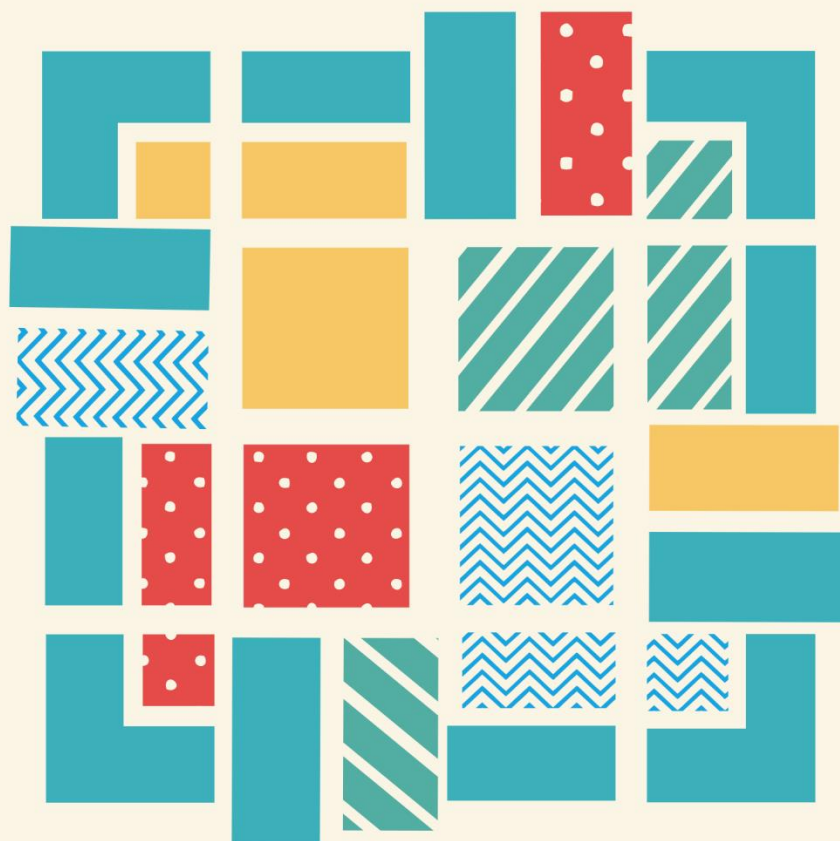


Fiscal Space for Health in Indonesia

Public Sector Opportunities and Constraints in Achieving the Goals of Indonesia's Mid-Term Development Plan (RPJMN) 2020-2024



Direktorat Kesehatan dan Gizi Masyarakat
Kedeputan Pembangunan Manusia, Masyarakat, dan Kebudayaan
Kementerian PPN/Bappenas

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Abbreviations

APBD	<i>anggaran pendapatan belanja daerah</i> (subnational government budget)
APBN	<i>anggaran pendapatan belanja negara</i> (government budget)
Bappenas	<i>Badan Perencanaan Pembangunan Nasional</i> (Ministry of Planning)
BOK	<i>bantuan operasional kesehatan</i> (health operational assistance funds)
BPJS-K	<i>Badan Penyelenggara Jaminan Sosial-Kesehatan</i> (national social health insurance agency)
DAK	<i>dana alokasi khusus</i> (special allocation fund)
DAU	<i>dana alokasi umum</i> (general allocation fund)
DBH	<i>dana bagi hasil</i> (revenue-sharing funds)
DBH-CHT	<i>dana bagi hasil cukai hasil tembakau</i> (tobacco excise profit-sharing fund)
DBH-SDA	<i>dana bagi hasil sumber daya alam</i> (natural resource revenue)
DID	<i>dana insentif daerah</i> (incentive funds)
GDP	gross domestic product
GGDP	government expenditure as percentage of GDP
GHE	government health expenditure
GHGE	government health expenditure as percentage of total government expenditure
GNI	gross national income
HP+	Health Policy Plus
IDR	Indonesian rupiah
IMF	International Monetary Fund
JKN	<i>Jaminan Kesehatan Nasional</i> (national health insurance)
PAD	<i>pendapatan asli daerah</i> (regional own-source revenue)
PBI	<i>penerima bantuan iuran</i> (government contribution beneficiaries)
PBPU	<i>peserta bukan penerima upah</i> (non-poor informal sector national health insurance [JKN] members)



PDRD	<i>pajak daerah dan restribusi daerah</i> (local tobacco tax)
Perpres	presidential regulation
Puskesmas	<i>pusat kesehatan masyarakat</i> (community health center)
RPJMN	<i>Rencana Pembangunan Jangka Menengah Nasional</i> (Indonesia's <i>Mid-Term Development Plan [RPJMN] 2020–2024</i>)
SPM	<i>standar pelayanan minimal</i> (minimum service standards)
USAID	U.S. Agency for International Development
VAT	value-added tax

Executive Summary

This report examines whether Indonesia's fiscal space for health, specifically in the context of budgetary capacity and the ability to mobilize contributions from households for health insurance, can be increased to meet the Government of Indonesia's *Mid-Term Development Plan (RPJMN) 2020–2024* goals. It was developed to support policy discussions around the resources needed to finance the costs to meet health sector goals under the RPJMN. This report should be read alongside the World Bank's 2020 *Public Expenditure Review*.

The report contends with specific research questions:

1. *Given the macroeconomic predictions regarding changes to growth and government revenue, what will be the baseline budgetary space for health at the central level, including for transfers to provinces and districts?* For 2020, the central government has lowered expectations for revenue collection and transfers to the subnational level. With increased deficit-led financing, higher COVID-19 and countercyclical spending will be afforded in 2020–2021, but space for expanding Ministry of Health spending is limited. Budgetary constraints will continue, especially given the higher premium rate for the substantial number of subsidized members of Indonesia's national health insurance (JKN) scheme, or PBI (Bahasa: *penerima bantuan iuran*) as initiated in late 2019. If PBI numbers subsidized from the national budget (Bahasa: APBN, *anggaran pendapatan dan belanja negara*) are not expanded further, there will be space for other non-JKN spending in the Ministry of Health budget, as central government revenue recovers post-COVID-19 and the Government of Indonesia returns to its long-term deficit target. However, to increase central health expenditures to accommodate expansion of JKN subsidies, additional budgetary space is required.
2. *Can subnational governments increase their prioritization of health?* Subnational governments will have a constrained budgetary environment in 2020–2021. Many of the transfers to subnational government are less flexible, such as the general allocation fund (*dana alokasi umum* or DAU), or they already have earmarked allocations to health. Ministry of Health spending at the local level through deconcentration funds do not offer sufficient autonomy for districts to direct spending. Positive trends include new rules since 2018 requiring more explicit prioritization of health from tobacco taxes devolved to the local level. More local resources could be explicitly prioritized for health if spending flexibility in certain other sources within transfers and in local own-source tax revenue are exploited.



3. *What are the budgetary impacts of the different policy options in the RPJMN to raise JKN coverage and sustainability?* To meet RPJMN goals to expand PBI membership and increase coverage of JKN overall, the Government of Indonesia must consider subsidizing informal sector members, yet these policy options require considerable resources from APBN. An increase in the PBI contribution rate in 2020 has already significantly increased APBN spending. With the national social health insurance agency's (*Badan Penyelenggara Jaminan Sosial-Kesehatan* or BPJS-K) financial deficit beginning to improve because of the increased PBI contribution rate, the key task for the Government of Indonesia is to examine sources of financing to accommodate an expansion of PBI beneficiaries, including through subnational government budgets (*anggaran pendapatan belanja daerah* or APBD), as possible.
4. *Given the needs for reaching expanded coverage goals for JKN, how is budgetary space for health affected if new or existing sources of government revenue are earmarked for health?* Here, there is the promise of better planning and negotiation during annual exercises between the Ministry of Health, Ministry of Finance, and Bappenas (Ministry of Planning) leading to new resources for the health sector. Specifically, more can be done with earmarked taxes over and above what is currently allocated. Tobacco excise tax rates have been raised recently and overall constitute a significant input into government revenue, including for transfers. However, Indonesia's allocation of such tax revenue to health is much below international experience. At the local level, some of the funds, though earmarked, are not always used for health needs. New sugary beverage excise taxes have been proposed but not approved. Allocating the entirety of the latter to health beginning in 2021, and additionally earmarking more tobacco tax revenue at central and local levels, will provide new fiscal space, which could allow for accommodating the expansion of PBI.

Introduction

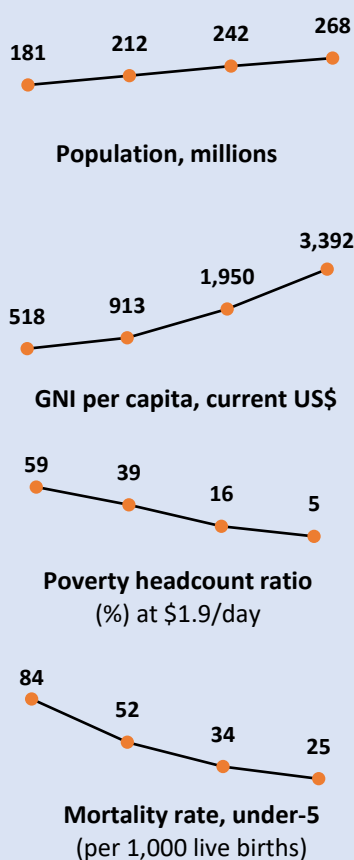
Fiscal space has been defined as “the budgetary room allowing a government to provide resources for public purposes without impacting fiscal sustainability and without threatening government solvency given existing fiscal conditions and long-term requirements.”² Related to this concept, budgetary space for health is defined as the “production of budgeted resources for health that derive from overall expenditure, budget allocation decisions, and rules and practices for budget use related to public financial management.”³

Recently, perspectives on fiscal space for health have moved around two axes. In the first, fiscal space is linked to *budgetary space* for health. Budgetary space for health is determined by whether a government allocates (prioritizes) health in its total budget. However, the size of the total government budget is driven by macroeconomic trends, and the government’s ability to borrow, its tax effort, and tax capacity.^{4,5} More experts now view the increase in government revenues driven by macroeconomic and fiscal trends as being more influential for mobilizing public sector resources for health.

In the second axis, governments can assign new and existing sources of revenue as earmarked for health, while also making efficiency gains^{5,6} to release additional fiscal space. However, on the latter issue, there is no consensus on how to reap major efficiency gains in a complex health system like that of Indonesia. There is more evidence around earmarking taxes on tobacco, alcohol, and sugary beverages as significant sources of revenue and their impact in terms of health gains.⁶

Recently, Indonesia’s health spending has been characterized by comments such as that it features “...low prioritization (of health)”⁷ and “...relatively low quantum of overall health spending ...one of the key

Figure 1. Indonesia: Key Indicators (1990, 2000, 2010, 2018)¹



bottlenecks toward achieving UHC [universal health coverage].”⁸ These views should be seen in the context of an increasingly more prosperous country with decreasing poverty and improving health outcomes (Figure 1). So, can Indonesia increase its spending? From which sources? Will this be feasible? This report examines whether Indonesia’s fiscal capacity for health can be increased to meet Indonesia’s *Mid-Term Development Plan 2020–2024* (RPJMN) goals. It should be read alongside the World Bank’s 2020 *Public Expenditure Review*.⁹

Indonesia’s total and per capita health expenditure is frequently considered to be relatively low.^{8,9} In Figure 2, the trend in the growth of per capita health spending in Indonesia (dashed red line) alongside gross national income (GNI) per capita is slightly behind the country’s Asian peers. The elasticity of central government health spending was 0.85 percent to each 1 percent change in gross domestic product (GDP) per capita, while local government spending was more responsive at an elasticity of 1.13 percent.⁸ Whether Indonesia increases its health spending matters, but the sources of spending also matter, especially if the funding is mobilized and spent in ways that reduce inequity and financial burden related to healthcare use. The charts in Figure 3 suggest that past health spending in Indonesia increased both in total and per capita terms. Since the advent of national health insurance (*jaminan kesehatan nasional* or JKN) in 2014, the share of out-of-pocket spending was decreasing, while that of government-supported health insurance was increasing. Therefore, looking toward future fiscal space, the role of JKN and local government spending should be part of the focus.

