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Narrative Summary on Public Expenditure for Health: Central Government Budgetary Spending in Indonesia

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Narrative Summary on Public Expenditure for Health: Central Government Budgetary Spending in Indonesia

This narrative summary was co-produced by the Indonesia-based members of the JLN collaborative on Domestic Resource Mobilization (DRM), including Nasruddin Djoko Surjono (Ministry of Finance), Mundiarno (BPJS Health), Pungkas Bahjuri Ali (Ministry of National Planning), Wahyu Nugraheni (Ministry of Health), Pujiyanto (University of Indonesia), Atikah Adyas (University of Mitra Indonesia), and Eka Yoshida (Ministry of Health) with Pandu Harimurti and Somil Nagpal (World Bank, Indonesia office). The narrative summary was supported by the DRM collaborative facilitation team in the World Bank, comprising of Ajay Tandon, Maria Eugenia Bonilla-Chacin, Jewelwayne Salcedo-Cain, Aditi Nigam, Danielle Elena Bloom, Lauren Oliveira Hashiguchi, and Valerie Gilbert Ulep.

The purpose of this narrative summary for Indonesia is to analyze trends in central government budgetary spending on health in Indonesia to demonstrate how policymakers can summarize and analyze their historical budgetary data in order to have a more informed within-country dialogue on issues related to domestic resource mobilization (DRM) for health. Central government budgetary spending is a subset of total public spending on health in Indonesia; sub-national spending on health by governments and social health insurance (SHI) spending are other key components. The analysis reported in the narrative summary is meant to be illustrative, to demonstrate how such information can form the basis for setting the stage for assessing DRM options for health by understanding better where the country is and where it has come from in terms of broader health financing trends and how these trends have interacted with the overall macro-fiscal context in the country.

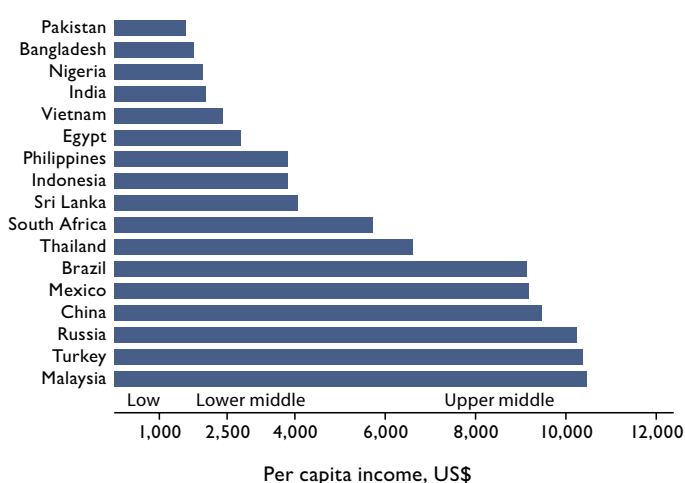
BACKGROUND

Indonesia is a large archipelago country in the World Bank's (WB's) East Asia and Pacific (EAP) region. Its population of 264 million is the fourth largest in the world, following China, India, and the USA. The latest estimate of its per capita income was US\$3,840, comparable to that of the Philippines and Sri Lanka (Figure 1). Although currently classified as a lower middle income (LMI) country, Indonesia is likely to transition to upper middle income (UMI) status in coming years. Only about 6% of the country's population is estimated to live below US\$1.90-per-day and 27% lives below \$3.10-per-day.

Per capita Gross Domestic Product (GDP) has grown steadily in the country in recent decades: annual economic growth rates averaged 3.4% in per capita terms over 2000-2006, accelerating to 4.3% over 2007-2017. The 'Pritchett Landscape' of Indonesia's per capita growth trajectory can be categorized as a 'hill' with growth rates exceeding 3% per year before and after a statistically-determined break in trend in 2007 (Figure 2).¹ As a result, in cumulative per capita terms, the size of Indonesia's economy almost doubled over the period 2000-2017.

