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Narrative Summary on Public Expenditure for Health in Armenia

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Narrative Summary on Public Expenditure for Health in Armenia

This Narrative Summary on Public Expenditure for Health in Armenia was written by Ajay Tandon, Adanna Chukwuma, and Jewelwayne Salcedo Cain with support from the DRM collaborative facilitation team in the World Bank, comprising Aditi Nigam, Danielle Elena Bloom, Lauren Oliveira Hashiguchi, and Somil Nagpal.

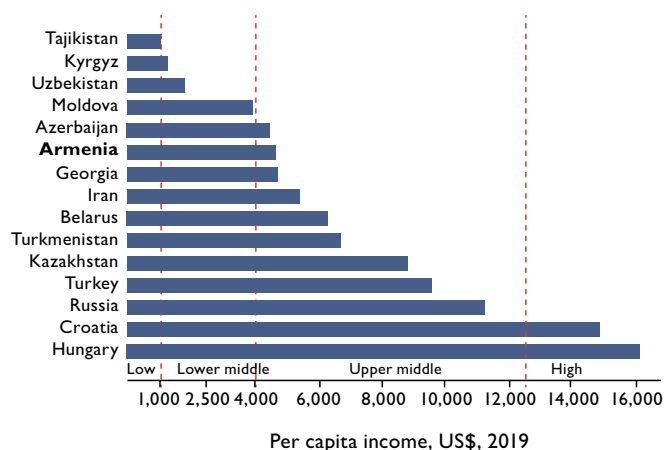
This narrative summary aims to summarize trends in health spending in Armenia and inform policy related to domestic resource mobilization (DRM) for health. The analysis examines health spending within the overall macro-fiscal context in the country.¹ The analysis reported in the narrative summary is meant to be illustrative, demonstrating how such information can set the stage for assessing DRM options for health by enhancing understanding of the historical context of Armenia in terms of broader health financing trends, and how these trends have interacted with the overall macro-fiscal context in the country.

BACKGROUND

Armenia is a small landlocked country in the World Bank's (WB's) Europe and Central Asia (ECA) region. Its population of almost 3 million makes it one of the least populous countries in ECA. In 2019, the per capita income was US\$4,680, classifying Armenia as an upper middle income (UMI) country in which approximately 2% of the population lives below US\$1.90-per-day, and 13% live below \$3.10-per-day (Figure 1).

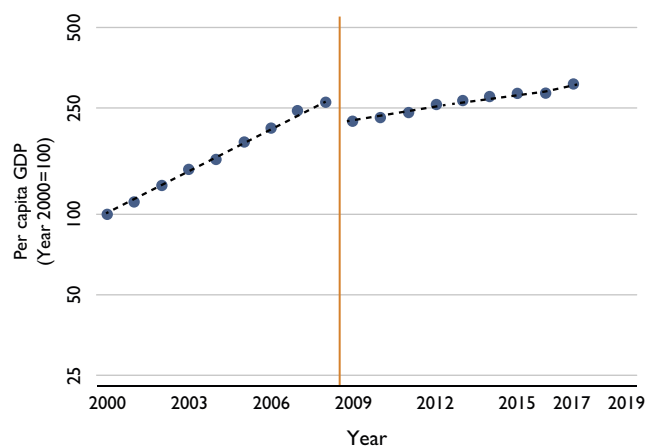
Annual economic growth rates averaged 12.6% in per capita terms over 2000-2008, decelerating sharply to 2.0% over 2009-2017 (Figure 2). The 'Pritchett Landscape' of Armenia's per capita growth trajectory can be categorized as a 'plateau', with growth rates exceeding 3% per year before a statistically-determined break² in trend in 2009, but lower than 3% per year after the break.³ In cumulative constant per capita terms, the size of Armenia's economy tripled over the period 2000-2017.

Figure 1: Per capita income in Armenia and comparators (US \$)



Source: Estimates are from the World Development Indicators (WDI) 2019.

Figure 2: Trends in per capita GDP



Source: Estimates are from the World Development Indicators (WDI) 2019.

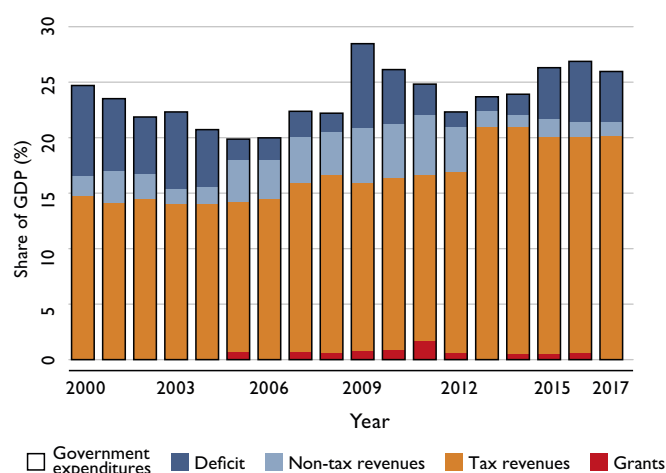
¹ Unless otherwise stated, health spending estimates are from the World Health Organization Global Health Expenditure Database (2017).