Figure 2. Indonesia vs. Peer Countries

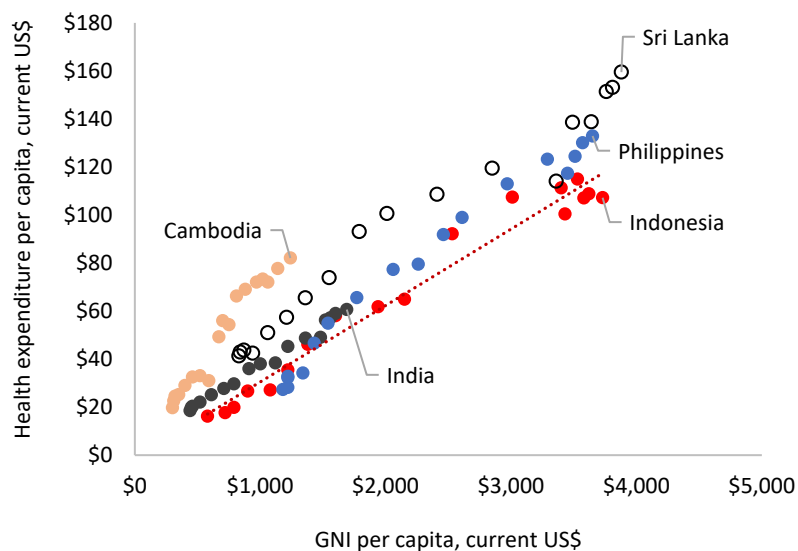
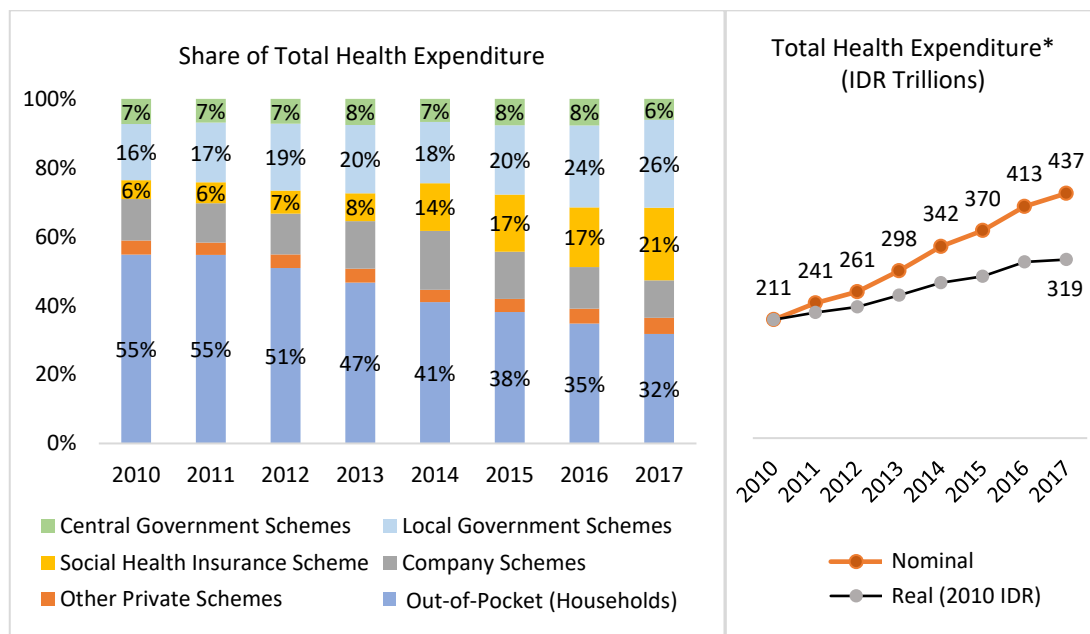


Figure 3. Results from Indonesia National Health Accounts, 2010–2017¹⁰



Source: Health Policy Plus (HP+) analysis using National Health Accounts data¹⁰

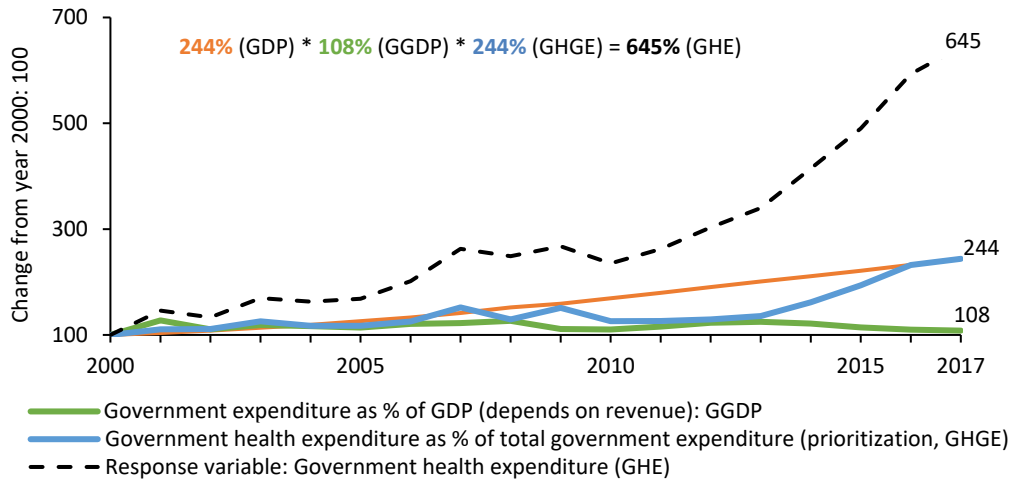
Determining the Focus of the Fiscal Space Analysis

Considering the impact of the COVID-19 pandemic in 2020 on public sector revenues, private economic activity, and government expenditure on epidemic control and mitigation actions, there is renewed interest in fiscal space for health. There is a realization that governments have hard choices to make in the short and medium term, as expenditure needs have increased while revenues are lower and will continue to decline. In this context, some experts are calling for a return to prioritization of health in government budgets,¹¹ as the underlying macro-fiscal situation will take time to restore, and households should not be expected to make up the difference in terms of healthcare needs from out-of-pocket. This can be compared to previous viewpoints suggesting that prioritization may not be as effective. In Indonesia, within the change in government health expenditure from 2000 to 2017, the contribution of the shift in budget prioritization was 37 percent of the total health expenditure change, equal to the impact of overall GDP growth and more than double the impact of total government spending growth. Another study found an even higher impact from prioritization in Indonesia.⁵

The rationale for focusing on budgetary space, i.e., on prioritization of health in the central and local government budgets, has two aspects in Indonesia. First, the

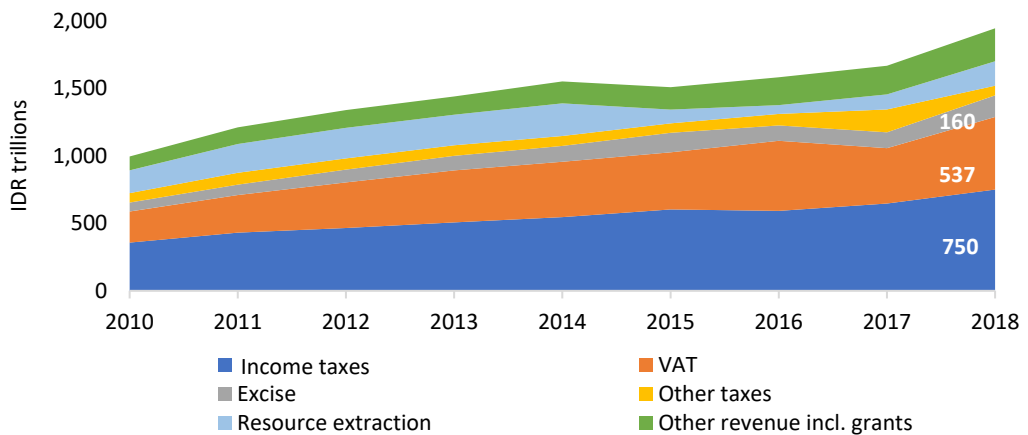
government revenue system is under reform and still underperforms compared to its potential.⁹ Chances of major structural changes that significantly increase revenue are limited in the medium term and, hence, these will not be major drivers of fiscal space. Second, some budgetary prioritization of health is mandated in the government budget across levels. In addition, there is the potential to prioritize health even more without distorting the government’s discretionary spending flexibility, and while promoting long-term changes which boost government revenue and indirectly benefit public health.

Figure 4. Change in Government Health Expenditure in Indonesia, 2017 vs. 2000



Source: HP+ analysis

Figure 5. Sources of Central Government Revenue, Indonesia



Source: Ministry of Finance¹²

Indonesia’s government revenue to GDP ratio of 14.6 percent in 2018 was much lower than the average of 27.8 percent across 38 middle-income economies.^{9,12} The *Public Expenditure Review* emphasizes that actual revenue has achieved only 50 percent of the estimated potential. Indonesia’s low revenue collection performance may be due to dependence on commodities (resource extraction), which have cyclical downturns in prices; a large informal economy from which direct taxes are hard to obtain; tax administration issues affecting compliance and the tax base; and problems with tax policy design, especially around value-added tax (VAT) exemptions and thresholds for various taxes.^{9,12} Direct taxes, i.e., primarily income taxes on firms and individuals, and VAT are still the main sources of government revenue (Figure 5). The *Public Expenditure Review* suggests that removal of VAT exemptions would yield 0.4 percent of GDP, valued at IDR 110–112 trillion (US\$7.7–7.85 billion) for 2019. The government’s draft law on Taxation Provisions and Facilities for Strengthening the Economy, or the “omnibus” tax bill, was expected in 2020 and does not feature extensive VAT reforms. The bill has been delayed due to COVID-19, which has led the government to prioritize immediate tax relief instead. Given the uncertainty around the VAT reforms, these issues as highlighted in the *Public Expenditure Review* are not taken up in this report.

Figure 6. Mandated Budgetary Prioritization of Health in Indonesia

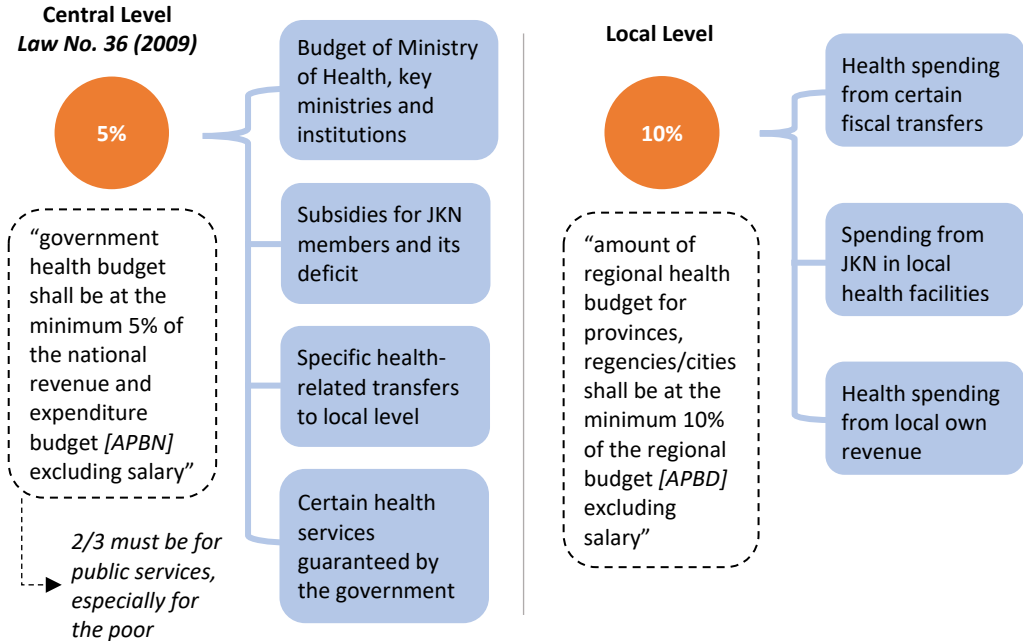
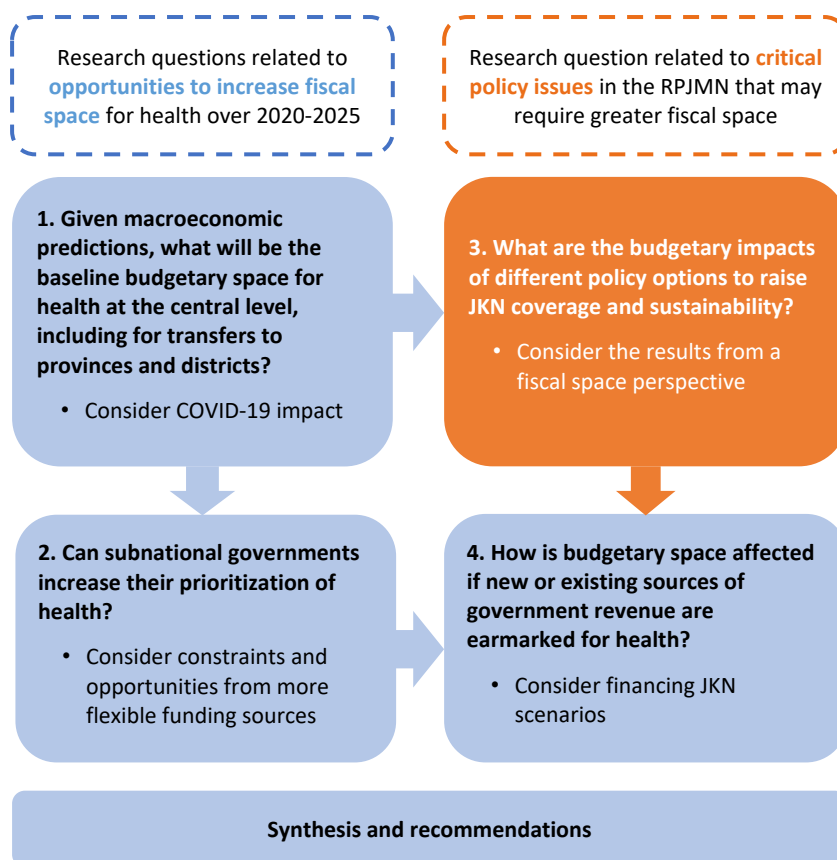


Figure 6 depicts the key rules through which government spending is earmarked for health. Some items, such as health-related transfers to the local level, have the potential to be double-counted in meeting the prioritization obligations of the government. While this system of suggested allocations has provided a strong basis for health to be a protected share of government spending since 2009, it is only more recently with JKN that the central-level goal is close to being met annually. This issue will be discussed in more detail in this report. Additional to this mandated prioritization, we analyze the possibility of further allocations to health from tobacco taxation at the central and local levels, over and above what is already allocated from this source. In Figure 6, allocations from tobacco tax revenue shared with local governments are considered as part of health spending from local own revenue. We will also consider taxes on sugary beverages as part of this process, to provide evidence on options from policy discussions initiated in Indonesia during 2019–2020, which is also important for the finalization of the omnibus tax bill.