At 17% of GDP, total government expenditures as share of GDP is relatively low, driven largely by low total government revenues (14% of GDP) as well as low tax revenues (11% of GDP). These numbers are

Figure 1: Per capita income (US\$) across countries

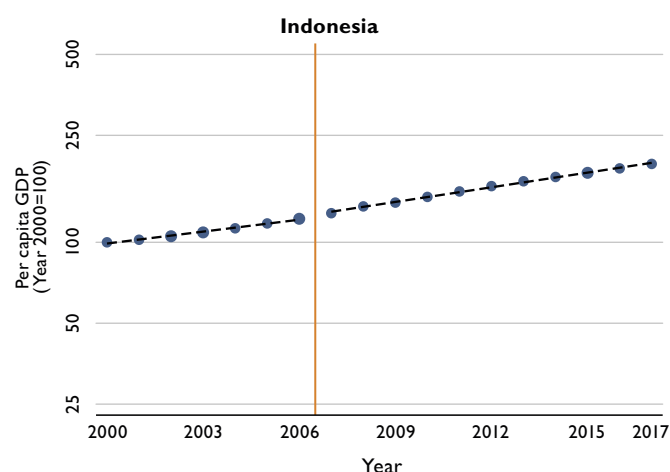


Source: World Development Indicators 2019.

¹ Pritchett, L. 2000. "Understanding Patterns of Economic Growth: Searching for Hills among Plateaus, Mountains, and Plains." World Bank Economic Review, 14 (2): 221–250.

particularly low when compared with averages for LMI and UMI countries (Table I). Indonesia's tax revenues do not reach the 15% benchmark that has recently been highlighted in a study by the International Monetary Fund (IMF) as being necessary for sustaining economic growth.² Indonesia's total government expenditure has remained in the 15-20% of GDP range over 2000-2017 (Figure 3).

Figure 2: Per capita GDP



Source: Author's estimates using data from the WHO Global Health Expenditure Database 2018.

Figure 3: Government Revenue and Expenditure in Indonesia



Source: The IMF World Economic Outlook and the IMF World Revenue Longitudinal Database.

Table I: Comparison of Government expenditures, revenues, deficit, and surplus

Country	Government expenditures	Government revenues		Government deficit/surplus
		Total	Tax	
Bangladesh	14	10	8	-3
Brazil	38	31	24	-8
China	32	28	18	-4
Egypt	32	22	13	-10
India	27	20	18	-7
Indonesia	17	14	11	-3
Malaysia	22	19	14	-2
Mexico	26	25	14	-1
Nigeria	12	7	4	-5
Pakistan	21	16	12	-6
Philippines	20	20	15	0
Russia	35	33	24	-1
South Africa	33	28	25	-4
Sri Lanka	19	14	13	-5
Thailand	22	21	16	-1
Turkey	34	31	18	-2
Vietnam	29	25	19	-5
EAP	44	44	16	0.4
LMI	31	27	17	-4
UMI	35	32	18	-3

Source: The IMF World Economic Outlook 2019 and the IMF World Revenue Longitudinal Database 2019.

² Gaspar, V., L. Jaramillo, and P. Wingender. 2016. "Tax Capacity and Growth: Is there a Tipping Point?" IMF Working Paper WP/16/234, Washington, DC: International Monetary Fund.

HEALTH SYSTEM

Indonesia has a mixed model of public-private provision of health care services, with the private sector increasingly taking a more dominant role. The health system is decentralized to the district level, with over 500 districts that have the primary responsibility for health care provision.

With a life expectancy of 71 years and an under-five mortality rate of 25 per 1,000 live births, most population health outcomes in Indonesia are as expected for its income level (Table 2).³ Challenges remain with relatively high levels of maternal mortality, childhood stunting, and in curtailing tuberculosis. Geographic and income-related inequalities are relatively large. Indonesia scored 0.53 on the WB's human capital index (HCI) indicating that a child born there today would be expected to be only 53% as productive as he/she could have been, and GDP per worker could be double what it is, with full education and health.

