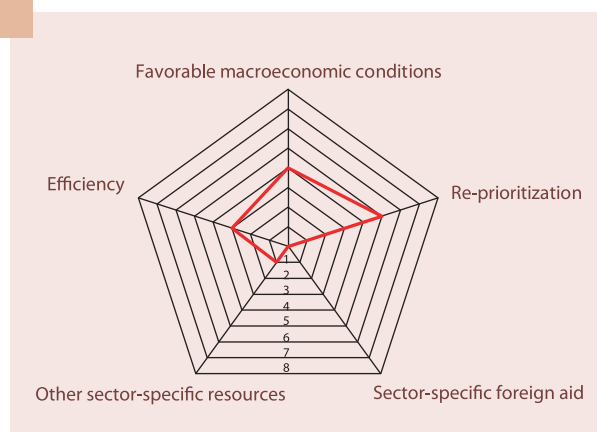




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Indonesia Health Sector Review



Financing Universal Coverage: Assessing Fiscal Space for Health¹

Introduction

In 2004, the Government of Indonesia made a commitment to provide its entire population with health insurance coverage. Attaining universal health insurance coverage in Indonesia is likely to require significant increases in public expenditure outlays for health. For instance, one possible option on the table is the expansion of Jamkesmas-style coverage for some or all of the population that currently does not have any coverage. Most of those without coverage are non-poor informal sector workers (and their dependents). Given the difficulties associated with payroll financing of coverage in the informal sector and the relative lack of local revenue-generating capacity in Indonesia, such an expansion of coverage is likely to require a significant increase in central government financing for health. This note outlines a framework within which options and alternatives to create fiscal space for health in Indonesia can be assessed. Can the Indonesian government increase health spending in the short- to medium-term to meet the needs of universal coverage? If so, what are some options and experiences from other countries that could be considered?

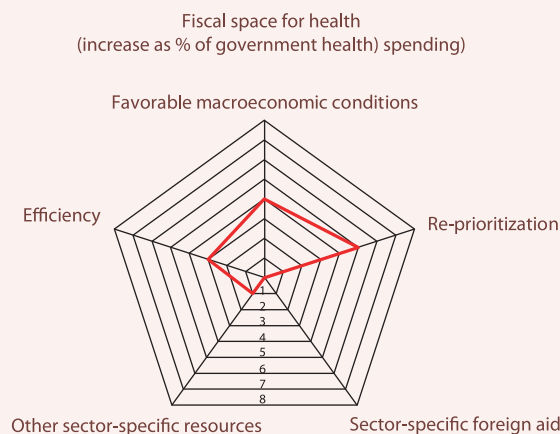
Finding additional public resources—fiscal space—requires an assessment of a government's ability to increase spending for a desired purpose without jeopardizing its long-term financial solvency (Heller 2005). Although fiscal space is usually assessed in aggregate, that is, without regard to a specific sector, the analytical framework within which fiscal space is assessed can be adjusted to take into account the prospects for increasing public spending specifically for health. One way of assessing fiscal space for health is to examine the different options for adding new sources of government financing as well as increasing the impact

of current sources through efficiency gains in existing public spending on health. These include:

- *Favorable macroeconomic conditions* such as economic growth and increases in overall government revenue that, in turn, could lead to increases in government spending for health;
- *A reprioritization* of health within the government budget;
- An increase in *health-specific foreign aid and grants*;
- An increase in *other health-specific resources*, for

Box 1 Visualizing Fiscal Space for Health: Hypothetical Scenario for Indonesia

One useful means of visualizing fiscal space for health is to use a “spider plot.” As can be seen in the figure below, there are five different axes, each representing a different means by which government spending on health could potentially increase. The figure shows the percentage increase in real government health spending relative to that in a given base year via each of the different options. The figure shows a hypothetical scenario for Indonesia in which a 4 percent increase in real government health spending can be expected from the favorable macroeconomic conditions (for example, as a result of economic growth). Similarly, a 5 percent increase could come from the reprioritization of government programs and a 1 percent increase from sector-specific sources such as the introduction of earmarked taxes for health.



