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An assessment of fiscal space for health in Peru*

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ABSTRACT

Objective. To assess the fiscal space for health in Peru needed to attain the target of raising public spending in health to 6% of gross domestic product, as agreed by member countries of the Pan American Health Organization in 2014.

Methods. The main sources of fiscal space were identified by means of a thorough literature review. Technical feasibility was determined from statistics and national and international surveys and by reviewing various documents and official reports. Political feasibility was ascertained by studying policy guidelines.

Results. The sources showing the greatest technical and political feasibility are economic growth, a broadening of the personal income tax base, and an increase in tobacco-specific taxes. Decreasing informality in the job market and increasing contributory coverage are considered to be less politically feasible, but there is ample technical space for these measures.

Conclusions. There is enough fiscal space to allow for an increase in public spending in health. Nevertheless, the 6% target will be reached only if the timeline is extended, tax revenues are increased, and informality in the job market is reduced.

Key words Healthcare financing; financial policy; universal coverage; health care rationing; Peru; Latin America.

Peru has a population of 30,973,148, 50.1 % male and 49.9% female. In the past 10 years, it has had the third highest gross domestic product (GDP) growth in Latin America, enabling it to achieve per capita income of US$ 6,550 in 2014.

This growth has led to an improvement in the country's social and health indicators, with the poverty rate falling from 55.6% to 22.7% between 2004 and 2014; extreme poverty, from 15.8% to 4.3%; and the infant mortality rate from 22.6% to 13.6%.Life expectancy at birth rose from 72.1 to 74.8 years (1–3).

Despite this progress, health coverage is still below the average for Latin America. Some 21% to 31% of the population is not covered by any type of health insurance (2).

The Peruvian health system is segmented and fragmented (4); 63.6% of the population is insured under the public system, 39% under Comprehensive Health Insurance (SIS), and 24.6% under Social Health Insurance (EsSalud). SIS is insurance prioritized for vulnerable populations living in poverty and is financed basically with general tax revenues. EsSalud is the contributory social security system for the enrolled population and its dependents.

Health expenditure in Peru stands at 5.3% of GDP, below the Latin American average of 7.7% and a long way from the 11.9% of the high-income countries. Some 58.7% of this total corresponds to public expenditure in health (PHE) and 41.2% to private health expenditure. Of this latter figure, 84.7% is out-of-pocket expenditure (3).

In recent years, there has been an attempt to promote a transition in health financing—that is, to increase public expenditure and reduce out-of-pocket expenditure. Progress has been slow, however. In 2013, PHE rose above 3% of GDP for the first time, representing a one-percentage-point gap with respect to the average for Latin America and a more than four-point gap with respect to high–income countries. Out-of-pocket expenditure, in turn, almost doubled between 2004 and 2012 (5).

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The country has reached national agreements and signed other international ones to increase the public sector share of health financing, while expanding the resources allocated to it. At the national level, in 2006, the political parties signed an agreement setting the goal of achieving the region's average expenditure; at the international level, as a member of the Pan American Health Organization (PAHO), Peru signed the commitment to raise PHE to 6% of GDP (6). The objective of this study is to evaluate the sources for creating fiscal space (FS) in Peru and estimate the existing margin for meeting this expenditure target.

MATERIALS AND METHODS

An observational study was conducted with secondary information. Fiscal space (FS) was defined as the additional economic resources that can be added to the public budget for a country development objective without jeopardizing economic stability or government solvency (7, 8). Based on the literature (7-12), six sources of fiscal space were analyzed: a) economic growth, b) tax revenues, c) reprioritization of health expenditure, d) social contributions, e) efficiency in public expenditure, and f) external financing.

FS through economic growth was based on the historical trend in PHE elasticity with respect to GDP over the past 10 years, a methodology used in similar studies (12). In an optimistic scenario, it was assumed that the extraordinary increases in PHE in 2009 and 2012 would be repeated in the future. In the pessimistic scenario, these two values were replaced with the two figures immediately preceding the decade in question. In the neutral scenario, an intermediate value from other studies (13) was used. The elasticities were 2.06, -0.54, and 1.62, respectively.