Indonesia has implemented several health financing reforms in recent decades. Landmark legislations in 2004 and 2011 helped realize a potential pathway to universal health coverage (UHC) based on a combined contributory and non-contributory SHI program, *Jaminan Kesehatan Nasional* (JKN), which was initiated in 2014 by consolidating and expanding several different existing schemes.⁴ Under JKN, premiums for the poor and near-poor are paid for by the government whereas the formal sector and the informal non-poor are mandated to contribute to receive coverage. With an estimated coverage rate of 80% of the population, JKN is now one of the largest single-payer SHI programs in the world.

Indonesia's per capita spending on health is roughly US\$115 per capita, about 3% of GDP (Table 3). Almost half of this is publicly sourced, including a large share from government budgets that pay for premiums for the poor and near-poor, for vertical programs, and for supply-side financing of public health care facilities across the country.

Table 2: Comparison of Health Outcomes

Country	Population (millions)	Life expectancy	Fertility	Under-five mortality	Adult survival	Maternal mortality	Childhood stunting
Bangladesh	165	72	2.1	30	76	173	36
Brazil	208	75	1.7	14	79	60	7
China	1,395	76	1.7	9	86	29	8
Egypt	97	72	3.4	21	76	37	22
India	1,334	69	2.2	37	71	145	38
Indonesia	264	71	2.3	25	75	177	36
Malaysia	32	76	2.0	8	81	29	21
Mexico	125	75	2.2	13	79	33	12
Nigeria	196	54	5.5	120	48	917	44
Pakistan	201	67	3.6	69	71	140	45
Philippines	107	71	2.6	28	72	121	33
Russia	147	72	1.8	7	72	17	-
South Africa	58	64	2.4	34	58	119	27
Sri Lanka	22	77	2.2	7	84	36	17
Thailand	68	77	1.5	9	81	37	11
Turkey	82	77	2.1	11	85	17	10
Vietnam	95	75	2.0	21	79	43	25
EAP	2,066	70	2.9	27	74	97	25
LMI	2,965	68	3.1	39	70	196	27
UMI	2,592	73	2.3	19	78	65	13

Source: The World Development Indicators 2019.

³ Data reported are from global estimates; the local estimated value is 71.34 (2019).

⁴ World Bank. 2016. Indonesia Health System Financing Assessment: Spend More, Spend More, Right, and Better. Jakarta: World Bank.

SHI contributions from enrollees currently account for less than one-quarter of public expenditures on health. About one-third of government budgetary spending on health occurs at the central level; the largest share, almost two-thirds, occurs at the sub-national level. Out-of-pocket (OOP) spending stands at about 35% of health spending. External financing for health that is channeled through the health sector is less than 1% of health spending.

Table 3: Comparison of Health Spending across countries

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	
Bangladesh	36	2.3	7	89	0	11	74
Brazil	929	9.5	390	100	0	0	27
China	441	5.2	250	51	49	0	36
Egypt	106	5.3	35	87	12	0	60
India	69	3.5	19	86	13	1	62
Indonesia	115	3.0	56	73	26	1	35
Malaysia	384	3.9	194	99	1	0	38
Mexico	495	5.5	255	55	45	0	41
Nigeria	74	3.8	11	93	5	2	77
Pakistan	45	2.9	14	97	3	0	60
Philippines	133	4.4	46	82	10	8	53
Russia	586	5.3	334	61	39	0	40
South Africa	499	8.1	268	100	0	0	8
Sri Lanka	159	3.8	71	96	1	3	50
Thailand	247	3.7	188	92	8	0	11
Turkey	445	4.2	346	49	51	0	17
Vietnam	130	5.5	65	51	45	3	45
EAP average	242	4.3	133	75	23	2	36
LMI average	96	3.8	36	84	13	4	57
UMI average	503	5.7	278	76	24	0.1	27

Source: The WHO Global Health Expenditure Database 2019.