Source: Author.

example, through earmarked taxation or the introduction of premiums for mandatory health insurance; and

- An increase in the *efficiency* of government health outlays.

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The first two of the above-mentioned options are largely outside the domain of the health sector itself; they

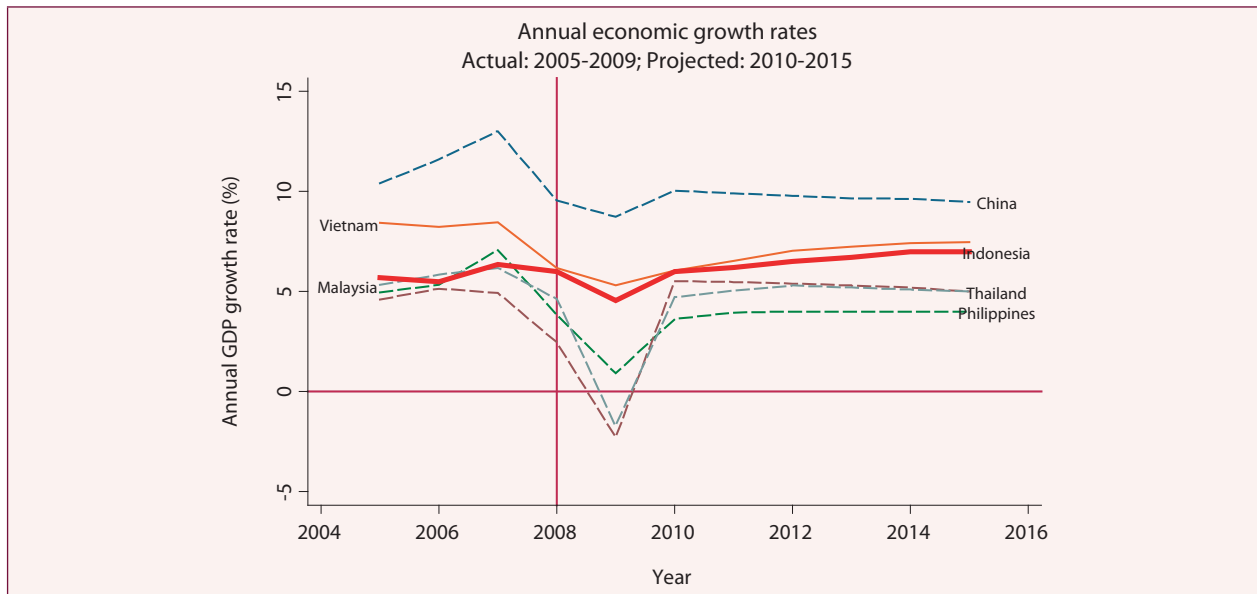
involve general macroeconomic policies and conditions as well as cross-sectoral political and economic trade-offs. Nevertheless, although exogenous to the health sector, it remains important to analyze the implications for government health spending of changes in the generalized macroeconomic and political environment within which the sector operates. The remaining three options are more in the direct domain of the health sector and merit particular attention given that they provide the potential for resources that are sector specific. See box 1 for a visual representation of the dimensions of fiscal space.

Favorable Macroeconomic Conditions

One of the strongest predictors of fiscal space and of rising government expenditure (including for health) is national income. Among other factors, economic growth is associated with higher revenue generation—both in levels and as a percentage of the economy—and this can help finance higher government spending.