² While some countries have experienced consistently steady linear growth in per capita public spending on health, others show systematic variations in the growth rates over 2000-2017. These large shifts in trends can be captured statistically and a policy-relevant "break-point"—a year when a break in trend for per capita public spending on health—can be identified. Capturing this instability in the growth rates is important in understanding the growth dynamics of public spending for health.

³ Pritchett, L. (2000). Understanding patterns of economic growth: searching for hills among plateaus, mountains, and plains. The World Bank Economic Review, 14(2), 221-250.

At 26%, the total government expenditure as a share of Gross Domestic Product (GDP) is below the UMI average of 33% (Table 1). The lower total government revenue as a share of GDP (21%, compared to the UMI average of 30%) is the primary driver of the low contribution of the total government spending to GDP. Armenia's total government expenditure has fluctuated in the 20-29% of GDP range over the period 2000-2017 (Figure 3).

Figure 3: Government revenue and expenditure as a share of GDP



Source: Estimates are from the IMF WEO 2019 and IMF World Revenue Longitudinal Data 2019.

Table 1: Comparing Government spending, revenue, deficit and surplus (as a share of GDP)

Country	Government expenditures	Government revenues		Government deficit/surplus
		Total	Tax	
Armenia	26	21	20	-5
Azerbaijan	36	34	14	-1
Belarus	39	39	25	0
Croatia	45	46	27	1
Georgia	28	27	26	0
Hungary	47	45	25	-2
Iran	19	18	8	-2
Kazakhstan	24	20	16	-4
Kyrgyz	37	33	20	-4
Moldova	31	30	20	-1
Russia	35	33	24	-1
Tajikistan	36	30	19	-6
Turkey	34	31	18	-2
Turkmenistan	18	15	9	-3
Ukraine	41	39	28	-2
Uzbekistan	23	25	18	2
ECA average	33	31	20	-2
LMI average	30	27	17	-4
UMI average	33	30	18	-3

Source: Estimates are from the IMF WEO and the IMF World Revenue Longitudinal database, and are from the latest available year.

HEALTH SYSTEM

With a life expectancy of 75 years and an under-five mortality rate of 12 per 1,000 live births, most population health outcomes in Armenia are better than the average among UMI countries (Table 2). Quality of care remains a challenge, as does coverage for non-communicable diseases (NCDs). An estimated 1,600 deaths occur annually due to poor-quality care⁴, while 1,396 deaths are attributed to lack of access to needed care, including for NCDs.⁵ Armenia scored 0.57 on the WB's human capital index (HCI), indicating that a child born there today would be expected to be only 57% as productive as they could have been, and GDP per worker could be almost double what it is, with complete education and full health.⁶

Significant health financing reforms included the introduction of a purchaser-provider split with the set-up of the State Health Agency (SHA) in the 1990s to purchase a basic package of services from public and private providers. Armenia is currently considering reforms to expand coverage of care. Primary care is universally covered, but outpatient drugs, inpatient care, and other forms of specialized services are only covered for vulnerable groups and civil servants, and are important contributors to out-of-pocket payments (OOPs) for health care. Before the COVID-19 pandemic, coverage rates for essential maternal and child health care was high overall. For example, 90% of children received their third diphtheria-pertussis-tetanus vaccine in the first year. As a result of the pandemic, service use has been disrupted, with childhood vaccination rates falling by

Table 2: Comparison of Health Outcomes

Country	Population (millions)	Life expectancy	Fertility	Under-five mortality	Adult survival	Maternal mortality	Childhood stunting
Armenia	3	75	1.8	12	81	26	9
Azerbaijan	10	73	1.7	22	79	26	18
Belarus	9	74	1.4	3	78	2	5
Croatia	4	78	1.5	5	86	8	-
Georgia	4	74	2.1	10	77	25	11
Hungary	10	76	1.6	4	80	12	-
Iran	81	76	2.1	14	88	16	7
Kazakhstan	18	73	2.8	10	76	10	8
Kyrgyz	6	71	3.3	19	76	60	12
Moldova	4	72	1.3	16	73	19	6
Russia	144	73	1.6	7	72	17	-
Tajikistan	9	71	3.6	35	76	17	18
Turkey	81	77	2.1	11	86	17	6
Turkmenistan	6	68	2.8	46	69	7	12
Ukraine	44	72	1.3	9	73	19	23
Uzbekistan	32	72	2.4	21	76	29	11
ECA average	412	74	2.0	13	79	18	10
LMI average	2,965	69	3.1	39	70	196	25
UMI average	2,592	74	2.3	19	78	65	14

Source: All data are from the World Development Indicators and from the latest year of availability, with the exception of population (millions) which is from the WHO Global Health Expenditure Database, of which the latest available year for all countries is 2017.