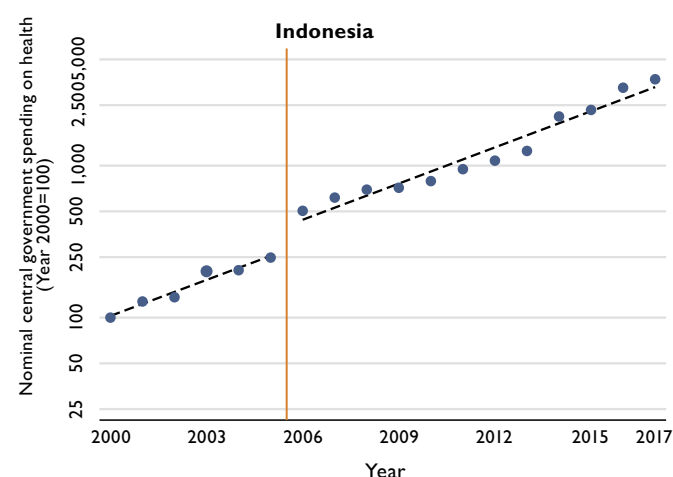
DOMESTIC RESOURCE MOBILIZATION FOR HEALTH EFFORTS

Domestic resource mobilization (DRM) for health efforts have focused on three areas: (i) as of 2014, collection of mandatory contributions from the formal sector and from the non-poor informal sector for JKN; (ii) as of 2009, ensuring that central government budgetary allocations are a minimum of 5% of the total central government budget (excluding salary outlays) and that district government budgetary allocations are a minimum of 10% of each district's total government budget (excluding salary outlays); and (iii) as of 2018, earmarking a share of the local tobacco tax for health. The next section focuses on the second of these DRM efforts, the 5% target for health's share of total central government expenditures.

TRENDS IN CENTRAL GOVERNMENT BUDGETARY SPENDING ON HEALTH

As per government budgetary data sources (APBN), central government budgetary spending on health

Figure 4: Nominal MOHFW Spending in Indonesia



Source: Author's estimates using data from the Ministry of Health, Republic of Indonesia.

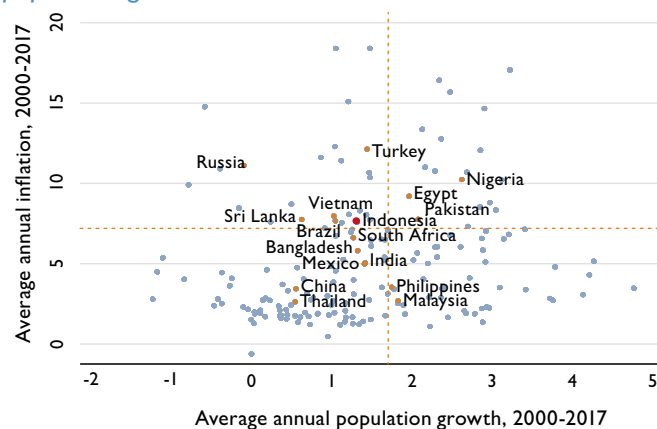
amounted to IDR 104,900 billion (~US\$7.8 billion) in 2017, up from IDR 2,835 billion (~US\$0.3 billion) in 2000: representing a more than 37-fold cumulative nominal increase over 2000-2017 and an average annual increase of 21.2% (Figure 4).

Indonesia has faced relatively high levels of inflation in recent decades. Over 2000-2017, the inflation rate was 7.7%, slightly higher than the average across all LMI countries over the same time period (Figure 5).⁵ At 1.3%, population growth is below the average for all LMI countries.⁶ Nominal budgetary increases would need to exceed at least $7.7\% + 1.3\% = 9.0\%$ per year to keep levels the same in per capita constant terms.

Adjusting for inflation and population growth (Figure 6) shows that, in per capita constant terms, central government budgetary spending on health in Indonesia has grown cumulatively eight-fold since 2000: averaging an annual growth rate of 12.3% per year and four times greater than the increase in the size of the economy over the same period. In 2017, per capita central government budgetary spending on health amounted to IDR 397,362 (~US\$30 per capita), up from only IDR 49,317 (~US\$4 per capita) in 2000.

Per capita central government spending on health is the product of three variables: health's share of total central government spending (health prioritization), total central government spending share of GDP, and per capita GDP. Over 2000-2017, the 12.3% increase in per capita constant central government spending on health (Figure 7) was primarily due to reprioritization of health's share in central government spending (8.0%) followed by economic growth (4.0%); only 0.3% of this increase was a result of higher total central government expenditures as share of GDP. As a result of reprioritization, health's share has now risen to 5% of the total central government budget.