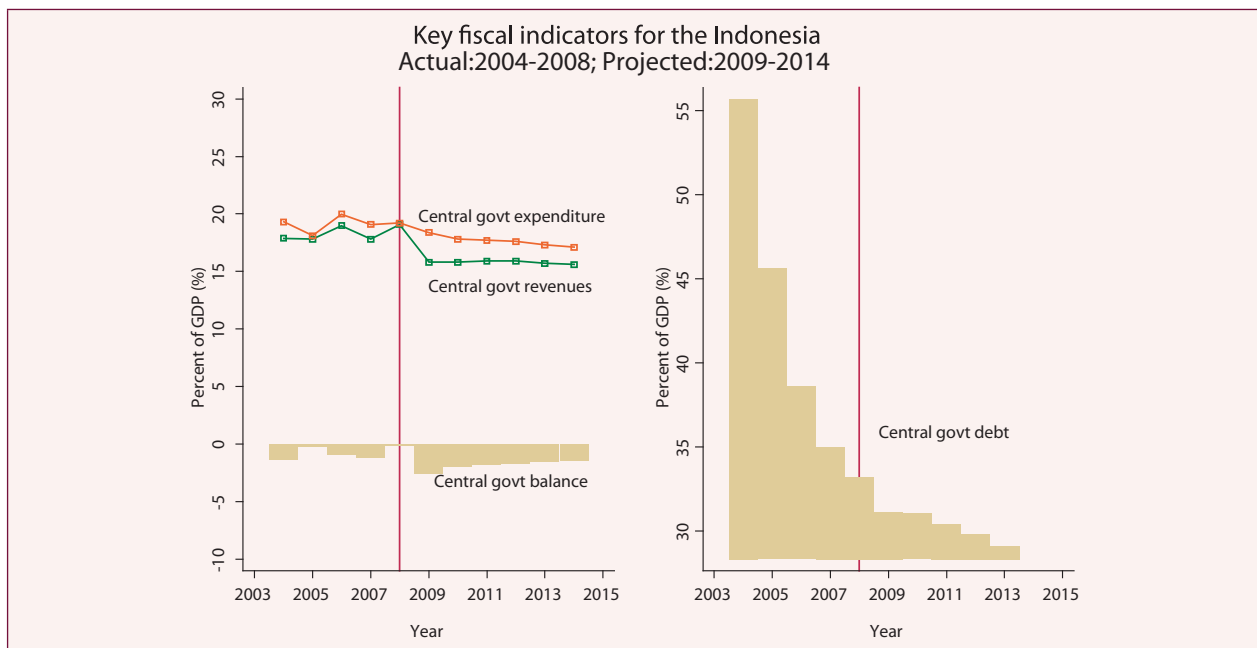
Indonesia’s economic growth record has been fairly

Figure 1: Economic Growth Rates for Indonesia and Regional Comparators



Source: IMF World Economic Outlook

Figure 2: Key fiscal indicators for the Indonesia Actual:2004-2008; Projected:2009-2014