Finally, the practice of fiscal space analysis now emphasizes increased efficiency as a way of releasing more funding into the system. An analysis of allocative efficiency—assigning financing to the most cost-effective and equitable uses in the health system—is beyond the scope of this report. Analyzing technical efficiency, i.e., the use of the current financing level to achieve the maximum output possible, would require detailed cost and output data on health service delivery across Indonesia corresponding to the different geographical and local health system contexts, but such data are not yet available. However, this issue is reviewed broadly in this report at a scheme level for JKN, and for local government spending. Finally, efficiency in health financing systems, especially public financial management problems such as unspent allocations and duplicated line items, should be explored. Of these, more data are available on central budget execution.

Figure 7 summarizes the interlined research questions for this fiscal space analysis emerging from the discussion above. Preliminary results based on these research questions were validated with stakeholders in Indonesia during May–June 2020, including Bappenas and the U.S. Agency for International Development (USAID) Indonesia.

Figure 7. Research Questions for a Fiscal Space Analysis for Health in Indonesia, 2020–2024



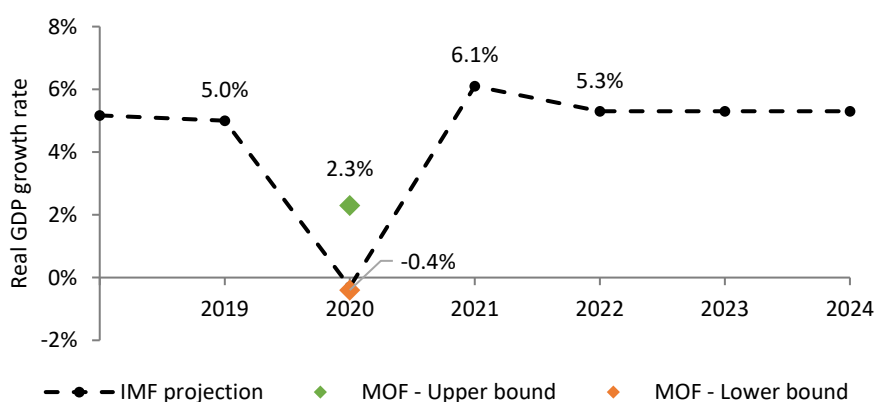
Methods and Data Sources

For this analysis, we built several different projection models in Microsoft Excel. First, we constructed a macro-fiscal model of Indonesia, which used historical data from the Ministry of Finance and projected indicators from various sources^{13,14,15} to analyze government central expenditures and revenue and primary budget deficit, as well as deficit financing. Second, based on this, we built separate projections of budgetary allocations to health as well as intergovernmental transfers under different heads. Finally, we built two additional models: one to analyze the expenditures and revenues of JKN under different future scenarios, building on previous published work,¹⁶ and the other analyzing earmarks to health scenarios using the base of excise taxes on tobacco and sugary beverages.

Results: Baseline Budgetary Space for Health at the Central Level

Current and projected macroeconomic and fiscal conditions. For 2020–2021, we used real GDP growth projections from the International Monetary Fund (IMF) published in June 2020. The IMF’s 2020 projection of -0.3 percent growth is comparable to the Ministry of Finance’s lower bound of -0.4 percent growth published in April 2020.^{15,17} Based on other sources, we projected a growth recovery in 2021 based on a restart of economic activity and an impact from the government COVID-19 stimulus. For 2022–2024, we assumed a return to a stable growth trajectory as projected by the IMF.¹³

Figure 8. Real GDP Growth Rate 2019–2024



Source: HP+ analysis based on various data^{13,15}

Total tax, non-tax, and grant revenues projected for 2020 were as per revised Ministry of Finance estimates.^{18,19} For 2021–2024, we assumed that tax collection effort and capacity will return to the pre-COVID-19 baseline by 2023 for tax revenue streams (e.g., income tax, VAT, excise tax) and by 2021 for non-tax revenue streams in terms of ratios of these to GDP. We assumed that grant revenue would be constant at IDR 1.3 trillion through 2024. Results for revenue are shown in Figures 9 and 10. Excise tax in Figure 9 is used as a baseline in later scenarios.

For expenditure in 2020, we used the revised central government budget (APBN) estimate, which included all planned COVID-19 related spending.^{18,19} The planned increase in spending and reduction in revenue is expected to produce a 6.3 percent fiscal deficit in 2020, which has been permitted under the government’s temporary relaxation of the normative fiscal deficit target of 3 percent of GDP (Figure 10).¹⁹ To estimate total national expenditure including net lending through 2024, we

incorporated the IMF’s recent 2021 deficit estimate and the government’s plans to return to the prior deficit target by 2023.^{17,20}

We projected government debt financing costs based on the latest projected debt¹⁷ and effective interest rates from the IMF’s Article IV Report from 2019.¹³ Data were not available to make assumptions on changes to effective interest rates on the additional debt in 2020. Results are shown in Figure 11. Total public sector debt as a share of GDP will be at least 37 percent in 2020 and will increase to 41 percent by 2022, before declining slightly because of GDP growth and reducing deficits.¹⁷ This exceeds the levels of 30–31 percent during 2018–2019.

Transfers to subnational governments. The central government makes a variety of fiscal transfers to subnational governments for specified and discretionary uses, which have been described elsewhere.^{9,21} The transfers are substantial and afford districts and provinces some autonomy, but they are also beset with a variety of structural concerns.⁹ Reforms to the system of transfers that derive from Law No. 33/2004 are being designed, though it is not clear when they will be promulgated. In the absence of this

information, we used historical patterns to project the future. We reviewed audited accounts of annual transfers to subnational governments during 2013–2019,²² as well as pronouncements of the Ministry of Finance in 2020 on the issue of subnational government budgets (*anggaran pendapatan belanja daerah* or APBD). Planned transfers for 2020 are already lower than 2019 in real and nominal terms, reflecting the centralization of resources to respond to COVID-19. In addition, disbursements have been delayed in 2020, and subnational governments were asked to submit readjustments to their APBD plans, given that local own-source revenues are also expected to be lower. Considering these issues, we assumed that transfers as a share of total expenditure will return to the pre-COVID-19 baseline only by 2022 and will then remain flat (Figure 10). Future reforms may shift this forecast.

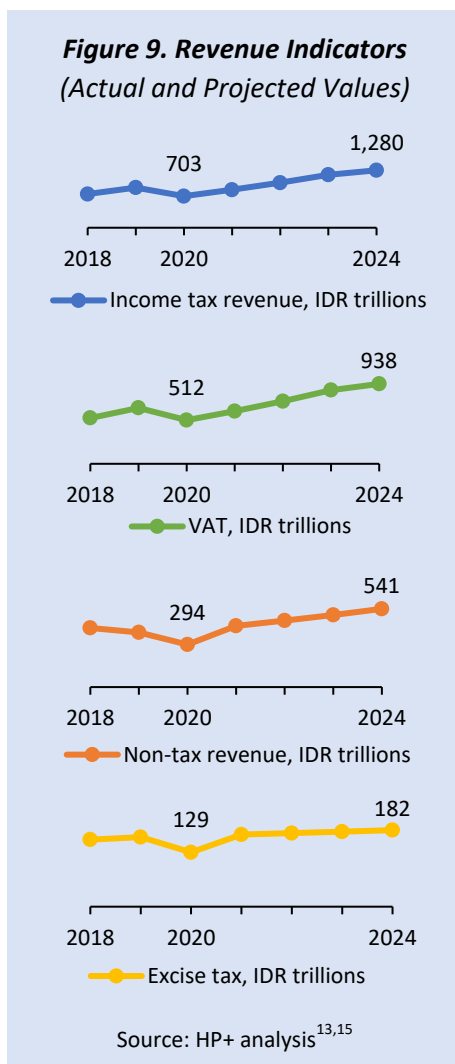
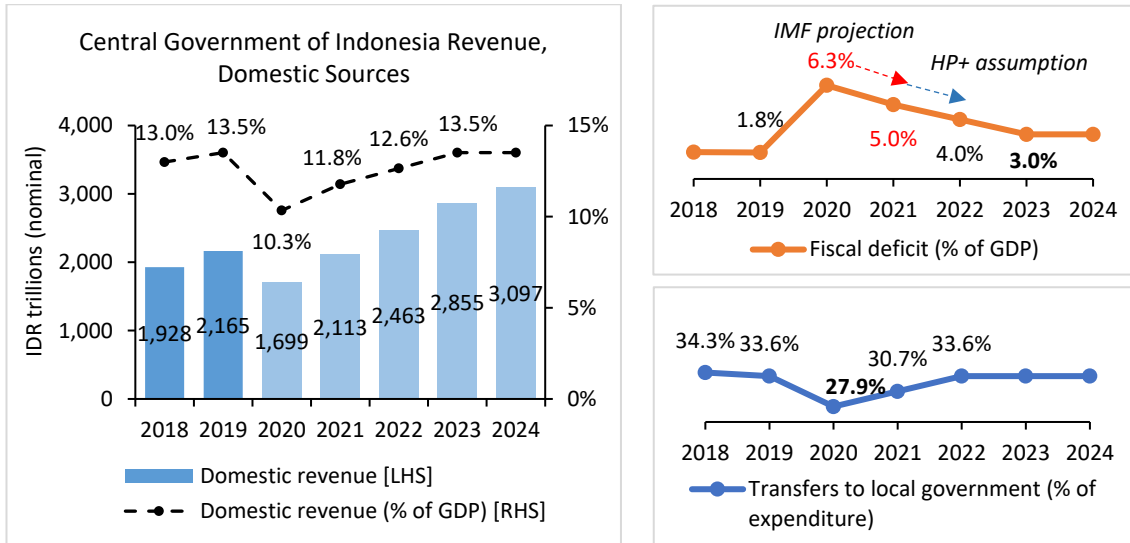


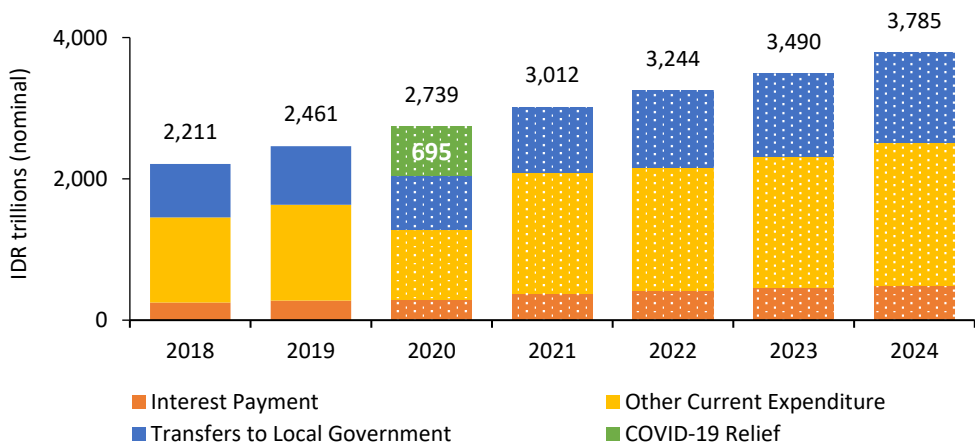
Figure 11 shows the projected central government total expenditure. Debt servicing, even at the beneficial terms secured by government, will increasingly compete with human capital investments for resources. The known level of planned COVID-19 spending as of June 2020 is IDR 695 trillion, of which 88 trillion (13 percent) is related to healthcare, while the remainder consists of spending on social safety net, support to industry, tax relief (including import duties), and the National Economic Recovery Program (Bahasa: PPEN).^{15,19}

Figure 10. Key Macroeconomic and Fiscal Projections



L/RHS: left- or right-hand side (y-axes)
 Source: HP+ analysis with various data^{12-15,19-20}

Figure 11. Central Government Expenditure: Recent Actuals, Current Year Budget, and Projected