⁴ Poor quality of care amongst those who accessed care is a main factor in global mortality that spanned many conditions including cardiovascular disease, vaccine preventable diseases, neonatal conditions, road injuries, maternal mortality TB, HIV, and other infectious diseases.

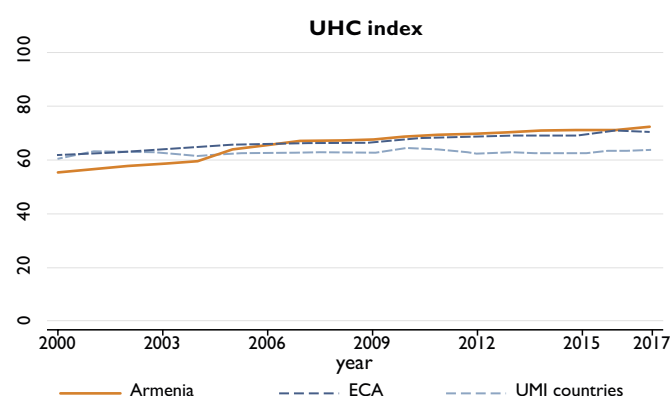
⁵ Kruk, Margaret E., et al. "Mortality due to low-quality health systems in the universal health coverage era: a systematic analysis of amenable deaths in 137 countries." *The Lancet* 392.10160 (2018): 2203-2212.

⁶ World Bank. 2020. *Survive, Learn, Thrive: Strategic Human Capital Investments Toward a More Prosperous and Inclusive Armenia*. World Bank, Washington, DC.

an estimated 27% as of October 2020.⁷ Armenia has made steady progress on its UHC service coverage index over 2000-2017, having recently overtaken the average for both ECA countries and UMI countries (Figure 4).⁸

Armenia's per capita spending on health is approximately US\$408 per capita, or 10.4% of GDP (Table 3). However, less than 15% of health spending is publicly sourced. OOP spending dominates and at more than 80% of health spending, is amongst the highest in the world. Approximately 16.1% of households spend over 10% of their income on health, above the regional average of 7.4%.⁹ Preliminary indications are that the proportion of households for whom OOP spending was 10% or higher of consumption has actually increased in recent years. External financing for health is 1.3% of total health spending.

Figure 4: UHC Effective Coverage Index



Source: Global Burden of Disease Collaborative Network 2019.

Table 3: Comparing public and private health spending

Country	Health spending		Public spending on health				OOP share of health spending
	Per capita (US\$)	Share of GDP	Per capita (US\$)	Share domestic government	Share SHI	Share external	
Armenia	408	10.4	55	98	0	2	84
Azerbaijan	276	6.7	43	98	0	2	84
Belarus	342	5.9	241	100	0	0	28
Croatia	902	6.8	747	21	79	0	11
Georgia	293	7.6	111	98	0	2	55
Hungary	981	6.9	675	73	27	0	27
Iran	475	8.7	244	91	9	0	42
Kazakhstan	280	3.1	174	100	0	0	33
Kyrgyz	79	6.2	33	75	15	10	56
Moldova	191	7.0	98	42	57	2	44
Russia	586	5.3	334	61	39	0	40
Tajikistan	58	7.2	19	87	0	13	63
Turkey	445	4.2	346	49	51	0	17
Turkmenistan	456	6.9	102	100	0	0	73
Ukraine	177	7.0	79	99	0	1	52
Uzbekistan	99	6.4	44	96	0	4	53
ECA	346	6.7	184	69	29	3	47
LMI	130	5.3	71	77	14	10	39
UMI	453	6.7	274	75	23	4	33

Source: All estimates are from the WHO Global Health Expenditure Database, of which the latest available year for all countries is 2017.

⁷ COVID-19 Health System Response Monitor. 2020. Armenia. the WHO Regional Office for Europe, the European Commission, and the European Observatory on Health Systems and Policies.