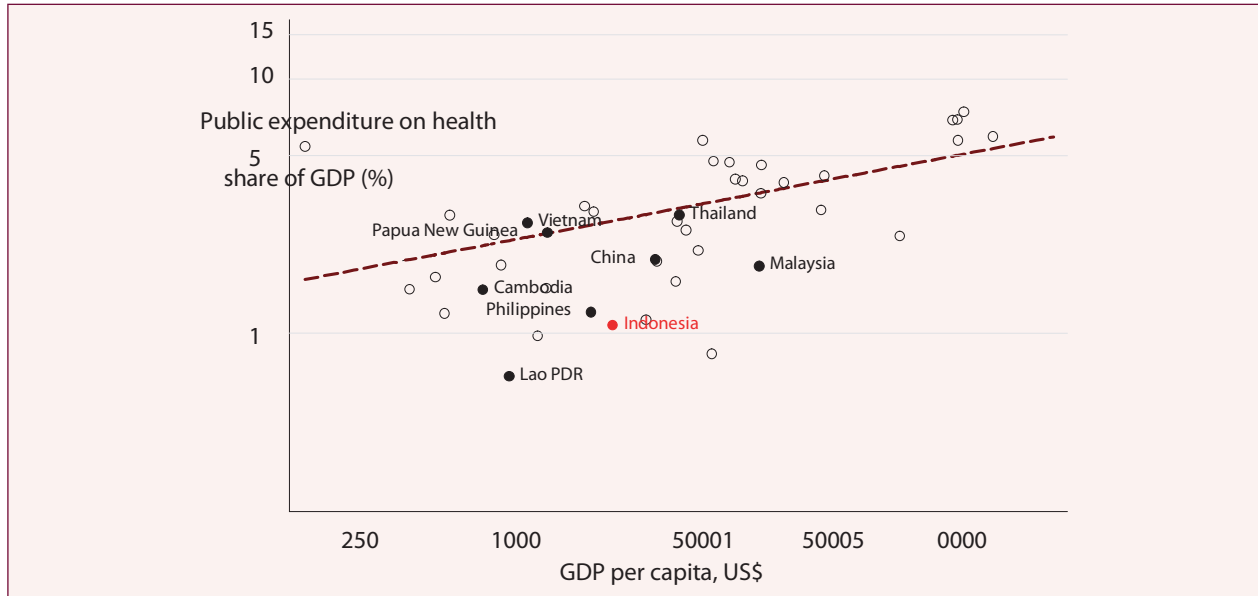


Source: IMF Article IV (various years)

robust. In 2008, Indonesia's GDP grew at a healthy rate of 6.0 percent. The financial crisis appears not have had a significant impact on Indonesia's growth prospects: the economy grew by 4.5 percent in 2009, and is expected to grow by 6.0 percent in 2010. Indonesia seems have weathered the economic downturn better than some of its regional neighbors such as Thailand,

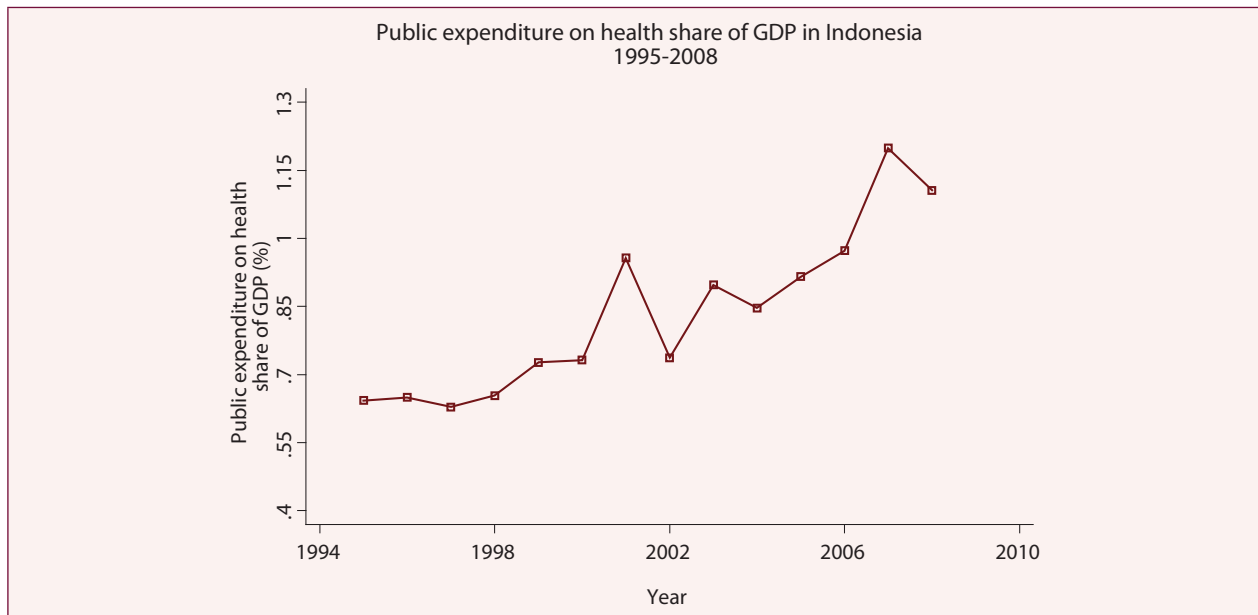
Philippines, Malaysia, Vietnam, and China (Figure 1). The primary fiscal impact of the crisis in Indonesia has been an increase in the deficit: the central government balance increased from -0.2 percent of GDP in 2008 to -2.6 percent of GDP in 2009. The deficit is projected to decline over time and is not expected to interrupt the declining trend in central government debt (Figure 2).