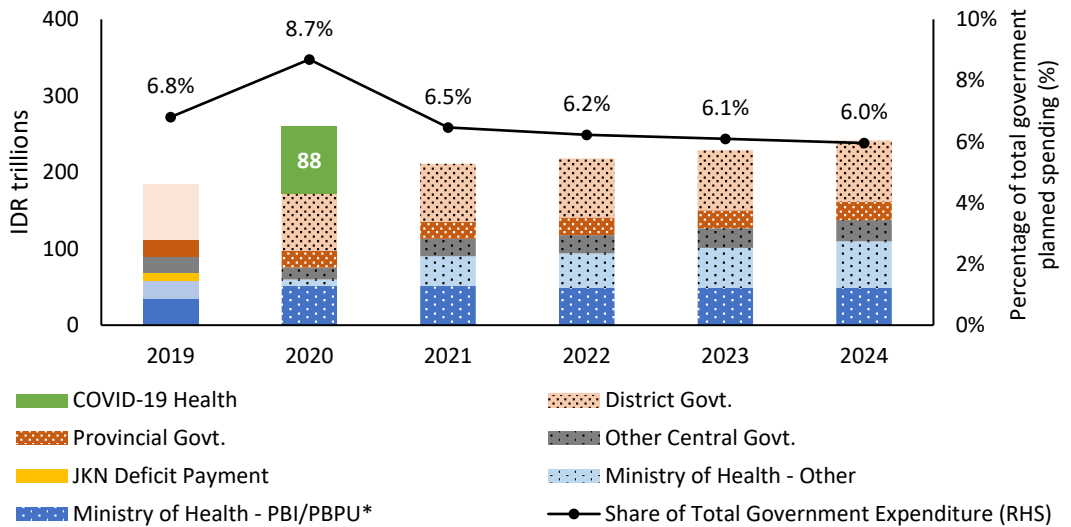
Source: HP+ analysis with various data^{19,20}

Projected spending on health. Health is not the only sector with a mandated share of spending. Education is allocated a minimum 20 percent share of general government expenditure as per Law No. 20/2003, which was nearly reached in 2016.⁹ We estimated planned central-level health spending within the overall expenditure envelope for 2021–2024 (Figure 11) based on several factors. For 2020, we had an APBN estimate that 5.2 percent of government expenditure would go to health—including spending by ministries and institutions (Bahasa: K/L), non-K/L central-level spending, and transfers to subnational government.²³ After including the IDR 695 trillion in COVID-19 relief, including IDR 88 trillion for health, the 2020 health share of total central government spending as per Law No. 36/2009 would be about 7.1 percent. For 2021–2024, we first assumed the health-related shares within a few specific transfers—the special allocation fund (*dana alokasi khusus* or DAK, both physical [*fisik*] and nonphysical [*nonfisik*]) and the special autonomy fund—would remain at planned 2020 levels.^{22,23} Then we estimated aggregate government health spending, predicated on meeting the 5 percent target using the Law No. 36/2009 denominator,²³ which is distinct from the calculation performed for the ratio in Figure 12. From these totals we subtracted the estimated health-related transfers and allocated the residual between central K/L and non-K/L health spending, assuming the non-K/L share—after excluding JKN deficit payments, which we project to end starting in 2020—remains fixed at planned 2020 levels. We assumed that the Ministry of Health will maintain its share of total ministry and institution health spending. In the Ministry of Health budget, a baseline scenario for premium payments for APBN-subsidized poor and near-poor (beneficiaries from the government budget [PBI APBN]) was derived from the JKN model. We also incorporated government plans to subsidize non-poor informal sector JKN members (*peserta bukan penerima upah* or PBPU) in 2020 and 2021 at planned levels.

Figure 12 suggests that future APBN outlays for health will have significant JKN spending, even if the need to finance the JKN deficit decreases. Based on our forecast of total central government spending, there will be future fiscal room for Ministry of Health budget areas not related to JKN, which include priority health programs, health workforce deployment incentives, and procurement of medicines and health equipment. As future central government spending is re-aligned to the long-term fiscal deficit target by 2023, and government health spending as per a Law No. 36/2009 denominator follows the 5 percent threshold, an overall effect we see is that the aggregate ratio for public health spending as a share of total government spending across levels will drop to 6 percent. If JKN-related PBI spending increases further to meet RPJMN goals, there will be declining fiscal room for other needs, and further budgetary prioritization of health may be required.



Figure 12. Projected Baseline Government Outlay for Health, 2020–2024
 (2019 Estimate, 2020 APBN/APBD, and Projected [dotted])



Source: HP+ analysis

Note: JKN outlay here is only from the payer side to avoid double counting. Subnational government planned spending on health *excludes JKN provider payments* and hence will be lower than other estimates.⁹ Subnational spending includes allocations from estimated DAK, general allocation fund (*dana alokasi umum* or DAU), revenue-sharing funds (*dana bagi hasil* or DBH), and other sources. The split between provinces and districts in health spending from these sources is projected at 23 percent and 77 percent, respectively, based on past values. National Health Accounts 2017 total subnational government spending was IDR 111 trillion, of which IDR 24 trillion may be related to JKN at the subnational level, leaving IDR 87 trillion as a comparable value to estimates in this chart.

* PBPU included for 2020 and 2021

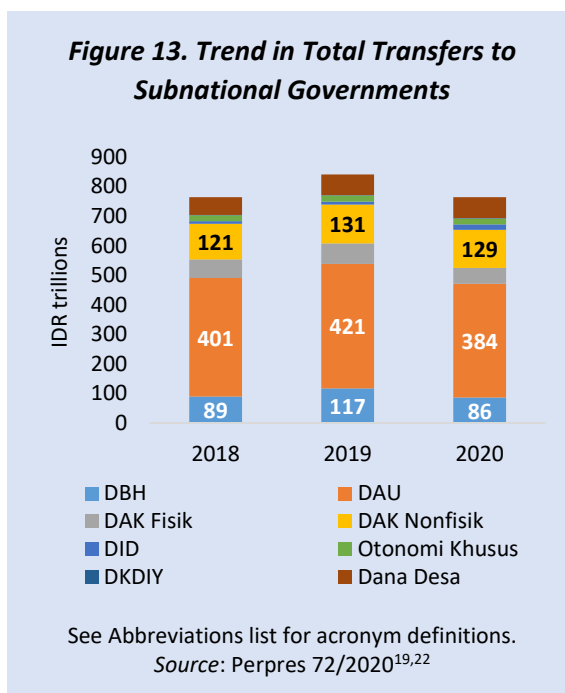
RHS: right-hand side (y-axis)

Results: Opportunities to Enhance the Role of the Subnational Level in Health

Before 2020, central transfers to provinces and districts were increasing in nominal terms, and the shares by type of transfer was stable (Figure 13). The three major transfer mechanisms are *dana alokasi umum* (DAU), a complex formula-based general transfer which accounts for almost half the subnational governments' wage bill; DAK, a special allocation fund; and *dana bagi hasil* (DBH), tax and natural resource revenue sharing.

Historically, the different transfers have had different purposes to address vertical and horizontal balance, where the former sense sees resources follow functions assigned, and in the latter sense,

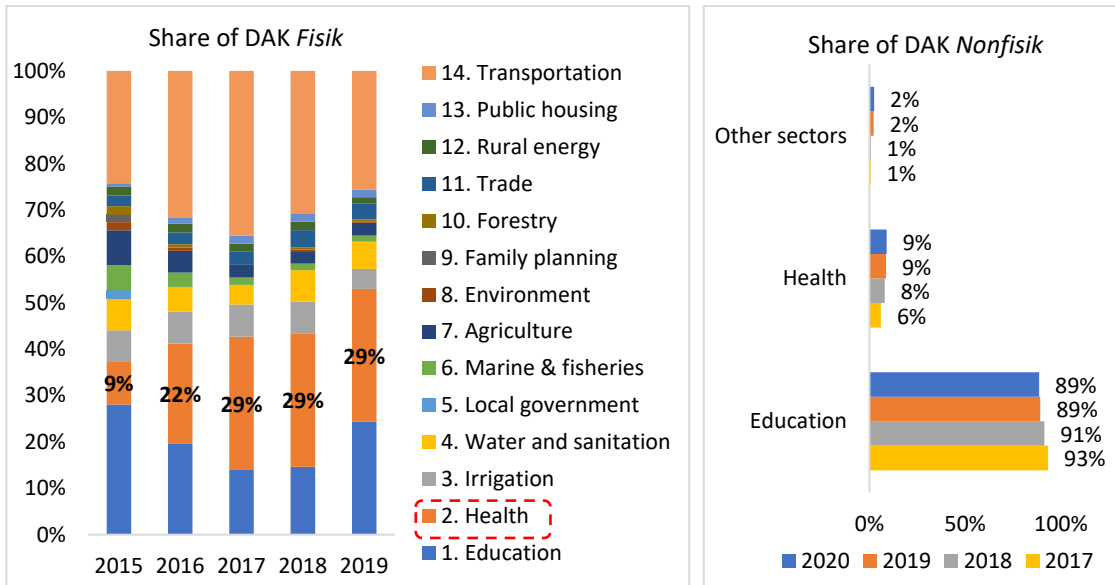
resource availability is equalized across subnational differences in socioeconomic deprivation, local tax-generation ability, and priorities in terms of national goals. Smaller flows are also shown in Figure 13.



DAK. DAK has over time become the second largest transfer. Since Law 14/2015, it has been split to separately cover physical capital investment (*DAK fisik*) within which there are three subcomponents: *regular*, *penugasan* (assignment), and *afirmasi* (affirmation), each with their own sector-specific allocations. The latter subcategory (*afirmasi*) particularly refers to allocations to 196 disadvantaged geographical areas. Recent allocations to health of *DAK fisik* have resulted in the largest shares within this component, comparing well with transportation and education (Figure 14). Another separate and larger category of *DAK nonfisik* covers operational needs and is allocated to a few sectors aligned to national priorities, mostly health and education. Since 2016, the *DAK nonfisik* component includes the health operational assistance funds (*bantuan operasional kesehatan* or BOK) for health, and the BOK for family planning (BOK-KB). The BOK funds can be used for preventive and promotive health. Overall, *DAK nonfisik* has had a relatively stagnant share for health (Figure 14). The DAK system has become fragmented, and it is unclear how well the funds are allocated and correlated to the prioritized needs they are meant to serve.⁹

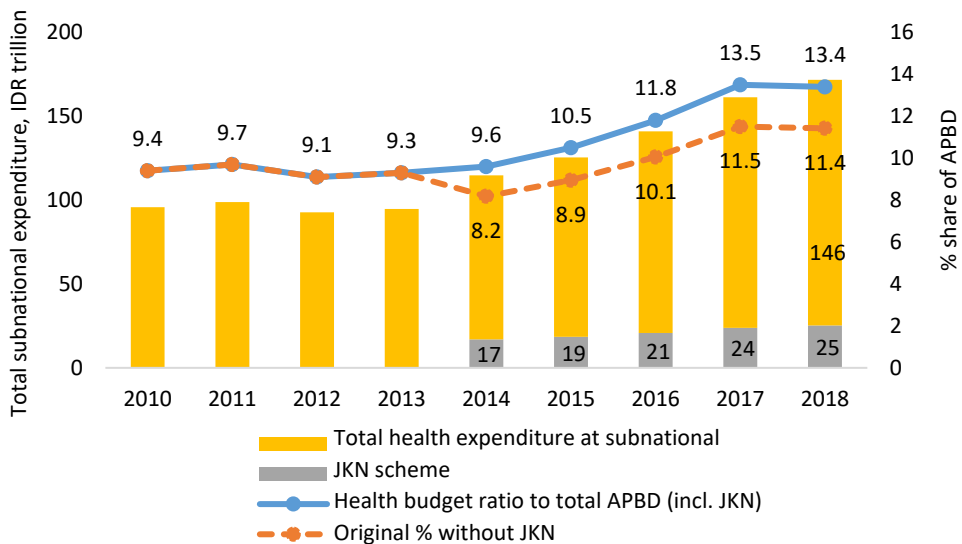
In addition to DAK, tobacco-related taxes shared as part of DBH have earmarks to health. The Ministry of Health is also required to spend its deconcentration (*dekon*) funds locally on program needs aligned to subnational priorities. These values are not shown in this section. Provinces retained 23 percent of DAU, DAK, and DBH transfers in 2017 and 2018, with the rest going to cities and regencies (districts).