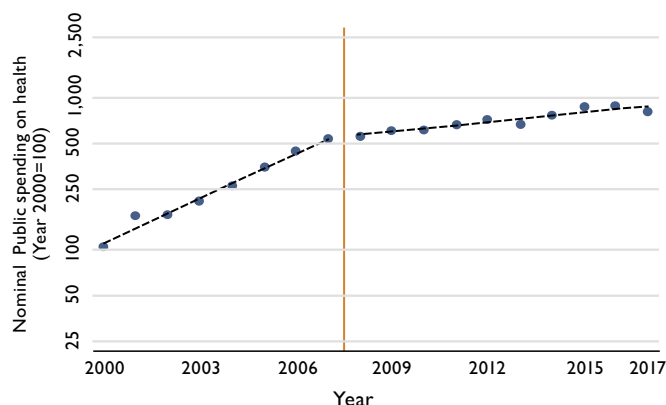
⁸ Global Burden of Disease Collaborative Network. 2020. Global Burden of Disease Study 2019: UHC Effective Coverage Index 1990-2019. Seattle, USA: Institute for Health Metrics and Evaluation.

⁹ World Health Organization, The Global Health Observatory Database. Unless otherwise stated, estimates are from the latest available year.

DOMESTIC RESOURCE MOBILIZATION FOR HEALTH

DRM reform efforts in recent years have focused on increasing health's share of total public expenditure. Data from the World Health Organization's Global Health Expenditure Database shows that total government spending on health amounted to AMD 77,992 million (~US\$ 162 million) in 2017, up from AMD 9,934 million (~US\$ 18 million) in 2000 – representing almost an eight-fold cumulative nominal increase over 2000-2017, more than 50% increase over 2000-2001, and an average annual increase of 13.9% in nominal terms (Figure 5).

Figure 5: Nominal public health spending

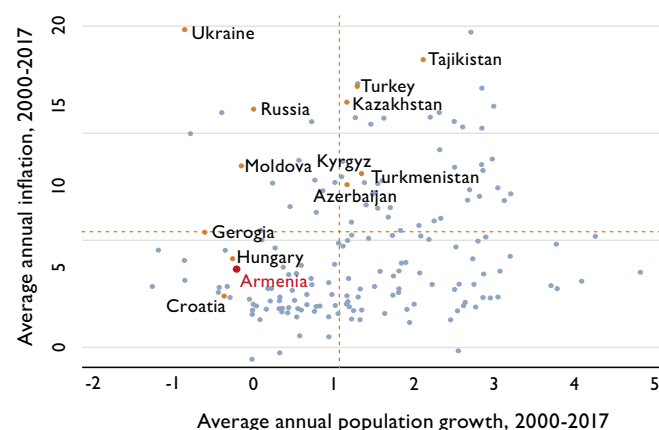


Source: Author's estimates using data from the WHO GHED.

TRENDS IN GOVERNMENT BUDGETARY SPENDING ON HEALTH

Armenia has faced relatively low levels of inflation in recent decades. Over 2000-2017, the inflation rate was 3.6%, which was much less than the average across all UMI countries over the same time period. Armenia experienced negative average annual population growth (-0.2%), which was also much lower the average for all UMI countries (Figure 6). Nominal budgetary increases would need to exceed at least 3.4% per year to keep levels the same in per capita constant terms.

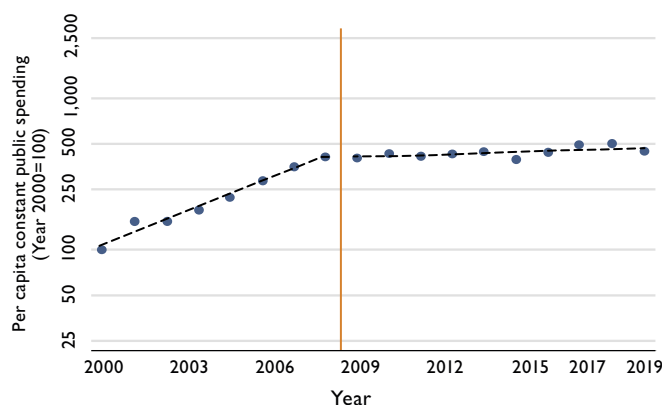
Figure 6: Average annual inflation and population growth



Source: Inflation and population data are from IMF World Economic Outlook (2019).

Trends in nominal values are adjusted for inflation and population growth to determine how much general government spending on health increased in constant per capita terms. Adjusting for inflation and population growth shows that in per capita constant terms, the government budgetary spending on health in Armenia has grown more than three-fold since 2000: averaging an annual growth rate of 8.8% per year (Figure 7). In 2017, per capita government budgetary spending on health amounted to AMD 26,614 (~US\$55 per capita), up from only AMD 5,992 (~US\$12 per capita) in 2000.

Figure 7: Per capita constant public health spending



Source: Authors' estimates using data from WHO GHED 2019.