The national information sources were studies and statistics from the Central Reserve Bank of Peru (BCRP) (14), the National Institute of Statistics and Informatics (INEI) (1, 2, 15), the Ministry of Economy and Finance (for women of reproductive age) (16) and the National Superintendency of Tax Administration (SUNAT) (17). The international sources were databases and reports of the World Bank (World Bank) (3), the International Monetary Fund (IMF) (18, 19), the Organisation for Economic Co–operation and Development (OECD) (20, 21), the International Labour Organization (ILO) (22), and the World Health Organization (WHO) (23-25). The 2010-2015 databases of the Web of Science and Scopus were used for the scientific literature review.

Finally, the political analysis was based on a review of political agreements, the policies actually implemented, and recent public debate.

RESULTS

The results are presented in Table 1 and analyzed by type of source.

Economic growth and stability

According to IMF 2015-2002 growth projections, the PHE trend was estimated for the three scenarios. The results show that in the optimistic scenario, fiscal space can be increased by up to 1.03 points of GDP and in the neutral scenario, by up to 0.56 points, while in the pessimistic scenario, it can fall by as much as 1.05 points (Table 2). The political analysis indicates that economic growth is the least contentious way of increasing FS. The Multiyear Macroeconomic Framework (MMM) is optimistic and assumes a scenario of economic upturn (16).

TABLE 1. Fiscal space for health (size of the source, political feasibility and analysis) in Peru, 2015-2020

	Size of the source	Political feasibility	Analysis
Macroeconomic conditions of stable growth	Up to 1.03% of GDP in the optimistic scenario; up to 0.56% of GDP in the neutral scenario	High	Good
Increase in fiscal revenues as a proportion of GDP			
Income and corporate taxes	4.1% GDP gap with OECD Up to 1 point of GDP under the assumption of reducing the margin with respect to the OECD by ¼	High on income Low on profits	Poor
Tax on tobacco	Up to 0.02% of GDP, raising cigarette prices to the average for the Latin American countries	High	Good
Tax expenditures	Up to 1.9% of GDP Up to 0.48% of GDP if reduced by ¼ of the total	Moderate	Good
Social contributions	Up to 0.75% of GDP Up to 0.1 point of GDP if informal employment is reduced to a historic average rate	Moderate	Fair
Increase in the efficiency of public expenditure	Up to 0.16 points of GDP with an annual increase of 0.5%	High	Poor
Reprioritization of health expenditure	In terms of the marginal increases in the national budget	Low	Poor
External financing	Ruled out	None	Unfeasible

GDP=gross domestic product; OECD=Organization for Economic Co-operation and Development.

Increase in tax revenues

This is analyzed in three sources of FS creation: direct and/or indirect taxes, specific or "sin" taxes, and tax expenditures.

Tax increases. Total tax revenues in Latin America and the Caribbean account for 21.3% of GDP, compared to 18.3% in Peru and 34.1% in the OECD countries (21).

By composition, the difference is due primarily to direct taxes. Peru brings in 49.5% through income taxes and 40.2% through production and consumption taxes (17). This relationship is inverse in the average for the OECD countries (21). In Peru, direct taxes on income and corporate profits account for 7.3% of GDP versus 11.4% in the OECD countries (21).

This is significant from the standpoint of empirical evidence in health, since, unlike the situation with indirect taxes, it indicates a positive correlation between the direct tax burden and better health indicators (26, 27).

In the political sphere, the possibility of raising direct taxes on profits arouses opposition. There is greater willingness to expand the personal income tax base.

Increasing income tax revenues would cause less resistance but would involve growing the tax base rather than raising the current rates. The government has officially stated its willingness to do this in the MMM 2014-2016 (16).