Figure 14. Sectoral Shares within DAK



Source: HP+ analysis²²

Figure 15. Subnational Health Expenditure



Source: HP+ analysis²⁴

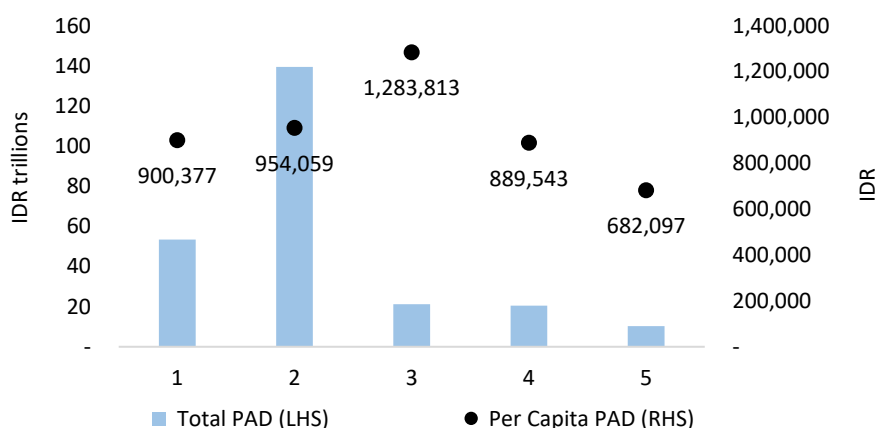
Given this system of transfers and locally oriented spending, health policy papers and the RPJMN have discussed how the subnational level can be incentivized to increase its spending on health, which has stagnated mostly because non-JKN spending did not rise further (Figure 15).²⁴ Subnational health spending as a share of the total subnational budget has recently exceeded the 10 percent goal set by Law 36/2009, but it would be on average 2 percentage points lower without counting JKN capitation and non-capitation payments to primary care facilities, as well as Indonesia case-based groups' payments to subnational government-owned hospitals. In fact, the spending excluding JKN may be lower than the historical trend, suggesting that some district-led spending has been displaced more than expected. Of about IDR 146 trillion of non-JKN spending in 2018 (Figure 15) at this level, only a small share is from earmarked allocations to health. Future increases in health spending would ideally come from new earmarks on sources that subnational governments have discretion over, i.e., those which are more flexible. However, it is not clear if incentives within the system of fiscal transfers and public financial management are aligned to yield this given the push and pull of different factors (Figure 16).^{25,26}

Figure 16. Factors Affecting Subnational Governments Increasing Health Spending



The future impact of factors from Figure 16 which can either increase or stagnate subnational health spending is uncertain. However, policy directives and guidance could change this. For example, districts should generate more own-source revenue (*pendapatan asli daerah* or PAD) from taxes and fees under their control, which would enable greater flexibility to pursue local health goals. Ability to generate PAD varies (Figure 17).²⁴ Overall, PAD is not a major source of revenue at 0.12 percent of GDP.⁹ Historically, DAU, DAK, and DBH transfers together were 60 percent or more of subnational revenues. It has been suggested that the DAU formula may inhibit PAD efforts.⁹

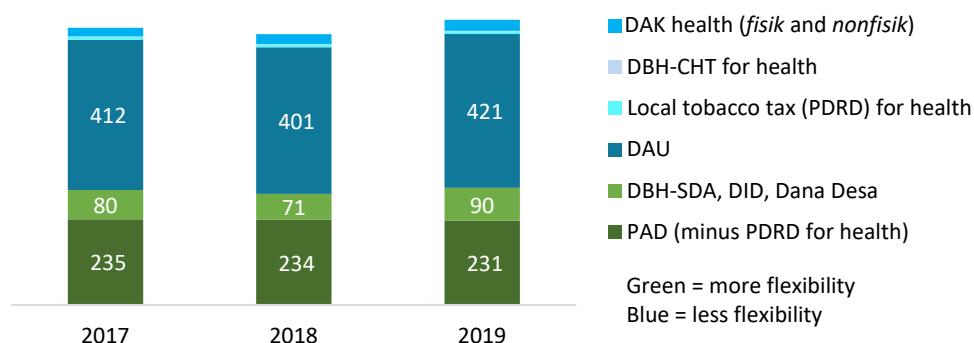
Figure 17. PAD (2019) by Region (Excludes Jakarta)



Region 1 = Sumatera; Region 2 = Jawa – Bali; Region 3 = Kalimantan;
 Region 4 = Sulawesi, Maluku, Maluku Utara; Region 5 = Papua/P. Barat, Nusa Tenggara
 L/RHS: left- or right-hand side
 Source: HP+ analysis²⁴

Using the data sources of Figures 13 and 15, we visualized funds by their flexibility toward additional use for health (Figure 18). Less flexible funds based on current norms include DBH from tobacco excise profit-sharing funds (*dana bagi hasil cukai hasil tembakau* or DBH-CHT), which have had an earmark for health since 2018, as has the local tobacco tax (*pajak daerah dan restribusi daerah* or PDRD) since 2009. The general allocation grant, DAU, has limited flexibility, as its larger part is allocated toward salaries, including health workers. More flexible funds include PAD; other DBH, especially natural resource revenue (*dana bagi hasil sumber daya alam* or DBH-SDA); village funds (*dana desa*); and the small incentive funds (*dana insentif daera* or DID). Flexible funds are not specifically earmarked for a sector, and health should be an allowable spending target. *Dana otonomi khusus* (Otsus), i.e., special autonomy funds given to Aceh and Papua, will phase out in 2021 and hence were not included. Over time, the flexible (green) funding sources have a stable volume, but they will be lower in 2020.

Figure 18. Subnational Funding Sources Compared by Flexibility (IDR Trillions)



Note: For illustration purposes, the chart shows what could have been earmarked from DBH-CHT and PDRD at a 50 percent level from 2017 onwards; however, firm earmarks to health from DBH-CHT only came into effect beginning in 2018.

Scenarios. We simulated the scenarios described in Box 1 using projected values for the flexible funding sources and adding DAK for health (*fisik* and *nonfisik*) to show the full fiscal space (see Figure 19). Future values of subnational transfers were taken from the APBN projection model and from the baseline scenario for DBH-CHT and PDRD earmarks (see Figure 23 in the next section). Scenario 2 is ambitious, especially if subnational governments look at PAD to finance competing demands. These choices firmly allocate **IDR 33–36 trillion** more per year for health. These are in addition to the spending on health worker wages from DAU. These new earmarked allocations should theoretically help create more protected budgetary space at the subnational level to help achieve RPJMN targets and health minimum service standards (*standar pelayanan minimal* or SPM).

Box 1. Scenarios for Earmarked Budgetary Space for Health at the Subnational Level

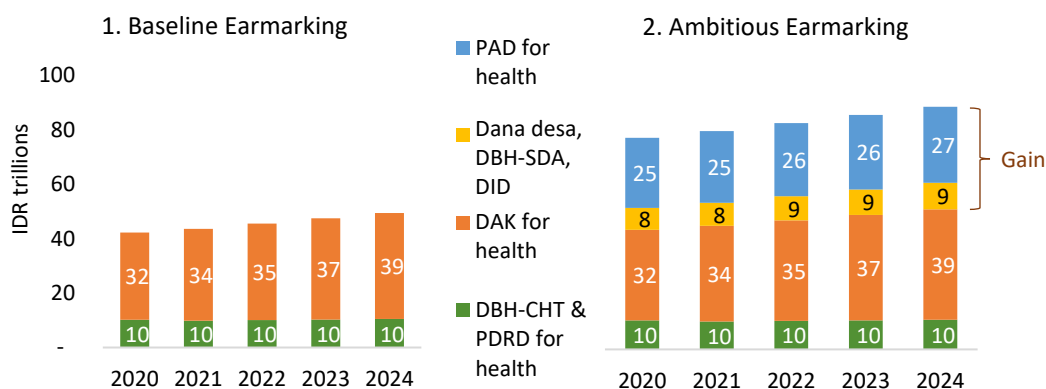
Scenario 1 (baseline): Earmarked allocations to health

1. Maintain the 50 percent share (minimum) from DBH-CHT and PDRD post-2020
2. DAK health share (*fisik* and *nonfisik*) assumed as fixed, total-value increases over time as in Figure 19

Scenario 2 (ambitious): Earmarked allocations to health

1. In addition to assumptions of Scenario 1, earmark a minimum of **10 percent** from DID, DBH-SDA, and *dana desa*
2. Earmark **10%** of PAD for health at a minimum

Figure 19. Scenario 1 (Baseline Earmarking) and Scenario 2 (Ambitious Earmarking)



Source: HP+ analysis

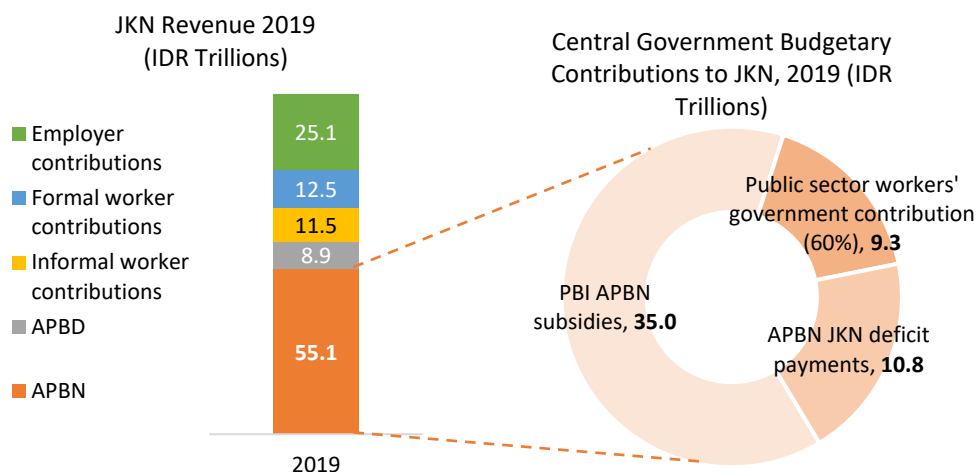
Results: Policy Options for JKN and Their Impact on Fiscal Space

National Health Accounts data show that JKN has a growing share of total health expenditure and may have contributed to a reduction in the share of out-of-pocket since 2014 given its generous benefits package, which currently requires no co-payments or additional fees for members to access healthcare. While coverage has increased steadily to reach 221 million people by mid-2020, coverage growth has stagnated in the first half of 2020. Further reducing the proportion of out-of-pocket health expenditure and, therefore, improving financial protection will require a concerted effort to reach the remaining unenrolled population, which amounts to more than 40 million people. However, the government must also strengthen and promote the sustainability of JKN considering the efficiencies in its spending for curative care and recent uncertainty in premium rate setting. A significant factor affecting scheme revenue from the voluntary informal sector segment is collectability, i.e., the proportion of JKN members who are up-to-date on their membership contributions. In 2019, of the 30.3 million informal sector members, approximately 40 percent had outstanding dues.²⁷

Figure 20 shows that the central government paid IDR 55 trillion into JKN through various channels in 2019. This was up from IDR 44 trillion in 2018. The 2019 value represented 49 percent of JKN revenue and comprised a mix of (1) full subsidy for 96.6 million persons identified as poor and near-poor (PBI APBN), (2) a 60 percent share of payroll contribution for public formal sector workers who contribute 5 percent of their salary as JKN premiums, and (3) an IDR 10.8 trillion payment toward the JKN deficit. Perpres No. 75/2019 mandated an increase in the PBI APBN rate from IDR 23,000 to IDR 42,000 per member per month effective August 1, 2019. Combined

with the addition of 4.5 million more PBI members over 2019, this meant an additional IDR 9.5 trillion in subsidies compared to 2018.

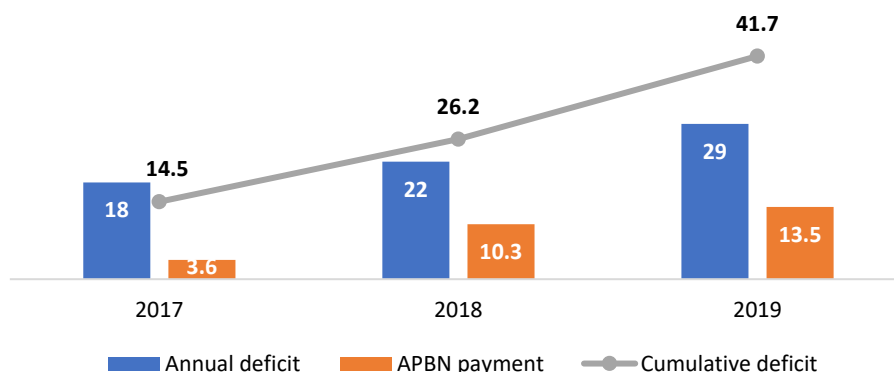
Figure 20. Mix of Sources for JKN Revenue in 2019



Source: HP+ analysis based on BPJS-K audited annual statements 2018 and BPJS-K reported enrollment 2019

Baseline scenario. Holding the number of members subsidized through PBI APBN constant is the core aspect of the baseline scenario. The rationale for maintaining the PBI APBN segment at 96.6 million members is that poverty levels have consistently declined in Indonesia while GNI per capita continues to rise (Figure 1). At the current PBI APBN size, which is more than 40 percent of population, many near-poor are already subsidized, even before JKN members fully subsidized by local governments (PBI APBD) are counted. Therefore, further expansion of subsidies would benefit non-poor populations and may not be an equitable or efficient use of government budgetary resources for health. However, if the total PBI APBN number remains unchanged, based on current growth JKN coverage will grow modestly to cover 87 percent of the Indonesian population by 2024. This is short of the RPJMN target of 98 percent coverage for that year. With PBI APBN membership fixed at current levels, JKN may still face future annual deficits and hence require APBN financing through extraordinary allocations. With JKN annual deficits reaching IDR 29 trillion in 2019 (Figure 21), the cumulative carried-over deficit is rapidly rising.

