure within a province, instead of measuring only the depth of fiscal decentralisation.

Figure 3. **VB and RCE in 2000**



IV. EMPIRICAL ANALYSIS

We employ a fixed-effects model for our analysis. Hence, the estimation model is:

$$y_{it} = \alpha + \beta X_{it} + \gamma C_{it} + \mu_i + u_{it} \qquad (4),$$

where μ_i is the unit-specific residual. As μ_i differs between units (provinces) but is time-invariant, it captures the unit-specific characteristics that do not change over time. In our model, these unit-specific characteristics can be considered to be provincial geographical characteristics, etc. The fixed-effects model is also supported by model tests[8].

To examine the impact of fiscal decentralisation below the province level on health outcomes, we examine the following sets of models, which focus respectively on vertical balance and the relative expenditure importance of the county concerned.

Models (a-b) $IMR = f(VB, Econ, Rural, Fer, Edu)$ (5),

where *IMR* is the provincial infant mortality rate (which is our dependent variable, i.e. health outcome), *VB* counties' aggregate vertical balance, *Econ* the economic level of the province measured by provincial per capita GDP, *Rural* the rural/urban ratio in the province, *Fer* the provincial fertility rate and *Edu* the illiteracy rate, which is a proxy for educational level. In the first set of models, we focus on the effect of vertical balance on health outcomes. Model (b) includes the *RCE* to control for the influence of the relative expenditure importance of the county concerned.

Models (c-d) $IMR = f(RCE, Econ, Rural, Fer, Edu)$ (6),

where *RCE* denotes the ratio of countries' aggregate expenditure to total provincial expenditure. In this set of models, we examine the effect on health outcomes of the relative expenditure importance of the county government compared with the provincial government. In model (d), the coefficient of *RCE* will be interpreted more clearly as the effect of the relative

[8] The model is tested by an F-statistical test and the Hausman test, which supports the fixed effects model.

importance of the county government on *IMR* than in model (c), because we control for the influence of the denominator of *RCE* by including provincial government size as a control variable.

Models (e-f) $IMR = f(VB, RCE, INT, Econ, Rural, Fer, Edu)$ (7),

where *INT* denotes the intersection term of *VB* and *RCE*. This term is included in model (e) to examine the effect on health outcomes of the interaction between these variables. Model (f) includes both the intersection term and provincial government size.

We need to give particular attention to the interpretation of models including the intersection term. The estimation equations of models (a) and (c) are, respectively:

$$\ln(IMR_{it}) = \alpha + \beta_1 \ln(VB_{it}) + \gamma C_{it} + \mu_i + u_{it} \quad (8),$$
$$\ln(IMR_{it}) = \alpha + \beta_1 \ln(RCE_{it}) + \gamma C_{it} + \mu_i + u_{it} \quad (9).$$

β is interpreted as the elasticity of *VB* or *RCE* with respect to the infant mortality rate; here, it is fixed as β_1.

The estimation equation of models (e) and (f) is:

$$\ln(IMR_{it}) = \alpha + \beta_1 \ln(VB_{it}) + \beta_2 \ln(RCE_{it}) + \beta_3 \ln(RCE_{it}) * \ln(VB_{it}) + \gamma C_{it} + \mu_i + u_{it} \quad (10).$$

In these models, the intersection term allows the elasticity to vary. The elasticity of *VB* to *IMR* is $\partial \ln IMR / \partial \ln(VB) = \beta_1 + \beta_3 * \ln(RCE)$. Similarly, the elasticity of RCE with respect to IMR is $\partial \ln IMR / \partial \ln(RCE) = \beta_2 + \beta_3 * \ln(VB)$. Therefore, the elasticity varies with the value of *VB* or *RCE*.

Table 2 summarises the main results. First, we examine the effect of *VB* on health outcomes (*IMR*). Vertical balance captures the importance of fiscal transfers, including various kinds of subsidies, from higher levels of government to counties, which fill the potential fiscal gaps of the counties. The simplest model is model (a), which includes *VB* as measure of fiscal decentralisation. In this model, the coefficient is negative and statistically significant; that is, when *VB* increases, *IMR* decreases. This result is confirmed in model (b), in which we control for *RCE*. This result suggests that intergovernmental transfers to county governments are important for achieving better health outcomes, after controlling for the influence of the relative expenditure importance of the county government. However, in model (e), which includes the intersection term between *VB* and *RCE*, the coefficient of *VB* is not statistically significant.

Second, we focus on the effect of *RCE* on *IMR*. Is an increase in the relative expenditure importance of the county government good for health outcomes? All coefficients of *RCE* are

statistically significant. The coefficient of the intersection term is statistically significant in model (e), but less significant in model (f). The coefficient of *RCE* is negative in models (c) and (d), which means that *IMR* is lower in provinces where the relative expenditure importance of county governments is greater.

Table 2. **Impact of Fiscal Decentralisation on Health Outcomes**

Dependent variable	Infant mortality rate (ln)							
	(a)		(b)		(c)		(d)	
Independent variable								
(a) VB: Vertical balance (ln)	-0.191	(-2.20)*	-0.230	(-2.57)**				
(b) RCE: Ratio of county gov't expenditure (ln)			-0.187	(-3.27)**	-0.161	(-2.81)**	-0.165	(-2.69)**
Per capita GDP (ln)	-0.221	(-2.43)*	-0.236	(-2.59)**	-0.313	(-3.74)**	-0.163	(-2.07)*
Rural/urban ratio	0.016	(0.74)	0.008	(0.38)	0.018	(0.84)	0.021	(1.10)
Birth rate	0.004	(4.21)**	0.003	(4.08)**	0.004	(4.36)**	0.004	(4.18)**
Illiteracy rate	0.009	(4.49)**	0.008	(4.35)**	0.009	(4.38)**	0.005	(2.24)*
Provincial gov't size							-2.158	(-4.47)**
Number of observations	182		182		182		182	
Number of groups	26		26		26		26	
R^2 within	0.503		0.522		0.506		0.580	