TABLE 2. Fiscal space for health (projection based on macroeconomic conditions), Peru, 2012-2020

Component and scenario	2012	2013	2014	2015	2016	2017	2018	2019	2020
Real GDP growth rate	5.95	5.77	2.35	3.81	4.98	5.50	4.82	4.49	4.51
GDP (billions)[a]	431.3	456.2	466.9	484.7	508.8	536.8	562.7	588.0	614.5
Population (millions)	29.99	30.38	30.77	31.38	31.77	32.17	32.55	32.94	33.32
Optimistic scenario									
Public expenditure in health[a] (millions)	14 494.7	14 250.8	14 941.6	16 115.1	17 769.3	19 783.0	21 750.9	23 766.4	25 978.6
Public expenditure in health (% of GDP)	3.36	3.12	3.20	3.32	3.49	3.69	3.87	4.04	4.23
Public expenditure in health per capita[a]	483.4	469.2	485.6	513.6	559.2	615.0	668.1	721.6	779.7
Neutral scenario									
Public expenditure in health[a] (millions)	14 494.7	14 250.8	14 793.5	15 706.4	16 973.0	18 484.2	19 928.7	21 379.5	22 943.0
Public expenditure in health (% of GDP)	3.36	3.12	3.17	3.24	3.34	3.44	3.54	3.64	3.73
Public expenditure in health per capita[a]	483.4	469.2	480.8	500.6	534.2	574.6	612.2	649.1	688.6
Pessimistic scenario									
Public expenditure in health[a] (millions)	14 494.7	14 250.8	14 068.9	13 777.9	13 405.5	13 005.4	12 664.8	12 355.7	12 052.9
Public expenditure in health (% of GDP)	3.36	3.12	3.01	2.84	2.63	2.42	2.25	2.10	1.96
Public expenditure in health per capita[a]	483.4	469.2	457.2	439.1	421.9	404.3	389.0	375.1	361.8

GDP=gross domestic product.
[a] millions of constant 2005 new soles.

Specific or "sin" taxes. This term refers to raising or imposing taxes on products or services that impair health, specifically cigarettes, alcoholic beverages, and food with a high sugar or fat content.

As in other international studies of fiscal space, the introduction and collection of taxes on sugary beverages is not considered for Peru. The closest precedent is Law No. 30 021 of 2013 on the promotion of healthy diets for children and adolescents, whose implementation and monitoring met with problems. A higher tax on alcoholic beverages has not been considered since the reform of 2013, in which the excise tax on beer was raised from 27.8% to 30% and the tax on wine and liquor from 20% to 25%, eliciting strong criticism from producers.

Thus, fiscal space in Peru through sin taxes is currently confined to the tobacco tax.

This tax has political support and is backed by scientific evidence. Multiple studies have empirically shown the link between smoking, the risk of lung disease, and tax policies (28).

The tax on tobacco in Peru is low. In the majority of the high-income countries, it is over 75% of the price of the most popular brand sold, while in Peru it is just 37.8%, even less than in other countries of the region (25).

This evidence shows that there is margin for increasing fiscal space from this source. Revenues from this tax total around 326 million new sols (29). If the elasticity of tobacco use in the country is considered (30), fiscal space of 95.4 million new soles could be created. This would be achieved by increasing the tax until the price reaches the average value for the Latin American countries (23.3% higher). This would represent fiscal space of 0.02% of GDP.

In the political sphere, the international scientific evidence indicates that raising the tax on tobacco is feasible.

Reduction in tax expenditures. Tax expenditures are revenues foregone due to exemptions that a government grants to activities or entities, permitting them to pay less or nothing at all under the prevailing tax regime. In Peru, tax expenditures have stood at 1.8% to 2.3% of GDP for the past eight years and accounted for 1.94% of GDP according to the last report in 2012 (17), a figure that is not comparable at the international level (20). FS is created by eliminating part of these tax expenditures. To accomplish this, it must be determined which of these expenditures are acceptable from a social and economic standpoint and which are not (11).