Figure 21. JKN Deficits (Annual and Cumulative), Net of APBN Payments (IDR Trillions)



Source: HP+ estimates, based on BPJS-K audited annual statements, 2018 and BPJS-K reported enrollment, 2019

In future years, even with a fixed total number of PBI members, the increase to the PBI contribution rate may significantly reduce, but not eliminate, JKN deficits. In 2020, the first full year of the implementation of the new PBI rate (IDR 42,000, an 83 percent increase), there will be IDR 22 trillion in additional APBN subsidies over 2020. The baseline scenario also considers the impact of the recent presidential regulation Perpres No. 64/2020, which has raised contribution rates for the informal sector since August 1, 2020 (Table 1).

Table 1. Revised Rates for Informal Sector (PBPU) Members, Perpres No. 64/2020

Member Class	Per Member per Month (IDR)	
	To July 31, 2020	From August 1, 2020
Class I	IDR 80,000	IDR 150,000
Class II	IDR 52,000	IDR 100,000
Class III	IDR 25,500	IDR 42,000

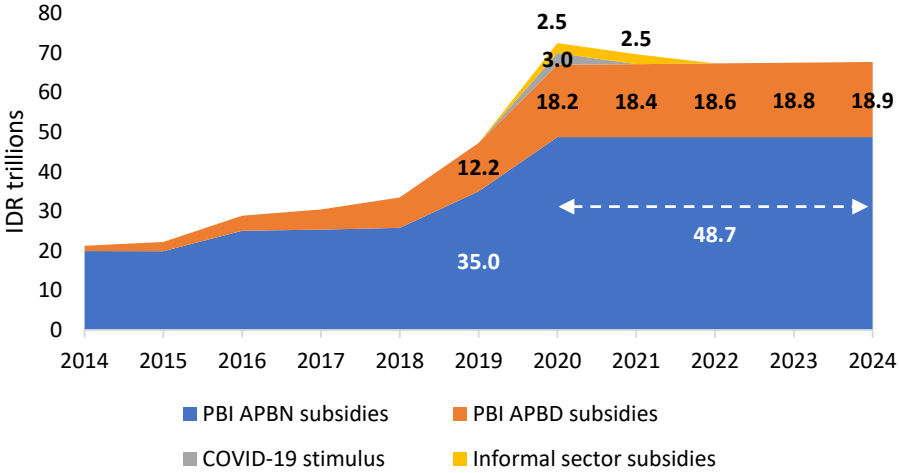
The baseline scenario also incorporates mitigating actions undertaken by the government in light of the COVID-19 pandemic, including a one-time IDR 3 trillion payment to the national social health insurance agency (*Badan Penyelenggara Jaminan Sosial-Kesehatan* or BPJS-K) to cover membership dues for voluntary informal sector workers (PBPU) who face precarious employment and income insecurity. This payment was sufficient to provide four months of coverage for all informal sector members at the Class III rates of IDR 25,500 per member per month.

After these four months, to ease the transition for Class III members, the Perpres states that the government will be providing partial, tiered subsidies for Class III

members. In the rest of 2020, the subsidy from APBN will be IDR 16,500 per member per month, in effect maintaining the members' contribution rate at the previous IDR 25,500 per month. In 2021, the subsidy will drop by more than 50 percent to IDR 7,000 per member per month, thus requiring each member to contribute IDR 35,000 per month. As the subsidies apply for different time periods in each year (i.e., five months in 2020 and 12 months in 2021), the cost in each year is projected to be roughly the same at an estimated IDR 2.5 trillion per year. In projecting PBPU members' JKN benefit class elections, we assumed that the significant increase in Class I and II rates (88 and 92 percent, respectively) from Table 1, coupled with the subsidy on offer for Class III benefits, would shift members' ongoing elections toward Class III, with a small increase in Class I and Class II elections each year thereafter as the partial subsidy toward Class III lessens in 2021 and is eliminated by 2022.

Figure 22 shows the cumulative fiscal impact of the baseline scenario, based on known government policies—specifically the impact of the COVID-19 stimulus from April to July 2020, the increase in PBI subsidy rates beginning in August 2020, and the tiered, partial subsidies for informal sector Class III members that will run from August 2020 to December 2021. All PBI APBD will have a monthly contribution rate increased to match the PBI APBN rate. All PBI APBD will have a monthly contribution rate increased to match the PBI APBN rate.

Figure 22. Baseline Scenario: Government JKN Subsidies



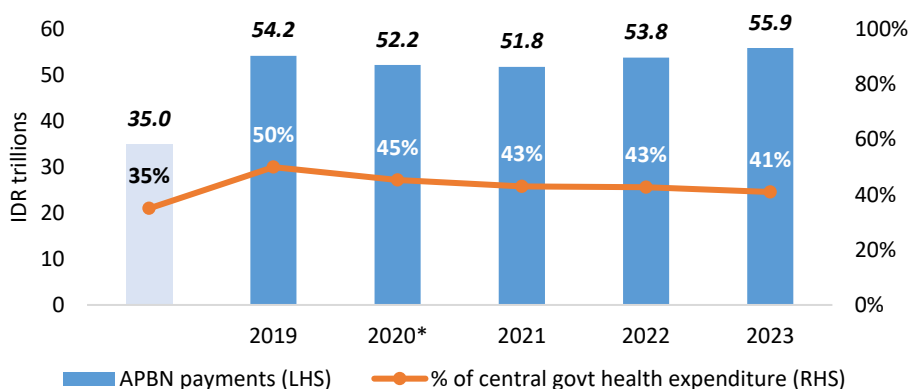
Source: HP+ simulation

In 2020, APBN contributions to JKN are projected to reach IDR 54.2 trillion, a 55 percent increase from 2019. Seventy percent of the increase comes from the increase in the PBI APBN premium contribution rate applying for a full year, and the remainder from the COVID-19 stimulus and the partial informal sector subsidies. The APBN contributions to JKN have peaked in 2020 due to the COVID-19 stimulus,

before reducing to IDR 51.2 trillion in 2022. Partial subsidies for informal sector members are also still in effect and will stabilize at IDR 48.7 trillion beginning in 2022 once those subsidies are phased out under the baseline scenario.

Scenario 1: Meeting the RPJMN PBI APBN target. The RPJMN states a target to expand subsidized PBI APBN to 112.9 million people by 2024, a total increase of 16.3 million over the current number. In this analysis, we consider the fiscal impact of this scale-up. For Scenario 1, we assume a linear expansion from 2021 to 2024 to reach the RPJMN target of 112.9 million PBI APBN members. Combined with the 80 percent increase in contribution rate for PBI APBN members effective from August 1, 2019, this goal would require the central government budget to pay IDR 55.9 trillion in PBI APBN subsidies in 2024 (Figure 23), a 60 percent increase on the IDR 35 trillion in PBI subsidies paid in 2019.

Figure 23. Government APBN JKN Subsidies to Reach RPJMN PBI Target



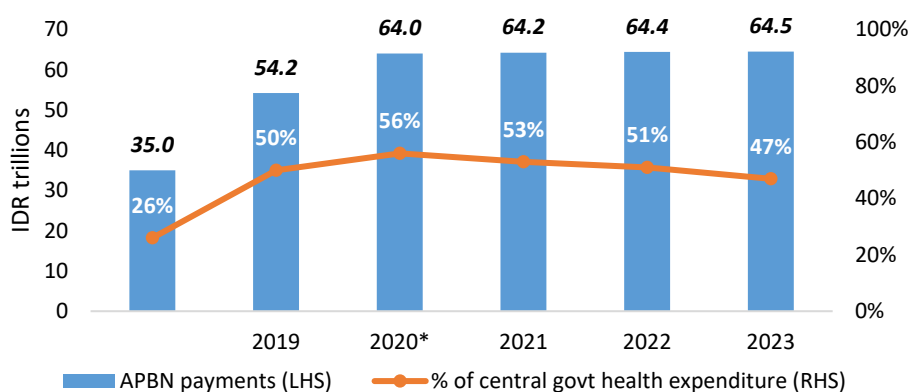
* Includes one-time IDR 3 trillion allocation related to COVID-19 mitigation
L/RHS: left- or right-hand side (y-axes)

There are several policy options to identify 16.3 million members over time to be newly covered as PBI APBN. Each has pros and cons and may face operational challenges in implementation. First, BPJS-K could consider bringing uninsured members who have never been previously enrolled into the JKN scheme as fully subsidized PBI. This would increase JKN enrollment coverage and support major strides toward universal coverage. Given our analysis, JKN can reach an estimated 96 percent of the population by 2024 with this approach. Second, a different option would be to target the current voluntary informal sector members (PBPU) delinquent on their membership dues. This would address collectability issues, which will support improvement in BPJS-K’s claims ratio. These members are more likely not to need specialized care, and subsidized coverage may not have much effect on their utilization in the short term. A third option would be to extend the partial subsidies offered to Class III members under Perpres No. 64/2020 over 2020–2021 into fully

subsidized membership as of 2022. This may be the most equitable approach if Class III membership is analogous to lower socioeconomic status. This group was likely to have been paying dues but may face an excessive financial burden with the revised Class III rates once the partial subsidies from Perpres No. 64/2020 expire.

Scenario 2: Subsidizing all informal sector members. In this alternative, more ambitious scenario, we assume that all non-poor informal sector workers become fully subsidized PBI APBN members. Based on the 2020 PBPU segment size, we assume 30.6 million informal sector members would be immediately subsidized in 2021. Thereafter, based on previous annual growth in this segment, the number would rise to 31.6 million by 2024. In this scenario, 70 percent of all JKN members would be fully subsidized in 2024 (i.e., 64 percent of the Indonesia population). This would address the longstanding collectability issue, which a myriad of other approaches such as enforced waiting periods, fines, household enrollment, and links to public services have not been fully able to resolve. However, the costs to the government budget are significant, and this policy could influence labor markets. For example, it may encourage some formal sector employers to adopt informal arrangements. Total costs are expected to reach IDR 64.5 trillion in 2024 (Figure 24), falling as a share of central government health expenditure from a projected peak of 56 percent in 2021 to 47 percent by 2024. The growth in informal sector members here may be understated if the subsidy encourages more uninsured Indonesians to become interested in JKN, in which case costs to APBN may increase faster. Nevertheless, costs will still stabilize in the longer term as universal enrollment is approached, resulting in overall PBI-related spending constituting a smaller share of central government health expenditure in the future after 2024.

Figure 24. Government APBN JKN Subsidies to Subsidize All Informal Sector Workers



* Includes one-time IDR 3 trillion allocation

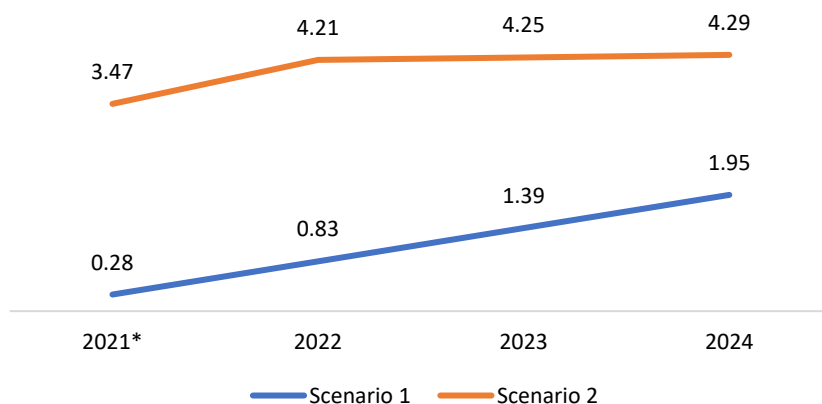
L/RHS: left- or right-hand side

Source: HP+ analysis



The role of subnational governments in subsidizing JKN PBI members. Local governments also provide JKN membership subsidies to some constituents (PBI APBD). Many of these members were previously covered by Jamkesda schemes and were transferred to JKN. Subnational governments have autonomy to determine how many of their constituents to subsidize and to what extent. As of mid-2020, subnational governments subsidized 34.4 million people. We have assumed that the PBI APBD rate was changed to that put forth in Perpres No. 75/2019. In presenting the fiscal impact of the two expansion scenarios above, we assumed that the APBN will fund the additional cost. However, there may be scope for local governments to absorb some of the costs of expanded subsidies for additional PBI. If we assume that the 2019 PBI APBN:PBI APBD ratio remains constant, this means that some of the additional PBI are under APBD, which could shift an additional IDR 2 trillion and IDR 4.3 trillion annual costs to subnational budgets by 2024 for Scenarios 1 and 2, respectively (Figure 25). These cost-sharing arrangements could be significant in magnitude. In 2024 the subnational governments would bear a 27 percent share of the incremental costs from pursuing expanded subsidized membership of JKN under either Scenario 1 and 2.