While Armenia is a ‘hill’ country for per capita, GDP as seen through its more than three-fold increase over 2000-2017, the country is categorized as a ‘plateau’ country¹⁰ for per capita public spending on health as growth in the latter was 19.1% per year on average before its statistically determined breakpoint of 2008 and 1.6% per year on average after its breakpoint (Figure 7).

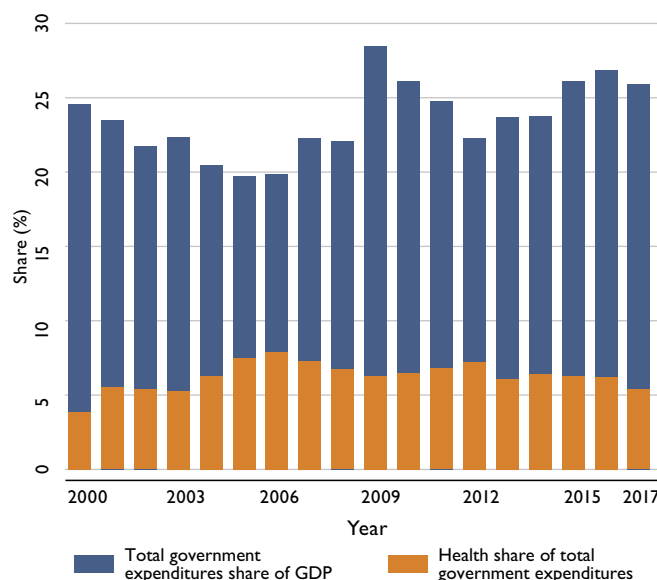
BROADER TRENDS IN HEALTH FINANCING AND UHC

Per capita government spending on health is the product of three variables: health’s share of total government spending (prioritization), total government spending share of GDP, and per capita GDP. Over 2000-2017, the 8.8% annual increase in per capita constant government spending on health was primarily due to economic growth (6.6% per year), with some marginal contribution coming from an annual 0.3% increase in total government expenditures as share of GDP and an annual 1.9% increase in health’s share of the total government spending, on average (Figure 8).

In 2017, Armenia’s per capita GDP amounted to US\$3,934. Of this, 26% was total government spending (representing spending across all sectors, including for health) and 5% of total government spending represented health’s share (amounting to (~US\$55 per capita, as noted below). In 2000, Armenia’s per capita GDP was US\$1,289 with 25% representing total government spending, of which 4% was health’s share (Figure 9).

Armenia’s 5% share of health in total government expenditure is much lower than the average for UMI countries. However, education’s share of total government expenditures is more than double the share of health’s, and health’s share is lower than the share of debt service payments (at 8%) (Table 4).

Figure 8: Total government expenditure and health share of total government expenditure



Source: Estimates are from the IMF WEO and the WHO GHED.

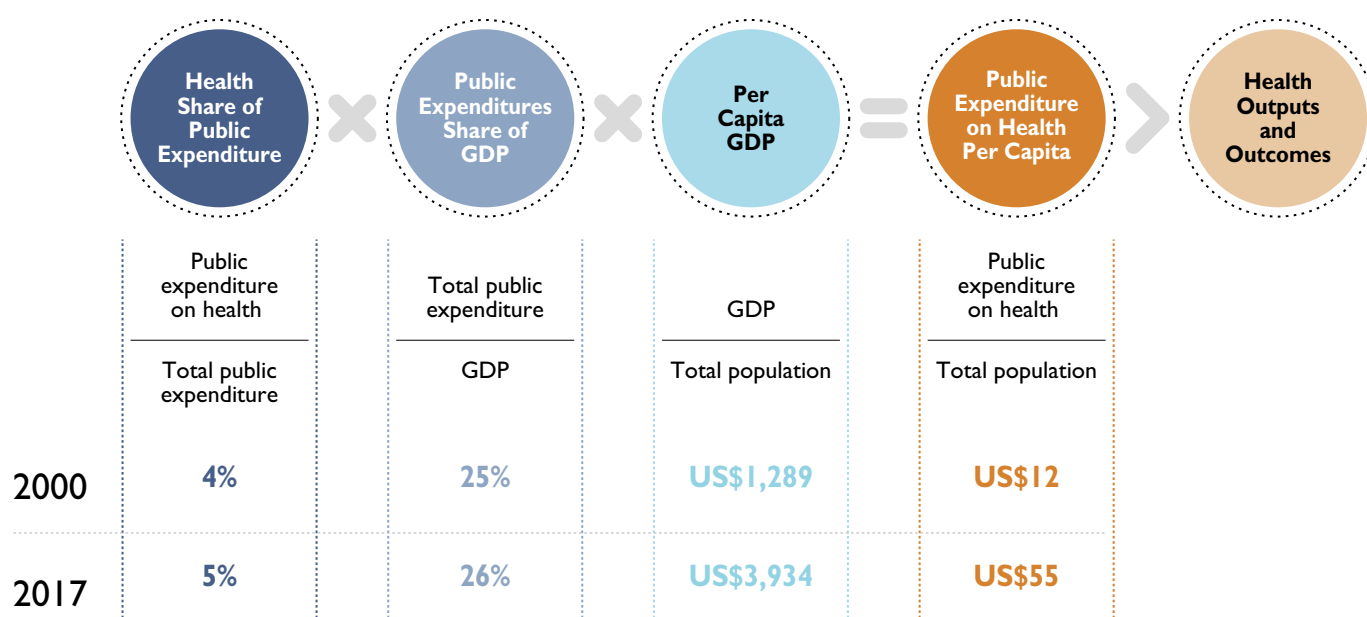
Table 4: Comparing sectoral shares of total government spending