Figure 3: Public expenditure on health vs income, 2008



Source: WDI & WHO

Figure 4: Public Expenditure on health share of GDP in Indonesia – 1995-2008



Source: WHO

At 19 percent, Indonesia’s combined central and local revenue share of GDP is lower than the average of 23 percent for its income level. A recent IMF country report suggested that an additional revenue yield of 1 percent of GDP annually could be realized if value-added tax exemptions were limited, property

taxes were increased, and fringe benefits taxes were introduced. If these revenue gains were realized, and assuming the health share of the budget remained at least 5 percent, this could potentially lead to additional fiscal space for health of 0.05 percent of GDP per year for the next several years (IMF 2007).

The impact of economic growth on government spending on health, although important, is not only a product of increased availability of revenues but of other factors as well. Across countries, the elasticity of government health spending to GDP tends to be greater than one, meaning that government health spending tends to rise at a faster rate than the rate of GDP growth. There are multiple reasons why such a trend is observed, including a change in societal preferences in favor of government provision of social services generally. Based on an analysis of trend data for the period 1995–2008, the nominal elasticity of public health spending for Indonesia was 1.17 (and of total health spending was 1.07), both of which are in line with what might be expected for Indonesia's income level. And, as Figure 3 shows, there has been an increase over the period 1995–2008 in the share of public spending on health in Indonesia. Public spending on health could potentially continue to increase as a share of GDP if the elasticity of public spending on health to GDP in Indonesia remains at the level it has been over 1995–2008 (i.e., at 1.17).

Re-prioritizing Health in the Budget

A second source of fiscal space for health in Indonesia could be a reprioritization of health within the budget. Several factors indicate that health has traditionally been accorded a relatively low priority by the government. WHO estimates that the Indonesian government allocated about 5.7 percent of its budget to health in 2008. This rate is far lower than the average for the East Asia and Pacific (EAP) region as well as the average for lower-middle-income countries generally, with countries in both of these groups spending about double that amount—almost 10 percent on average—on health as a share of the government budget in 2008. As can be seen in Figure 4, Indonesia's public spending on health as a share of GDP is far lower than the average for its level of income. Lower budgetary allocations need not necessarily be a constraint to health care provision, especially if lower expenditure amounts are offset by higher levels of efficiency as in some countries. However, there are numerous indications that this is not the case for Indonesia.

High fuel and energy subsidies are prominent in budgetary allocations. In 2006, Indonesia reduced fuel subsidies and brought down debt levels, which

created additional overall fiscal space that resulted in a 20 percent increase in total government expenditures (World Bank 2007). Additional fiscal space for health could be generated by further reducing fuel subsidies, which continue to consume about 15 percent of the total budget and tend to benefit wealthier population groups.

Sector-Specific Foreign Aid

Another way to generate fiscal space for health is for governments to seek additional health-specific foreign aid and grants from international donors such as the Global Fund to Fight AIDS, Tuberculosis, and Malaria and the Global Alliance for Vaccines and Immunization. WHO estimates that about 1.8 percent of total health expenditure in Indonesia for 2008 was financed by external sources. This proportion—following an increase in the post-crisis period 1997–2000—has generally declined over time for Indonesia. The 2008 proportion for Indonesia was lower than the average for lower-middle-income countries (10.1 percent) and for the EAP region as a whole (17.6 percent), although the latter average in particular is biased upward because of the inclusion of small Pacific countries. Given recent declining trends in external resource dependency and Indonesia's lower-middle-income status, it does not appear as though foreign aid would be a viable option for generating fiscal space for health (except, perhaps, in an emergency stop-gap situation).