Dependent variable	Infant mortality rate (ln)			
	(e)		(f)	
Independent variable				
(a) VB: Vertical balance (ln)	0.208	(1.01)	0.100	(0.41)
(b) RCE: Ratio of county gov't expenditure (ln)	-0.317	(-3.73)**	-0.229	(-2.64)**
(c): Intersection term: (a) * (b)	0.577	(2.10)*	0.242	(0.77)
Per capita GDP (ln)	-0.226	(-2.50)**	-0.146	(-1.69)
Rural/urban ratio	0.014	(0.67)	0.020	(1.02)
Birth rate	0.003	(3.80)**	0.003	(3.89)**
Illiteracy rate	0.008	(3.83)**	0.005	(2.21)*
Provincial gov't size			-1.938	(-3.64)**
Number of observations	182		182	
Number of groups	26		26	
R^2 within	0.534		0.583	

Note: The numbers in parentheses are t-statistics, corrected for panel heteroscedasticity. The symbol * indicates significance at the 5 per cent level, while ** indicates significance at the 1 per cent level.

In models (e) and (f), we must consider the effect of the intersection term. The elasticity of *RCE* is $\beta_2 + \beta_3 * \ln(VB)$, which varies depending on variable *VB*. The elasticity of *RCE* varies from –0.47 to 0.23 in model (e) and from –0.29 to 0.00 in model (f). These results suggest several

important points. When we do not consider the interaction effect between *RCE* and *VB*, the empirical result suggests a simple interpretation of the impact of counties' relative expenditure importance on health outcomes (*IMR*): that is, when counties have greater relative importance in expenditure responsibility, *IMR* decreases. When we consider the interaction effect, however, the interpretation is less straightforward. The positive effect on *IMR* of increasing counties' relative importance seems to hinge critically upon a low value of *VB* (such a value indicating that counties' expenditures are basically financed by counties' own revenues).

Regarding the control variables, the effects on the infant mortality rate are as expected. Economic development leads to better health outcomes (a lower value of *IMR*). A higher fertility rate or higher illiteracy rate (i.e. a lower education level) corresponds to worse heath outcomes (a higher value of *IMR*). A higher rural/urban ratio in a province will lead to worse health outcomes.

To conclude, our empirical work suggests that, first, if the relative importance of the county (the ratio of county expenditure to total provincial expenditure) is constant, greater fiscal transfers are needed to obtain better health outcomes. In general, county governments tend to face fiscal difficulties in carrying out their responsibilities, and hence they are dependent on financial transfers from the provincial level. This result implies that if fiscal decentralisation is not accompanied by the provision of adequate resources to lower tiers of government, the expected outcomes will not be achieved[9].

Second, increasing the relative expenditure responsibility of a county government will improve health outcomes if this expenditure can be more financed from the county's own revenue. Broadening the relative expenditure responsibility of the county government does not automatically lead to better health outcomes. The results depend critically on the county's own fiscal capacity, i.e. its own fiscal resources. This implies that in order to obtain better health outcomes, it is important to strengthen the revenue-raising capacity of county governments when their expenditure responsibility is increased.

[9] This empirical finding is supported by previous studies which also found that the theoretical benefits of decentralisation materialise on the ground only when certain conditions are met (Jütting *et al*., 2005).

V. CONCLUSION

Fiscal decentralisation, Chinese style, deviates substantially from the classical textbook scenario provided in fiscal federalism theory. This paper finds that more decentralised provinces perform better with respect to health outcomes if two conditions are met: first, if a functioning transfer system is established between the province and county levels, and second, if county governments' own fiscal capacity is strengthened. An equally important challenge that is not addressed in this paper is to combine fiscal decentralisation with health-sector financing reforms in such a way that out-of-pocket payments are reduced and access to health care services is improved. This is an important topic for further research. A better understanding of the factors that could help to improve health care delivery in China will be a crucial determinant of China's progress towards a harmonious society. Currently, many citizens, particularly in poor and remote areas, are still deprived of access to basic social services.

It is also crucial to provide incentives for local governments, as local authorities generally may have little interest in provision of public services, especially those characterised by interjurisdictional spillover. Mapping resources to expenditure is an important tool for this purpose, but not the only one. Setting up a transfer system to redistribute funding is important to boost poorer regions' fiscal capacity. To make this function, responsibilities at the various levels of government and health institutions must be clearly defined and enforced. To this end, the Chinese authorities might want to consider making local civil servants accountable to the local population instead of to the upper layer of government through effective political devolution of powers. More work is needed on how such a change could be put into practice, what the likely risks and benefits would be and who would ensure proper implementation.

APPENDIX

Table A1: **Description of Variables**

Indicator	**Description**
Fiscal decentralization	
Ratio of county govt expenditure (RCE)	Ratio of aggregate counties' expenditures to total provincial fiscal expenditure
Vertical Balance	Ratio of aggregate counties' expenditures to aggregate counties' own fiscal revenues
Control Variable	
Economic level	Provincial per capita GDP
Rural/urban ratio	Ratio of rural population to urban population in province
Birth rate (Fertility Rate)	Ratio of number of births to the average population in province (times 1000 (%))
Illiteracy rate (Education level)	Ratio of number of illiterate population to total population, aged 15 and over (%)
Provincial govt. size	Total Provincial fiscal expenditure relative to provincial GDP

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