Country	Share of total government expenditure			
	Health	Education	Military	Debt Service
Armenia	5	11	15	8
Azerbaijan	3	7	11	1
Belarus	11	11	30	5
Georgia	10	7	7	4
Iran	23	19	16	1
Kazakhstan	8	12	3	4
Kyrgyz	7	16	4	2
Moldova	12	19	1	4
Russia	9	11	12	1
Tajikistan	7	16	-	1
Turkey	10	12	6	4
Turkmenistan	9	21	-	-
Ukraine	8	13	8	9
Uzbekistan	11	-	-	1
ECA	10	12	7	4
LMI	9	16	7	8
UMI	12	15	7	7

Source: Estimates are from the WHO GHED 2019, the WDI 2020, and the IMF WEO 2020. ECA, LMI, and UMI are presented as averages.

¹⁰ Pritchett, L. (2000). Understanding patterns of economic growth: searching for hills among plateaus, mountains, and plains. The World Bank Economic Review, 14(2), 221-250.

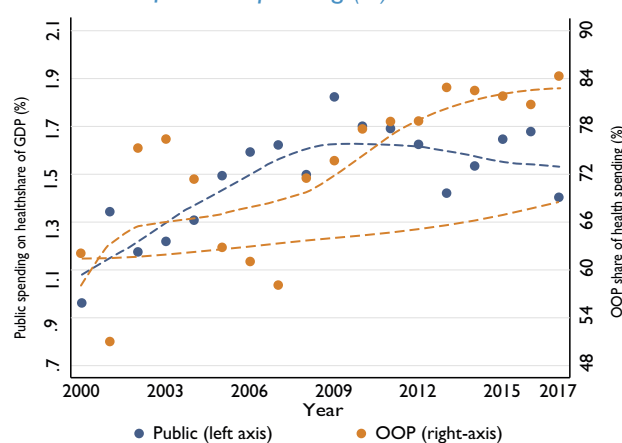
Figure 9: Calculation of per capita health expenditure in Armenia



Source: Author's estimates using data from the WHO GHED.

The pace of increase in per capita OOP spending on health (19.4% per year) has exceeded that in per capita public spending on health (8.8% per year). As a result, OOP share of health spending has increased at a faster rate than the increase in public spending on health share of GDP, which indicates that Armenia has regressed in its health financing transition (Figure 10).¹¹

Figure 10: Public health spending as a share of GDP and OOP share of health spending (%)



Source: Author's estimates using data from the WDI, the WHO GHED, and the IMF WEO.

¹¹ Fan, Victoria Y., and William D. Savedoff. The health financing transition: a conceptual framework and empirical evidence. *Social science & medicine* 105 (2014): 112-121.

GLOSSARY & METHODS¹

Catastrophic Health Expenditure (CHE): occurs when out-of-pocket health spending exceeds 10% or 25% of total household consumption or income).

Constant: Also referred to as ‘real’, refers to the value of a monetary variable with adjustments made to remove the impact of changes in prices of goods and services due to inflation. Constant series show the data for each year in the value of a particular base year. Thus, for example, data reported in constant 2017 prices show data for 2000 to 2017 in 2017 prices. Constant series are important as it is used to measure the true growth of a series (i.e., adjusting for the effects of inflation).

How to Convert a Time Series Variable from Nominal to Constant? Nominal time series data can be converted to constant time series data using a GDP deflator. Constant time series data is calculated by dividing nominal time series data by the GDP deflator (expressed in hundredths term):

$$\text{Constant time series} = \frac{\text{Nominal time series}}{\text{GDP deflator (in hundredths)}}$$

Debt Service Payments: Debt service is a type of government expenditure that covers the repayment of interest and principal on a debt or liability by the government for a particular period of time.