Figure 25. Government APBN JKN Subsidies to All Informal Sector Workers (IDR Trillions)



* For Scenario 2, Perpres 64/2020 partial subsidies are APBN funded.
Source: HP+ analysis

Summary. Above we analyzed a baseline scenario and two expansion options the government can consider to expand JKN coverage and improve financial protection. Countries that have achieved near universal health insurance enrollment, e.g., Thailand, Korea, Japan, China, and Taiwan, have done so through diluting a payroll-based or labor-linked social health insurance model, and they have embraced the expansion of subsidies beyond the poor and near-poor to also include non-poor informal sector participants. By contrast, Indonesia has seen overall coverage growth

stagnate at 82 percent or 221 million people since early 2020. The full impact of expanding APBN subsidies on enrollment coverage and scheme sustainability will ultimately depend on whether policy implementation is targeted towards any new members, or specifically to informal sector members. Scenario 2 has a larger equity benefit from the outset as it assumes 30.6 million informal sector members are immediately transferred over to fully subsidized membership beginning in 2021, while Scenario 1 assumes a gradual scale-up to 112.9 million subsidized members by 2024. The RPJMN target for 2024 can be addressed through either approach, but the expansion of subsidies to all informal sector members will address collectability issues that have plagued the scheme and contributed to deficits to date. Subnational governments should also be considered as a potential source of funding for the expansion of subsidized members. While fiscal capacity will vary by subnational area, if we assume the current ratio of national to subnational subsidized members is maintained, this could reduce future burden on APBN. Table 2 in the Discussion section considers the PBI expansion scenarios in terms of how they could be financed.

Results: Additional Fiscal Space from Earmarked Taxes

In Indonesia, additional revenue to be allocated to health from tobacco taxation is a frequently raised policy issue.⁹ Recently, sugary beverages were included in these discussions.²⁸ This section discusses the recent trends in such tax collection in Indonesia and the potential to collect more, including from a new excise tax on sugary beverages.

Tobacco products are subject to both excise duty (tax) and VAT in the country. Only tobacco and alcohol currently incur excise tax. Given the high prevalence of smoking in Indonesia, the public health benefits of induced demand reduction would be significant. A study of demand elasticity projected that a 10 percent increase in the average price of a pack of cigarettes would reduce smoking prevalence by only 0.05 percent and demand by 4.7 percent.²⁹ This suggests that taxation could increase prices substantially before demand and, hence, revenues would be majorly affected. Indeed, excise taxes are a substantial part of the retail price, as shown in Figure 26b. The average rate has increased annually, except in 2019, with the largest ever increase in 2020 (Figure 26a).³⁰ The potential for further increase may be limited. Tobacco taxation in Indonesia has been extensively studied, including the use of these revenues for health.^{8,31,32} The topic of reform of tobacco excise taxes in Indonesia is complex across product types, social and employment concerns, and patterns of demand. Since the excise tax is implemented on an *ad valorem* basis rather than a specific amount per unit, producers behave strategically to avoid very high average tax liability and, overall, compared to other countries in the region, prices are relatively low.³³ How much of the excise tax rate increase is passed on as a



retail price increase depends on the type of cigarette. In 2020, the price increase could be as much as 35 percent for the more expensive product types. Reduction of the number of rate tiers and of illegal production (tax avoidance) could increase average price and revenue.^{9,33}

The role of tobacco excise in government revenue and for health.

Tobacco excise tax collections contribute 95 percent to 96 percent of all excise taxes. In recent years, total tobacco taxes (excise and VAT) have contributed 11 percent to 12 percent of central tax revenues, including projected collections for APBN 2020 prior to COVID-19. Tobacco excise taxes are allocated to health based on several

laws. For illustrative purposes, Figure 27 shows diagrammatically how a notional IDR 110 trillion would be allocated to health as per regulations in 2020. As per Law No. 39/2007, 2 percent of the tobacco excise collection must be statutorily transferred to subnational governments as DBH-CHT, allocated by a specific formula that favors tobacco-producing regions. An additional 10 percent of tobacco excise collected is transferred to subnational governments proportional to their population, as per Law No. 28/2009. This is considered a form of PAD and referred to as PDRD. At least 50 percent of this must be allocated to health. Since Perpres No. 82/2018, 50 percent of the DBH-CHT transfers must also be allocated to health, of which 75 percent should support efforts to achieve universal health coverage in line with JKN and the aims of BPJS-K. A large amount of tobacco excise tax is available for general use in Indonesia, and only **6 percent** is earmarked to health across levels, compared to 50 percent in the Philippines.³⁴

Figure 26a. Increase in Tobacco Excise Rates (Average Increase across Types, Yearly)

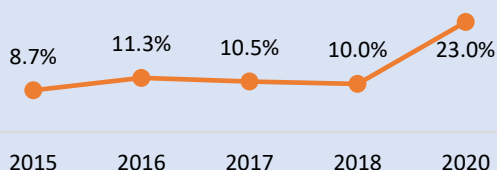
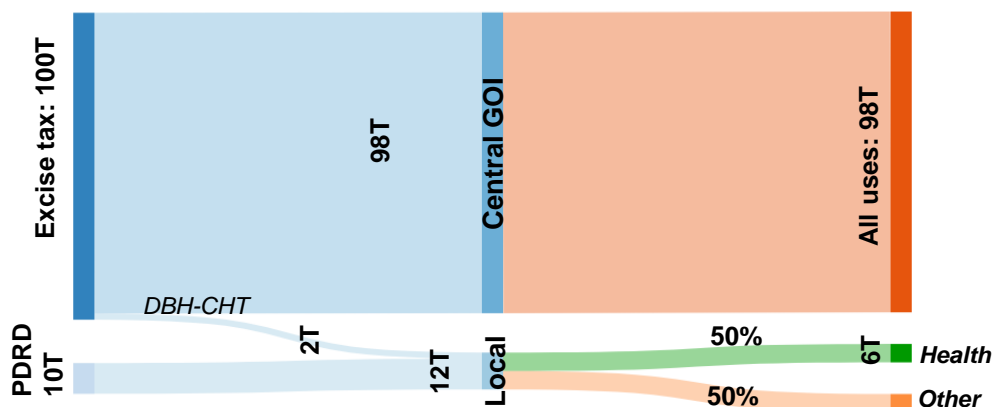


Figure 26b. Elements of Final Retail Price of a Cigarette Pack*



*Assumes price of IDR 18,000 for hand-rolled cigarettes, excise rate of IDR 740/gram (2020), 16 cigarettes per pack
PDRD: 10% of excise
Source: HP+ analysis with data³⁰

Figure 27. Distribution of Notional IDR 110 Trillion (T) in Tobacco Excise Taxes in 2020



GOI: Government of Indonesia
 Source: HP+ simulation

Scenarios of increased allocation of tobacco excise to health. We

constructed scenarios for allocating to health more of the currently unrestricted revenue from tobacco excise tax collections retained at the central level. Scenarios are described in Box 2. We projected centrally collected tobacco excise taxes, which is the bulk of total excise revenue used in previous calculations (see Figure 10). Historical collections and previously projected collections for 2020 are shown in Figure 28. The Ministry of Finance had projected an 11 percent reduction in production for 2020 given the increase in excise tax rates, set before COVID-19 impact on production and demand. The Ministry of Finance projected a net revenue of IDR 173 trillion, which would be an increase.

Box 2. Scenarios for Increased Fiscal Space for Health from Tobacco Excise

Scenario 1: Allocations to health.

Assumed 5 percent of centrally retained tobacco excise revenue could be earmarked (currently zero), as well as 55 percent from DBH-CHT and PDRD at subnational government levels (up from 50 percent currently).

Scenario 2: Allocations to health (ambitious).

Assumed 7.5 percent of centrally retained tobacco excise revenue could be earmarked (currently zero), as well as 60 percent from DBH-CHT and PDRD at subnational government levels (up from 50 percent currently).

We assumed no further increases in excise tax rates over 2021–2024, but a further decline in production of 5 percent in 2021 given the lagged effect of low 2020 demand and anticipated weak 2021 demand. We assumed that beginning in 2022, production will recover and grow at 2 percent. Results of the scenarios can be seen in Figure 29. The scenarios in Box 2 would still leave most of the tobacco excise revenues unrestricted, maintaining fiscal flexibility for the government. Scenario 1 would increase earmarking to health from tobacco excise tax revenues across levels to 11 percent, while Scenario 2 would increase this to 13.8 percent, still below that of the Philippines. Scenario 1 would nearly double the overall earmark to health compared to baseline, with 40 percent of the total contribution coming from the new earmark from centrally retained tobacco excise taxes, which were previously unconstrained. For Scenario 2, the equivalent values are 2.3 times the baseline, with 48 percent of the total earmark contributed from the centrally retained excise taxes. Overall, these policies could release an additional **IDR 9–13 trillion** per year for health.

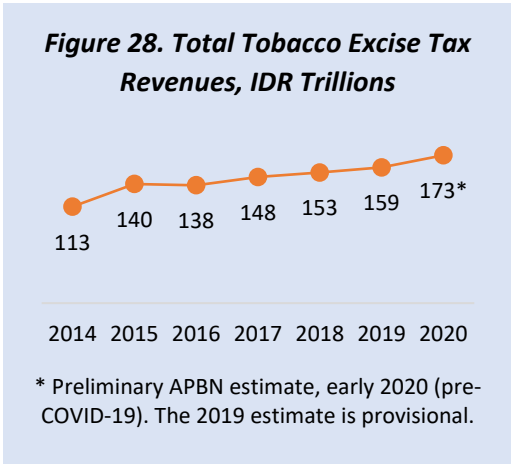
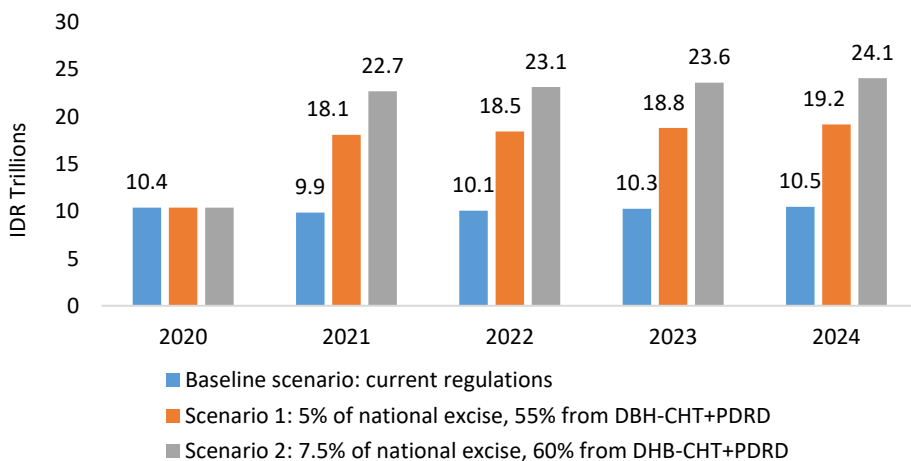


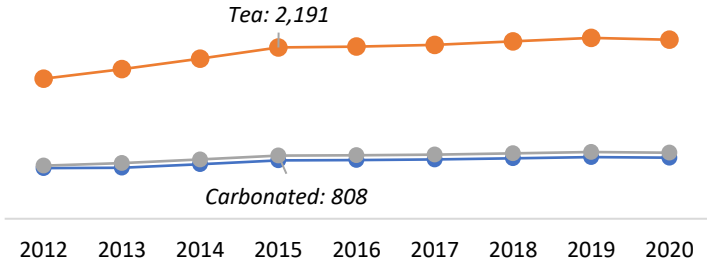
Figure 29. Scenarios of Increased Allocation from Tobacco Excise Taxes to Health



Source: HP+ analysis

Scenarios of an excise tax on sugary beverages and allocations to health. As part of the discussions for the omnibus tax bill, in February 2020, the Ministry of Finance proposed expanding the excise list to add three categories: sugary beverages, plastic bags, and polluting vehicles. This proposal was still pending approval as of May 2020. The Ministry of Finance made proposals for specific excise rates per liter of sugary beverages, i.e., not *ad valorem*, for three categories: bottled tea at IDR 1,500, carbonated beverages at IDR 2,500, and other drinks such as energy drinks, also at IDR 2,500.

Figure 30. Total Production, Sugary Beverages (Millions of Liters)

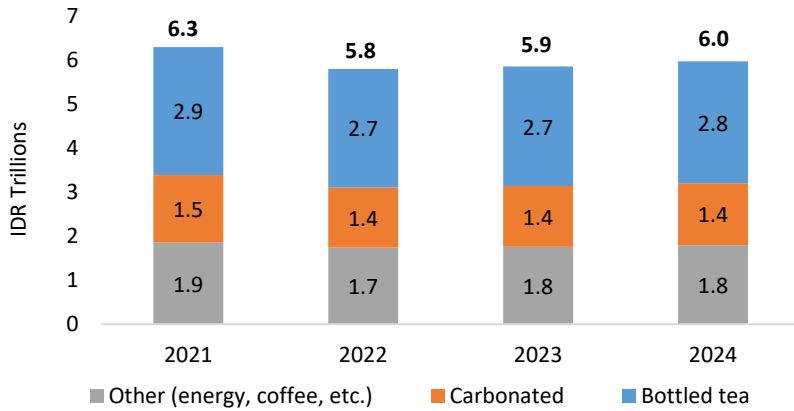


Source: HP+ analysis³⁵

The Ministry of Finance’s preliminary estimate of revenue from the excise tax was IDR 6.5 trillion per year, using dated production volumes. In Figure 30, we show our estimate of the production trend for two categories, using best available industry data from 2015 (circled in the chart). Based on news from the industry association, *Asosiasi Industri Minuman Ringan*, we updated the volume trends to 2020, assuming slow recent growth.³⁵ We assumed that the new excise rates will go into effect in 2021, along with a sharp demand reduction that year as per price elasticity assumptions in a recent study²⁸ and a smaller lagged reduction in production volume in 2022. Thereafter, we assumed a small recovery in production and demand over 2023–2024. We assumed a full earmark to health.