Other Sector-Specific Resources

The health sector is somewhat unique in that, internal to the sector, there are a number of possible ways by which fiscal space could potentially be generated. For instance, earmarked "sin" taxes on tobacco and alcohol are a popular way of generating fiscal space for health. One advantage of such taxes is that, even if they turn out not to be a major source of revenue, they can help reduce consumption and the ensuing morbidity and mortality related to tobacco and alcohol use. Conversely, earmarking used as a means to augment resources may end up displacing existing funding and thereby have no significant net impact on overall resources for health (McIntyre 2007).

Political obstacles could be raised to taxing tobacco in Indonesia. Indonesia is the only Asian country not to have signed WHO's Framework Convention for

Tobacco Control. One cited reason is that excise taxes on tobacco production account for almost 10 percent of government revenues, and estimates indicate that the sector employs almost 7 million people (*Economist* 2007). Taxes on cigarettes in Indonesia are among the lowest in the region, amounting to only about 31 percent of the price of cigarettes. Studies have suggested that a 10 percent increase in the price of cigarettes could lower consumption by 3.5 to 6.1 percent and increase government revenues from cigarette taxation by 6.7 to 9.0 percent (Achadi, Soerodo, and Barber 2005). However, cigarette and alcohol taxation is often regressive and may result in evasion and the development of underground markets.

Although economists argue that earmarked taxes are needlessly restrictive and can lead to sustained over- or underfunding of the activities that benefit from the earmarked taxes, they tend to be popular from a political perspective. Thailand successfully implemented an earmarked tax that directly funds health promotion activities. In 2001, it instituted the Thai Health Promotion Foundation (ThaiHealth), funding for which comes directly from a 2 percent earmarked tax on tobacco and alcohol consumption that provides an estimated annual revenue stream of US\$50 million (WHO-SEARO 2006). Thailand has also steadily increased cigarette taxation over the years— from 55 percent in 1993 to 75 percent in 2001— leading to declining consumption rates but increased government revenue from tobacco taxes.

Another potential health sector-specific mechanism for generating fiscal space is the introduction of mandatory universal health insurance. This strategy facilitates the “capture” by the public sector of high out-of-pocket payments by collecting the premiums required in mandatory health insurance for non-disadvantaged groups. The basic economics behind any insurance mechanism is the idea that individuals would prefer payment of a predictable (and relatively small) dedicated tax or premium to avoid unpredictable (and potentially large) payments when a health or other shock materializes. There is some evidence that individuals may be more willing to pay earmarked taxes or premiums as long as there are clear benefits attached to the payment of such a tax

or premium (Buchanan 1963).² The successful creation of fiscal space through mandatory health insurance is dependent on the size of the population and the ability to enroll the premium-paying segment of the population. Indonesia’s success in generating fiscal space from mandatory insurance would depend on the extent to which the uncovered population can be encouraged to enroll in a national health insurance program so that some of the additional resources collected can be used to subsidize the non-premium-paying population. A significant issue in Indonesia is the size of the informal sector: at more than 60 percent of the labor force, it remains large despite periods of sustained economic growth (Sugiyarto, Oey-Gardiner, and Triaswati 2006). With such a large share of employment in the informal sector, enrollment, and thus obtaining premium contributions that would generate fiscal space, is likely to be extremely challenging.

Efficiencies in Health Spending

In addition to increasing budgeted amounts for health, effective fiscal space might be generated by increasing the efficiency of spending. Improvements in the efficiency of health systems can be an important source of fiscal space. Sri Lanka has been able to attain excellent health outcomes with relatively low levels of resources, in part because of the underlying efficiency of its health system.