Domestic Resource Mobilization (DRM): the willingness and ability of countries to increase domestically-sourced public financing for health, ideally in an efficient, equitable, and sustainable manner.

Government Deficit/Surplus: The difference between total government revenue and expenditure is called government deficit (if expenditure is greater) or government surplus (if revenue is greater). This is an important fiscal account that measures the extent to which general government is lending financing resources (in the case of government surpluses) or borrowing financial resources from other sectors and nonresidents in order to finance government spending (in the case of government deficits).

Gross Domestic Product (GDP): is a monetary measure of the market value of all the final goods and services produced within a country's borders in a specific time period, often annually.

Gross National Income (GNI): is the sum of value added by all resident producers plus any product taxes (less subsidies) not included in the valuation of output plus net receipts of primary income (compensation of employees and property income) from abroad.

Health Financing Transition: An empirically observed phenomenon that shows that as countries grow

¹ This glossary was adapted from “Glossary & Methods,” in the JLN DRM Collaborative. Ministry of Health & Family Welfare Budgetary Spending in Bangladesh. Domestic Resource Mobilization Collaborative. Joint Learning Network for Universal Health Coverage, 2020. Definitions derived from the present text were added. Other sources consulted were the Global Monitoring Report on Financial Protection in Health (2019), the World Health Organization and the International Bank for Reconstruction and Development, and the World Bank World Development Indicators (2019)

and develop there is a rise in health spending but that there is also a change in the composition of health spending with a higher share coming from public and other compulsory prepaid sources and a lower share from external and OOP sources.²

How to Account for Changes in Per Capita Public Spending on Health Over Time? There are different ways to account for changes in per capita public spending on health.³ One way is to focus on uncovering the relative contributions from a sub-set of factors by exploiting a key macroeconomic identity that, in any given years t and $t+1$, the following must hold true:

$$P_t = H_t E_t Y_t$$

$$P_{t+1} = H_{t+1} E_{t+1} Y_{t+1}$$

where P is per capita public financing for health in constant local currency units (LCUs), H is health's share of public expenditure, E is the public expenditure share of GDP, and Y is real GDP per capita in LCUs. Taking the logarithmic difference in $t+1$ versus t (denoted by lowercase with 'hat') of public spending on health must mathematically equal the sum of the logarithmic growth rates in health's share of public expenditures, of aggregate public expenditures as share of GDP, and of GDP per capita:

$$\hat{p}_t = \hat{h}_t + \hat{e}_t + \hat{y}_t$$

In other terms, this implies that the growth rate of public financing for health (\hat{p}_t) over a given time period must be exactly accounted for by changes in GDP per capita (that is, by economic growth, or \hat{y}_t), changes in aggregated public expenditures as share of GDP (\hat{e}_t), and by changes in health's share in aggregate public expenditure (\hat{h}_t).

The log-difference method of calculating growth rates is frequently used in economic growth theory and calculates rates that are a very close approximations to the simple growth rates. The advantage of using this method is that it allows a multiplicative decomposition of the growth rate of a variable into the growth rates of its components.

High Income Countries (HICs): Are currently defined by the World Bank as those countries that in 2018 had per capita income of US\$12,376 or higher.

Human Capital Index: A cross-country benchmarking exercise completed in 2018 by the World Bank Group Human Capital Project.⁴ The index measures the amount of human capital that the average child born in 2018 expects to achieve.

Inflation: An increase in the prices of goods and services over time (a decline in prices is referred to as 'deflation'). Inflation is typically measured in terms of how prices of a representative basket of goods and services changes over time (referred to as changes in the consumer price index) or changes in the prices of actual goods and services consumed in an economy over time (based on changes in the GDP deflator).

² Fan, V. Y., and W. D. Savedoff. 2014. "The Health Financing Transition: A Conceptual Framework and Empirical Evidence." *Social Science and Medicine* 105: 112–121.

³ Tandon, A., J.S. Cain, C. Kurowski, and I. Postolovska (2018). *Intertemporal Dynamics of Public Financing for Universal Health Coverage: Accounting for Fiscal Space Across Countries*. HNP Discussion Paper. Washington, D.C.: World Bank Group. Available: <http://documents.worldbank.org/curated/en/639541545281356938/Intertemporal-Dynamics-of-Public-Financing-for-Universal-Health-Coverage-Accounting-for-Fiscal-Space-Across-Countries>

⁴ World Bank Group. 2018. *The Human Capital Project*. Washington DC: International Bank for Reconstruction and Development.

The GDP deflator is defined as the ratio of the GDP at market prices in current U.S. dollars to the GDP at market prices in constant (2000) U.S. dollars.⁵

Low Income Countries (LICs): Are currently defined as those countries that in 2018 had per capita income of US\$1,025 or less.