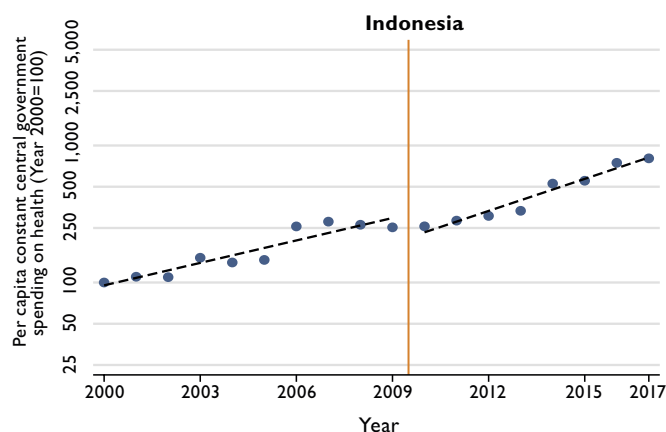
Figure 5: Average annual inflation against average annual population growth in select countries



Note: Dotted red lines indicate LMIC averages

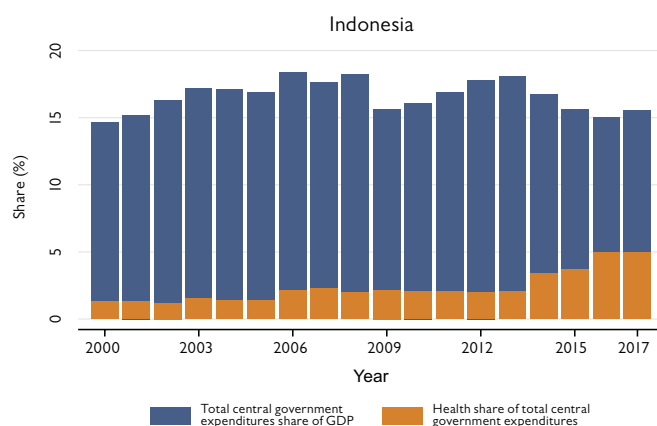
Source: Author's estimates using data from the Ministry of Health, Republic of Indonesia and the WHO Global Health Expenditure Database.

Figure 6: Per capita constant MOHFW spending in Indonesia



Source: Author's estimates using data from the Ministry of Health, Republic of Indonesia and the WHO Global Health Expenditure Database.

Figure 7: Total central government expenditure as a share of GDP compared to the health share of total central government expenditures in Indonesia, 2000-2017



Source: Author's estimates using data from the Ministry of Health, Republic of Indonesia and the WHO Global Health Expenditure Database.

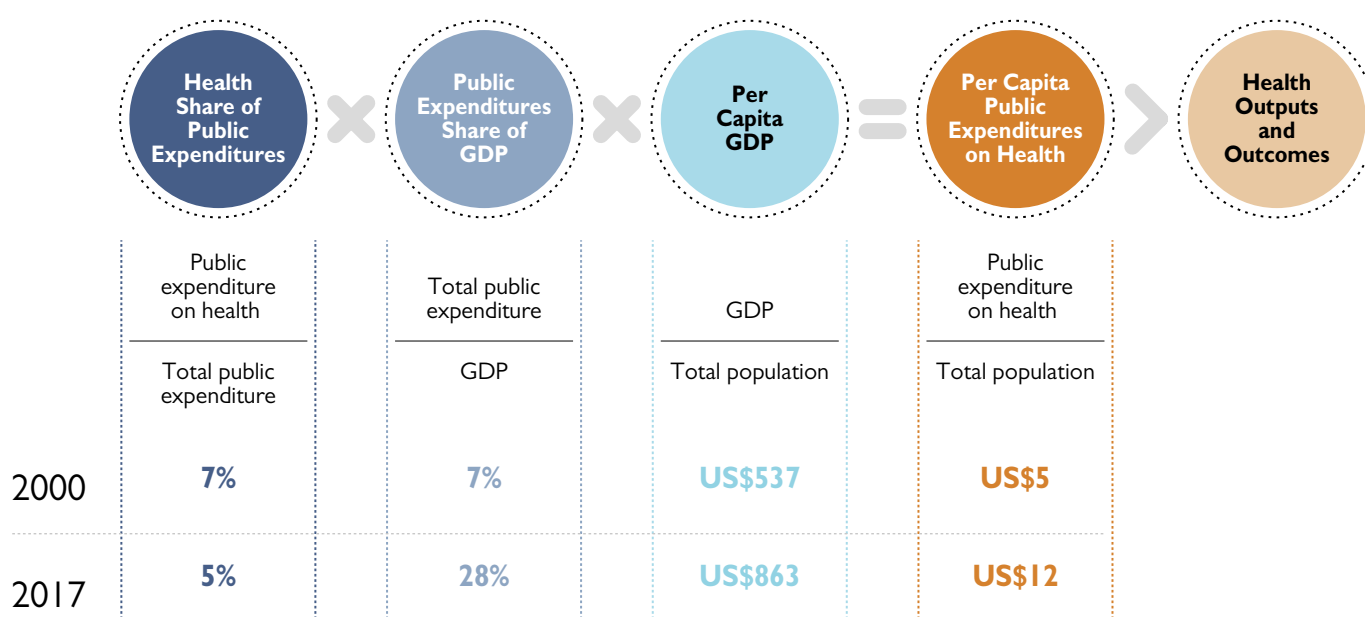
⁵ Data are reported from global estimates; local estimated value is 7.18% (Indonesia Statistics Bureau 2019).