In the Peruvian case, some tax expenditures are particularly sensitive: 11.69% of them benefit the education sector, 0.38% culture, and 0.2% health. Moreover, 3.89% promote investment in the Amazon region and 18.78% benefit the agriculture sector, both of which are politically sensitive. Other less justifiable tax expenditures include aid to the financial sector (11.44%) and at least some of the generally applicable tax expenditures (33.14%). The discussion examines who ultimately benefits from tax expenditures and the impact of eliminating them (11).

Political positions vary in this regard. On the one hand, the MMM 2014-2016 explicitly mentions reducing the fiscal benefits of the income tax (16), but at the same time, there is resistance among certain political sectors to altering the benefits enjoyed by the agriculture sector, whose workforce is poor.

Social contributions

The analyses of the government revenue structure show that the proportion of social contributions in GDP is very low in Peru. While averaging 9% in the OECD countries and 3.6% in Latin America, it is just 2% in Peru (20).

Peru had an employed population of 15.68 million in 2013, but only 5.61 million were enrolled in EsSalud (14). If the total employed population is considered, 74.3% of all jobs in 2012 were in the informal sector; and if only non-agricultural employment is considered, this rate was 66.7% (15). According to the ILO, 68.8% of non-agricultural employment was in the informal sector (22). With the exception of domestic work, one out of four salaried Peruvian workers is employed in the informal sector and only 58.5% have social security coverage.

The perpetual informality of employment in Latin America is a longstanding problem. Nonetheless, its reduction is absolutely necessary. A long-term scenario would be to assume a one-third reduction in non–agricultural informal employment.

This could create fiscal space of 0.75 points of GDP and fill one quarter of the gap necessary for meeting the PHE target of 6% of GDP. However, it does not appear to be feasible in the medium term. According to the ILO, Peru reduced its informality rate from 79.9% to 74.3% between 2007 and 2012 (22). A conservative scenario would be to assume that this rate of reduction would continue in the coming years and generate, *ceteris paribus*, fiscal space of 0.1% of GDP in 2020.

The political situation is complicated, since EsSalud and SIS operate as totally compartmentalized funds, and the emphasis on expanding insurance is centered particularly on SIS. Efforts have been made to reduce informality, but their failure has resulted in an unwillingness to put new proposals forward.

Efficiency of public expenditure

Nearly all the studies describe this source as an important factor but fail to get very far when quantifying it. Some of the proposals at the national level compare different regions and measure expenditure against health production indicators (12, 8). The limitations noted by these studies are the lack of disaggregated data and the specific characteristics of each territory.

At the international level, comparative studies abound, but with dissimilar results. Most of them show good results for Peru in terms of expenditure and life expectancy, healthy years, or other indicators (31, 32). In a comparison of five rankings for 191 countries, Peru is situated between the first and second efficiency tercile (33).

Here, it should be added that the evidence suggests that efficiency follows the diminishing marginal utility of a concave function (33). That is, as expenditure increases, productivity increments decrease and efficiency values fall. Thus, while Peru has good indicators in comparison with countries at the same income level, they are unlikely to improve much more with increases in health investment. Even a 5% increase in expenditure efficiency would only free up resources of 0.16% of GDP (based on the weight of PHE in GDP).

There is a strong political consensus on maintaining and increasing PHE efficiency. The monitoring of women of reproductive age in PHE through results-based budgets has narrowed inefficiency margins. Nevertheless, there appears to be limited capacity for regional budget execution, with unexecuted balances at the end of each period.

Reprioritization of health expenditure

The reprioritization of PHE in Peru is hindered by the low level of tax revenues, and thus, total public expenditure. Total public expenditure accounted for 22.5% of the country's GDP in 2014, lower than the regional average of 34.3% and far lower than the 40.5% of the developed economies. The Peruvian government allocated 14.75% of this total public expenditure to health, a figure higher than the regional average of 13.42% and not very far from the 17.01% of the high-income countries.

Although Peru has a high level of fiscal rigidity, close to 95% (34), it has not kept it from complying with the consolidated fiscal surplus rule. Nevertheless, the transfer of allotments from one sector to another is rather unfeasible.