Lower Middle Income (LMI) Countries: Are currently defined by the World Bank as those countries that in 2018 had per capita income between US\$1,026 and US\$3,995.

Nominal: Also referred to as ‘current’, refers to the value of a monetary variable without any adjustments made for changes in prices of goods and services due to inflation.

Non-Tax Revenue: Revenue received by the general government from other revenue sources other than taxes. These include social contributions, grants, and other revenue such as property income, sales of goods and services, and fines, penalties, and forfeits.

Out-of-Pocket (OOP): Households’ out-of-pocket expenditure is a direct payment for health care goods and services from the household primary income or savings (no third-party payer is involved). The payment is made by the user at the time of the purchase of goods or use of services.

Pritchett Landscape: is a way of classifying trend patterns in growth rates of any variable inspired by and building upon Pritchett (2000).⁶ Statistically identifiable policy-relevant ‘break points’ are determined using Pritchett’s method as the year when a break in trend for a variable can be identified by estimating the equation below and finding the breakpoint year (t^*) that minimizes the sum of squared errors over all t :

$$Y_t = a_1 * I(t \leq t^*) + b_1 t * I_1(t \leq t^*) + a_2 * I(t > t^*) + b_2 t * I(t > t^*) + \varepsilon_t$$

where Y is any variable of interest such as per capita GDP or per capita public spending on health, $I()$ is an indicator function (1 if the argument holds; 0 otherwise), $t=[t_0, \dots, T]$ where t_0 is 2000, T is 2017, t^* is the breakpoint year that is chosen subject to the constraint that each segment of the trend covers a minimum of three years (that is, $t^* - t_0 \geq 3$ and $T - t^* \geq 3$) and a and b are the intercept and time-trend slope, respectively, where the suffix 1 or 2 represent the estimates before and after the estimated breakpoint. Once the breakpoint is determined, the landscape of growth patterns is classified as follows:

Pattern	Growth rate	
	Before break	After break
Steep Hill	≥ 5 percent	≥ 5 percent
Hill	≥ 3 percent	≥ 3 percent
Accelerator	0 percent \geq & < 3 percent	≥ 3 percent
Steep Valley	< 0 percent	≥ 5 percent
Plateau	≥ 3 percent	0 percent \geq & < 3 percent
Valley	< 0 percent	0 percent \geq & < 3 percent
Plain	0 percent \geq & < 3 percent	0 percent \geq & < 3 percent
Mountain	≥ 3 percent	< 0 percent
Cliff	0 percent \geq & < 3 percent	< 0 percent
Slippery Slope	< 0 percent	< 0 percent

⁵ World Bank Group Data Catalog. <https://datacatalog.worldbank.org/gdp-deflator-index-2000100-us-series>

⁶ Pritchett, Lant. 2000. “Understanding patterns of economic growth: searching for hills among plateaus, mountains, and plains (English)”. The World Bank economic review. -- Vol. 14, no. 2 (May 2000), pp. 221-250.

Social Health Insurance (SHI): Social health insurance is a mandatory financing arrangement that ensures access to health care based on a compulsory payment of a non-risk-related contribution by or on behalf of the eligible person. Contributions are raised mainly through wage-related (and occasionally income-related) contributions that are shared between employers and employees. The social health insurance scheme is established by a specific public law, defining, among others, the eligibility, benefit package and rules for the contribution payment.

Tax Revenue: Revenue received by the general government from taxes. Taxes are compulsory, unrequited amounts receivable by government units from individuals, public enterprises, trade, royalties on natural resources and/or foreign aid.

Total Government Expenditure: Total expense and the net acquisition of nonfinancial assets by the government in order to fulfill their role of providing public goods and services and redistribution of income and wealth.

Total Government Revenue: Taxes, social contributions, grants receivable, and other revenue received by the government. Governments collect revenue in order to finance selected public goods and services that they provide to their citizens and to redistribute income and wealth by means of transfers.

Universal Health Coverage (UHC): As defined by the World Health Organization,⁷ means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.⁸

Universal Health Coverage (UHC) Service Coverage Index: Measures the average coverage of essential services that include reproductive, maternal, newborn and child health, infectious diseases, noncommunicable diseases and service capacity and access, among the general population (as well among the most disadvantaged population).

Upper Middle Income (UMI) Countries: Are currently defined by the World Bank as those countries that in 2018 had per capita income between US\$3,996 and US\$12,375.

⁷ World Health Organization 2019. "Universal Health Coverage" Accessed September 2020. Last updated January 2021.

⁸ World Health Organization 2021. WHO Universal Health Coverage data portal. Accessed September 2020. Last updated January 2021.

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