⁶ Data are reported from global estimates; local estimated value is 1.4% (Indonesia Statistics Bureau 2019).

BROADER TRENDS IN HEALTH FINANCING AND UHC

Whereas the previous section focused on central government spending on health, the same exercise can be done to assess broader trends in public spending on health in Indonesia using WHO's Global Health Expenditure Database. In 2017, Indonesia's per capita GDP amounted to US\$3,846. Of this, 17% (~US\$637) was total government spending (representing spending across all sectors, including for health) and 9% of total government spending represented health's share (amounting to ~US\$56 per capita). In 2000, Indonesia's per capita GDP was US\$1,965 with 15% representing total government spending (~US\$301 per capita) of which only 4% was the share of health (amounting to ~US\$12 per capita) (Figure 8).

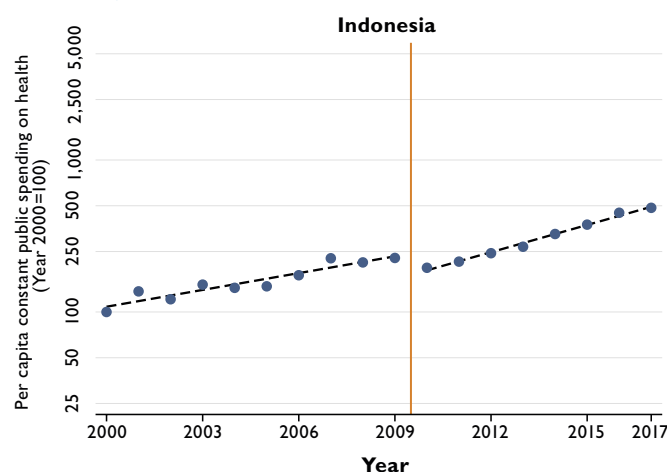
Figure 8: Calculation of Per Capita MOHFW Expenditure in Indonesia



Source: Author's estimates using data from the Ministry of Health, Republic of Indonesia and the WHO Global Health Expenditure Database.

Even though per capita GDP doubled in Indonesia over 2000-2017, per capita public spending on health increased almost five-fold over the same period (Figure 9). This was primarily due to reprioritization. Although Indonesia is a 'hill' country for per capita GDP, it can be characterized as an 'accelerator' country for its 'Pritchett Landscape' of per capita public spending on health as growth in the latter exceeded 5% per year before and after its statistically determined breakpoint of 2010. On an annualized basis, per capita public spending on health grew by 9.3% per year due to reprioritization (4.9%) and economic growth (4.0%); only 0.5% of this increase was a result of higher total government expenditures as share of GDP.