This means it would be hard to create fiscal space through this source without adversely affecting other budget allotments that are perhaps as necessary as health (7). Some authors therefore suggest working on margin-based criteria (11); that is, prioritizing increases in annual, rather than historical, budgets.

Here, the political will coincides with theory, because efforts since 2011 to expand insurance and create a package of basic services for the population have supported an increase in public expenditure in health without reducing spending in other sectors through greater proportional allocation to health and education in budget increases.

External financing

External financing can be obtained in the form of credit and cooperation assistance. Peru's debt level is low, and external assistance flows are volatile and relatively low (24). However, as in other studies (7, 8, 10), resorting to these measures to finance health is considered politically unfeasible.

DISCUSSION

The review of the international evidence shows that there is capacity to create fiscal space in the majority of the cases studied. Peru is no exception. The country has the potential to increase public expenditure in health without jeopardizing economic sustainability.

In the technical sphere, the results coincide with the international evidence on sources. Sustained growth, higher tax revenues, and contributions offer the greatest fiscal space, but at the same time, take longer to achieve.

Cross-comparison of technical results with feasibility and political acceptance yields consistent conclusions about the need to increase public resources for health, but with significant differences on how to do so.

The sources with the greatest technical margin and political feasibility are economic growth, an expansion of the personal income tax base, an increase in specific taxes on cigarettes, and an increase in the efficiency of public spending.

Increasing contributions through efforts to eliminate informal employment is one of the sources with the greatest technical potential, but less political debate. This is partly because general taxes and social contributions are currently administered as separate sources for SIS and EsSalud, respectively, and it appears that the achievement of universal coverage is being focused on SIS.

Exploring other sources, such as higher direct taxes on profits or natural resources or the significant elimination of tax expenditures, does not appear to be very feasible.

Three limitations of the study should be noted. The first is that its purpose is not to determine the expenditure gap necessary for achieving universal health coverage; it does not calculate the cost of this measure, which would require another type of study. The ultimate goal of this work is to reach public expenditure in health of 6% of GDP, in keeping with the PAHO commitment. The second limitation is that the study does not address how this fiscal space is implemented or its timeframe; the total fiscal space is presented, even though part of it is not included in the study period. The third limitation is that the study does not evaluate the distributive impact of each measure, which would depend on each particular source of FS, the markets it affects, and the ultimate destination of the expenditure.

CONCLUSIONS

The challenge of achieving public expenditure in health of 6% of GDP is ambitious and will require diversification of the sources for the creation of fiscal space and a robust political will to do so. It will be hard to achieve without increasing direct tax revenues or reducing informality. Thus, it will be necessary to reach a consensus on economic stability criteria and social preferences while closely linking financing and outcomes in order to facilitate political feasibility.

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Evaluación del espacio fiscal para la salud en Perú

RESUMEN

Objetivo. Evaluar el espacio fiscal para la salud en Perú para alcanzar la meta de un gasto público en salud de 6% del producto interno bruto acordada por los Estados Miembros de la Organización Panamericana de la Salud en 2014.

Métodos. Se han identificado las principales fuentes de espacio fiscal mediante una revisión bibliográfica profunda. Su factibilidad técnica se valoró a través de estadísticas y encuestas nacionales e internacionales y la revisión de documentos y reportes oficiales. Su factibilidad política se evaluó con el análisis de lineamientos de políticas.

Resultados. Las fuentes con mayor factibilidad técnica y política son el crecimiento económico, el aumento de la base tributaria del impuesto al ingreso de las personas naturales y el aumento de la tributación específica sobre el tabaco. Con menos factibilidad política, pero con un amplio espacio técnico, se considera la reducción de la informalidad en el mercado de trabajo y el aumento de la cobertura contributiva.

Conclusiones. Existe espacio fiscal para aumentar el gasto público en salud. No obstante, la meta de 6% solo se puede alcanzar con más plazo, mayor recaudación impositiva y menor informalidad en el mercado de trabajo.

Palabras clave Financiación de la atención de la salud; política financiera; cobertura universal; asignación de recursos para la atención en salud; Perú; América Latina.