One of the issues with respect of efficiency in the Indonesian health system is that of decentralization, which occurred in 2001. Current estimates indicate that up to one-half of all public expenditure on health occurs at the district level. However, district health spending remains, for the most part, nondiscretionary or routine, largely covering the wages of the publically employed health workforce. In addition, some confusion remains about accountability and responsibility of the different levels of government. The clarification of these roles could potentially help improve efficiency of the health system in Indonesia. In addition, health system outputs vary significantly across districts in Indonesia, suggesting lessons can be learned from better performing districts. One possible avenue for improving the effective fiscal space in a

decentralized context would be to design inter-fiscal transfers so they are geared toward attainment of health outputs and outcomes (e.g., via the use of result-based financing mechanisms). Such mechanisms have been found to be quite successful in Argentina and Rwanda and could be considered in the Indonesian context as only a small percentage of transfers are currently tied to specific sectors, and even those are not tied to attainment of specific outputs or outcomes. In addition to efficiency gains from better coordination across all levels of government, several studies have indicated other avenues through which efficiency gains may be realized in Indonesia. For instance, an IMF analysis argues that Indonesia—by rationalizing its spending and eliminating energy subsidies—could expand overall fiscal space by almost 1.5 percent of GDP. This would entail moving the bulk of expenditure away from its current categories of personnel, interest payments, subsidies, and government apparatus (which allow little room for investment in infrastructure, health, and education; IMF 2008). In addition, the recent Public Expenditure Review (World Bank 2007) shows that public health expenditure is dominated by spending on salaries of personnel and primarily benefits the richer quintiles: some efficiency gains may be actualized by better targeting and increasing the discretionary elements of health spending.

Another indication that room for efficiency gains is available comes from a study of health worker absenteeism in Indonesia. Based on unannounced visits to primary health care facilities in Indonesia, the study found a 40 percent absenteeism rate among medical workers (Chaudhury et al. 2006). Absenteeism rates tended to be higher for doctors than other types of health workers. Clearly, there is a need to reevaluate incentives and governance issues related to delivery of health services given that—in “real” terms—expenditure outlays may not be translating effectively into human resource inputs in the health system in Indonesia.

Conclusions

The Government of Indonesia has made an ambitious commitment to provide universal health insurance coverage to the population. With the current low

rates of public health expenditure, as well as the poor performance on several key health indicators and expected epidemiological and demographic pressures, the government will need to increase fiscal space for health to fulfill its promise.

Indonesia has the advantage over many countries of a relatively positive prognosis for economic growth in the near future. Given Indonesia’s low government revenues as a share of GDP and small share of health in the government budget, however, measures to increase government revenues and better prioritize budget expenditures will be needed to ensure that economic growth translates into significant increased fiscal space for health. Additional mechanisms for increasing fiscal space to fund universal public health insurance coverage will almost certainly be necessary. An earmarked payroll tax or fixed premiums could be considered, but the high level of informal employment is a significant obstacle. Some combination of contributory mechanisms and increased government budget funding may be the most feasible approach.

Under any scenario, the efficiency of public health expenditures should be improved, both to create additional effective fiscal space and to increase the absorptive capacity for new resources. The high level of decentralization in the health system has created a high degree of fragmentation and inefficiency. Effective fiscal space in a highly decentralized context such as Indonesia may be increased by streamlining the funds flow, freeing up the constraints on allocation of funds at the sub-national level, and linking inter-fiscal transfers more closely to health need and to the attainment of health outputs or outcomes. These steps may be achieved as a national health insurance system is consolidated and the purchasing function can be strengthened.

Finally, generating better information for analysis is a key step for Indonesia to make accurate estimates of the fiscal space needed to achieve universal coverage and to develop the most appropriate approaches. Critical data such as national health accounts updates, claims data from existing insurance programs, and cost and coverage information are needed to make accurate actuarial projects and to identify where key sources of inefficiency need to be addressed.

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1 This note was prepared by Ajay Tandon, Senior Economist (EASHH). It summarizes and updates previously-published analytical work on fiscal space for health in Indonesia; The author would like to thank Ilaria Regondi for comments, and Claudia Rokx, George Schieber, and Pandu Harimurti for inputs and discussion.

2 Colombia was able to generate increases in public sector health spending and declines in out-of-pocket expenditures when it introduced mandatory health insurance in 1993.

For more information please contact Claudia Rokx (crokx@worldbank.org) or visit the WB website.