Figure 31 suggests that about **IDR 6 trillion** could be released annually for health over 2021–2024 from an earmarked excise tax on sugary beverages.

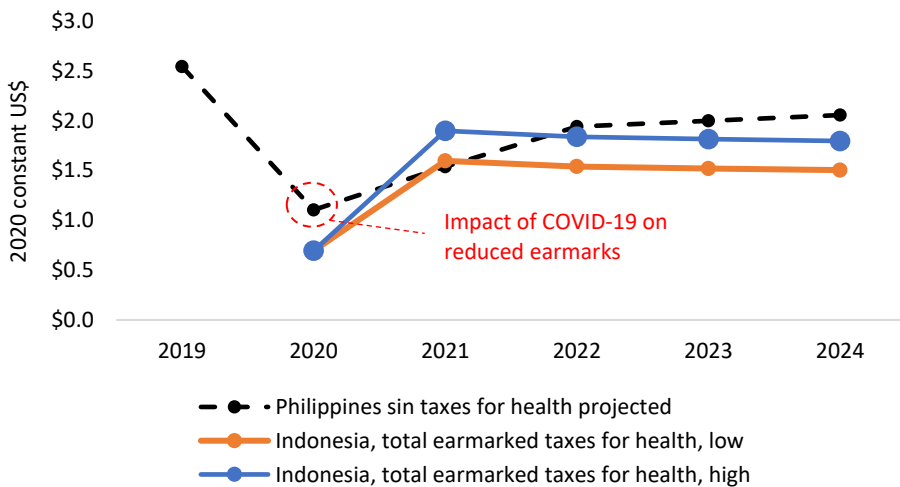
Figure 31. Revenues from an Excise on Sugary Beverages (100% Earmark to Health)



Source: HP+ analysis

Combining the scenarios from Figures 29 and 31 in real US dollar terms and comparing them with a recent fiscal space for health projection for the Philippines,³⁶ it appears that Indonesia has the chance to catch up to its neighbor by 2021 in terms of earmarks to health if it adopts the more ambitious tobacco tax earmarks as proposed in this report (Figure 32). However, with legislated future annual increases to tobacco excise rates and a diverse mix since 2012 of earmarks to health from gaming revenues and excise taxes on sugary beverages, alcohol, and tobacco (including vapor products), the total collections in the Philippines will recover and continue to outperform those of Indonesia.

Figure 32. Comparison of Earmark Taxes for Health, Constant US\$ Billions



Source: HP+ analysis, other³⁶

Discussion

Additional fiscal space for health. Given the persistent calls for Indonesia to increase its levels of spending on health, and to allocate spending more efficiently,⁹ there is a need to relate the additional release of fiscal space from the analyses above to its potential key uses. Table 2 maps sources to potential uses.

Table 2. Sources and Potential Uses of Additional Budgetary Space for Health

Sources	Potential Applications of Additional Funds
<p>1. Subnational: Using more flexible sources within overall fiscal transfers to fix additional allocations to health</p> <p><i>Value: IDR 33–36 trillion more earmarked per year</i></p>	<p>Related to JKN: Accommodate PBI APBD contributions over time, which increase to a total need of IDR 18–19 trillion per year compared to IDR 12 trillion in 2019</p> <p><i>Additional costs: Average IDR 6–10 trillion more per year over 2020–2024^a</i></p>
<p>2. Subnational: Earmarking more from tobacco tax revenues transferred to the subnational level</p> <p><i>Value: IDR 11–13 trillion more per year</i></p>	<p>Related to public and primary health: Accommodate increased public sector service delivery costs of essential health interventions, which increase from IDR 38–44 trillion in 2020 to 42–54 trillion by 2024³⁷</p> <p><i>Additional costs: IDR 5–10 trillion more annually by 2024 compared to 2020^b</i></p>
<p>3. Central: Earmarking more from centrally retained tobacco excise taxes and adding an excise tax on sugary beverages for health</p> <p><i>Value: IDR 13–18 trillion more per year</i></p>	<p>Related to JKN: Accommodate PBI APBN contributions over time, which increase to a total need of IDR 60–76 trillion per year compared to IDR 55 trillion in 2019</p> <p><i>Additional costs: Average IDR 15–27 trillion more per year over 2020–2024^a</i></p>

^a Range based on scenarios for expansion of PBI or coverage of the non-poor informal sector members, as well as share of the increase in subsidized members between APBN and APBD

^b Range driven by assumptions on subtracting private sector costs from within annual totals from RPJMN costing of essential health interventions, which comprise mostly primary healthcare³⁶

Table 2 suggests that at the central level, additional earmarking from tobacco and sugary beverage excises taxes, of which the latter do not exist and would have to be introduced, can help meet the additional costs of scenarios to expand JKN coverage via subsidized members and absorb the cost of increased premium rates for PBI members. The additional earmarks are modest and below the levels of allocation to health seen in the Philippines. This prioritization of health in the APBN will preserve the gains for health from a return to GDP growth in the future and a concomitant increase in central health expenditures, especially in applying this natural increase toward other acute needs from the Ministry of Health budget, such as spending on essential disease programs, public and community health, human resource deployments, and medicines and equipment. At the subnational level, more focused



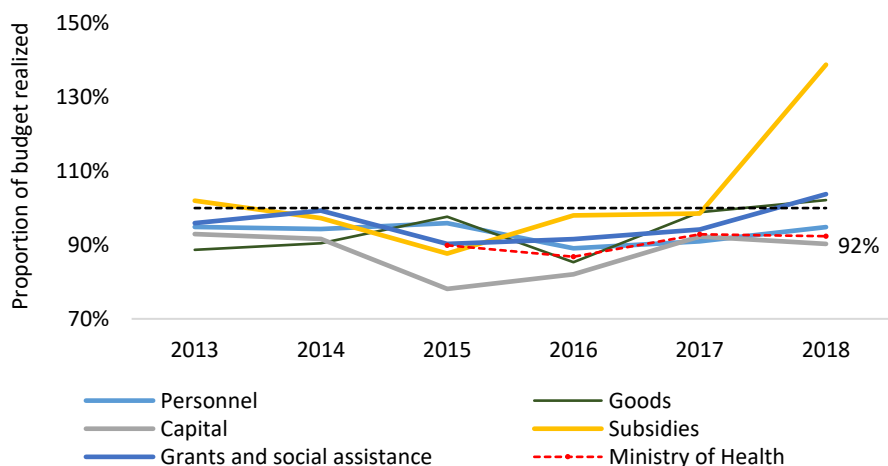
allocations from flexible sources, as well as a minor increase in earmarks from tobacco taxes transferred to this level, can help to accommodate the increase in costs of service delivery expected in public facilities to meet RPJMN-linked expansion in coverage of interventions and quality. The additional protected allocations to health at the subnational level can also help districts absorb some of the increase in numbers of subsidized members of JKN under APBD.

The sources of additional budgetary space analyzed here exclude funds which could be released through improved contribution design for JKN. For example, in the formal sector, these may include revisions to the payroll contribution rate, increasing the ceiling for assessable income for the formal public sector segment as it was increased for the private sector in 2020, etc. There may be more effective mechanisms which focus on reducing collectability losses in the voluntary informal sector membership in the absence of the expansion of subsidies. These measures may yield significant annual income for BPJS-K and assist in meeting the needs of a growing overall JKN membership and increasing utilization of benefits.

The issue of charging co-payments for utilizing certain types of JKN benefits was not explored. While co-payments are used for cost sharing and to influence unnecessary or inappropriate care in many health insurance systems, they should be appropriately targeted to high-cost and elective interventions, and where imposing such payments is not inequitable and can generate improved care pathways. Such measures were proposed and permitted (Perpres No. 82/2018) but have not been analyzed systematically.

Gains in efficiency of spending for health needed. Efficiency-generating measures for JKN or for spending on health at the subnational level were not analyzed. However, we considered execution of the Ministry of Health budget as a possible public financial management inefficiency. While Ministry of Health budget execution rates could improve further, they are on par with the rest of the central government (Figure 33).³⁸ Ministry of Health execution of its *dekon* budgets (82 percent in 2018) could particularly be improved to raise the overall rate. Budget execution rates for subnational governments were not available by sector; however, overall health spends must be utilized fully before additional earmarked funds are envisaged.

Figure 33. Central Government Budget Execution Performance, including Ministry of Health



Continued health expenditure growth for JKN will be driven by increasing membership and increasing the use of benefits, especially in PBI APBN and formal sector segments where past claims ratios were below 100 percent. Reduction of JKN benefits to seek efficiency gains is unlikely from a political perspective in the short term other than through the occasional use of health technology assessments led by the Ministry of Health to prune the list of covered procedures, diagnostic techniques, and medicines which are high cost and less effective. Expenditure reduction should be more intensively explored by eliminating claims inefficiency and fraud, increasing compliance with the gate-keeping and referral policies of the system as already designed or possible through reform, and imposing overall caps on hospital care using global budgets. The latter is in the trial phase at selected hospitals. Overall, the impact of these expenditure-reduction policies on JKN spending have not been conclusively studied or publicly disseminated. The *Public Expenditure Review* has suggested that gaining efficiency in hospital-based care under JKN along the lines of other hospital systems (from 5 to 11 percent of total) would yield savings of IDR 3.6–7.9 trillion, which is significant.⁹ In addition, linking health spending from transfers to subnational governments to performance and quality measures will generate efficiency, though the economic value of these changes as proposed elsewhere⁹ is hard to measure prospectively.

Summary of conclusions and recommendations. Table 3 summarizes our key conclusions from the fiscal space analysis against the research questions from Figure 7.

Table 3. Summary of Conclusions and Recommendations

Research Question	Conclusions/Recommendations
<p>Given macroeconomic predictions, what will be the baseline budgetary space for health at the central level, including for transfers to provinces and districts?</p>	<p>For 2020, the central government has lowered expectations for revenue and fiscal transfers. With increased deficit-led financing, higher COVID-19 and countercyclical spending was afforded for 2020–2021. Fully spending this extraordinary allocation is crucial for maintaining the health sector’s status as an effective user of fiscal resources, especially since execution was initially lagging. In the future, the budgetary space for significantly expanding Ministry of Health spending will be limited. Constraints will continue, especially given the higher PBI APBN premium rate from late 2019. However, if PBI APBN spending is not expanded further, there will be space for other non-JKN spending in the Ministry of Health budget as central government revenues recover and expenditure is raised, even as the government returns to its long-term deficit target. However, to increase central health expenditures to accommodate expansion of JKN subsidies, additional budgetary space is required, or other sectors must face cuts.</p>
<p>Can subnational governments increase their prioritization of health?</p>	<p>Subnational governments will have a constrained fiscal environment in 2020–2021. Many of the transfers to subnational government are less flexible (e.g., DAU) or already have earmarked allocations to health. Ministry of Health spending through <i>Dekon</i> funds do not offer sufficient autonomy for the districts to direct their uses. Positives include new rules since 2018 requiring more explicit prioritization of health from tobacco taxes devolved to the local level. However, more guidance and tracking are needed for how districts should use or are using these earmarked funding sources for health effectively. This should link to needs under the SPM. More local resources could be explicitly prioritized for health if spending flexibility in certain other sources within transfers and in local own-source tax revenue are exploited.</p>
<p>What are the budgetary impacts of different policy options in the RPJMN to raise JKN coverage and sustainability?</p>	<p>To meet RPJMN goals to expand PBI membership and to increase the coverage of JKN overall, the government must consider subsidizing informal sector members, yet these policy options require considerable resources from APBN. The increase in PBI contribution rate in 2020 has already significantly increased APBN spending. With the BPJS-K financial deficit beginning to improve because of the increased PBI contribution rate, the key task for the government is to examine sources of financing to accommodate a PBI expansion, including through APBD, as possible.</p>

Research Question	Conclusions/Recommendations
<p>How is budgetary space for health affected if new or existing sources of government revenue are earmarked for health?</p>	<p>Tobacco excise tax rates have been raised recently and overall constitute a significant input into government revenues, including for transfers. However, allocation of such tax revenues to health is much below international experience. Sugary beverage excise taxes have been proposed, but not approved. It is likely they will be approved in 2021. Allocating the entirety of the latter tax revenue to health from 2021, and additionally earmarking more tobacco tax revenue at central and local levels, will provide new fiscal space, which could allow for accommodating the PBI APBN/APBD expansion.</p>



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