Figure 9: Per capita constant public spending on health in Indonesia, 2000-2017



Source: Author's estimates using data from the Ministry of Health, Republic of Indonesia and the WHO Global Health Expenditure Database.

Indonesia's 9% share of health in total government expenditure is similar to that of China, Malaysia, Russia, and Sri Lanka and equal to the average for LMI countries (Table 4); education's share of total government expenditures remains more than double the share of health's, and health's share is lower than the share of debt service payments (10%).

More generally, the pace of increase in per capita public spending on health (9.3% per year) has exceeded that in per capita OOP spending on health (5.1% per year; Figure 10); as a result, the OOP share of health spending has declined as the public spending on health share of GDP has increased indicating progress is being made on Indonesia's 'health financing transition' (i.e., the empirical trend observed that when countries grow and develop, there is a tendency not only to increase levels of health spending but also increase the share from public sources and decrease the share from external and OOP sources).⁷

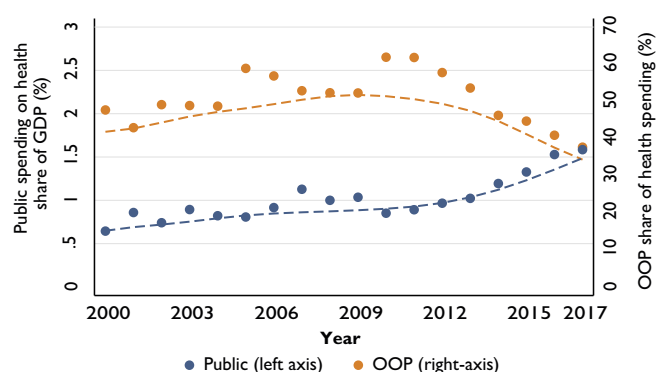
Indonesia has also made steady progress on its UHC service coverage index over 2000-2017 (Figure 11), having overtaken the average for both EAP countries and LMI countries recently.⁸ With regard to financial protection, preliminary indications are that the proportion of households for whom OOP spending was 10% or higher of consumption has actually increased in recent years, although more recent analysis of data is needed to confirm this.

Table 4: Comparison by country of share of total government expenditure

Country	Share of total government expenditure			
	Health	Education	Military	Debt Service
Bangladesh	3	15	11	14
Brazil	10	16	4	16
China	9	13	6	3
Egypt	5	11	4	25
India	3	14	9	17
Indonesia	9	21	5	10
Malaysia	9	20	5	8
Mexico	11	18	2	14
Nigeria	5	-	4	12
Pakistan	4	15	18	20
Philippines	8	13	6	9
Russia	9	11	12	1
South Africa	13	19	3	11
Sri Lanka	9	11	11	28
Thailand	15	19	7	3
Turkey	10	8	6	4
Vietnam	10	15	8	7
EAP	10	15	6	5
LMI	9	15	7	8
UMI	12	15	7	8

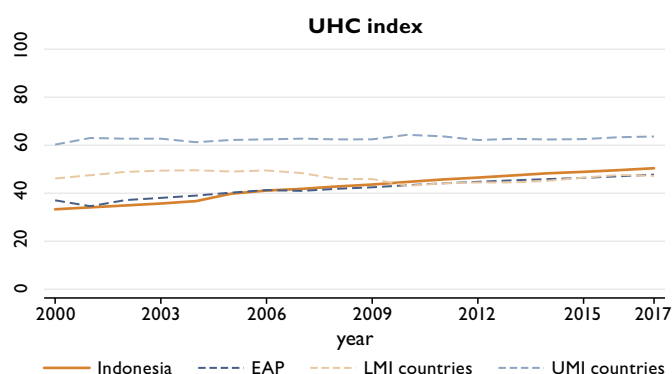
Source: Author's estimates using the World Development Indicators, the WHO Government Health Expenditure Database, and the IMF World Economic Outlook.

Figure 10: Public spending on health as a share of GDP vs OOP share of health spending in Indonesia, 2000-2017



Source: The WHO Global Health Expenditure Database.

Figure 11: UHC Effective Coverage Index



Source: Global Burden of Disease Collaborative Network 2020.

⁷ 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

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

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

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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