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Narrative Summary on Public Expenditure for Health: Ministry of Health & Family Welfare Budgetary Spending in Bangladesh

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Narrative Summary on Public Expenditure for Health: Ministry of Health & Family Welfare Budgetary Spending in Bangladesh

This Narrative Summary on Public Expenditure for Health was co-produced by the Bangladesh-based members of the DRM collaborative, including Mohammad Shahadt Hossain Mahmud and Subrata Paul (Health Economics Unit, Health Services Division, Ministry of Health & Family Welfare, Government of Bangladesh), with Shakil Ahmed and Tahmina Begum (World Bank, Dhaka office). This was supported by the DRM collaborative facilitation team in the World Bank, comprising of Maria Eugenia Bonilla-Chacin, Ajay Tandon, Jewelwayne Salcedo-Cain, Aditi Nigam, Danielle Elena Bloom, Lauren Oliveira Hashiguchi, Somil Nagpal, and Valerie Gilbert Ulep.

The purpose of this narrative summary for Bangladesh is to analyze trends in revised estimates of Ministry of Health and Family Welfare (MOHFW) budgetary spending in Bangladesh to demonstrate how policymakers can summarize and analyze their historical budgetary data for having a more informed within-country dialogue on issues related to domestic resource mobilization (DRM) for health. 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.

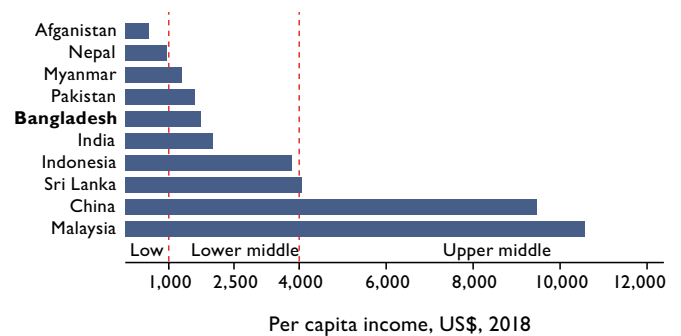
BACKGROUND

With a population of 165 million¹, Bangladesh is the eighth most-populated country in the world, and the third most-populated – following India and Pakistan – in the South Asia Region (SAR) of the World Bank. The latest estimate of its per capita income was US\$1,750, comparable to that of Kenya, Nigeria, Pakistan, and India. Bangladesh is classified as a lower middle income (LMI) country (Figure 1). About 15% of the country's population is estimated to live below US\$1.90-per-day and 53% 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 4.5% in per capita terms over 2000-2013, accelerating to 6.0% over 2014-2017 (Figure 2). The 'Pritchett Landscape' of Bangladesh'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 2014.² As a result, in cumulative per capita terms, the size of Bangladesh's economy increased two-and-a-half times over the period 2000-2019.

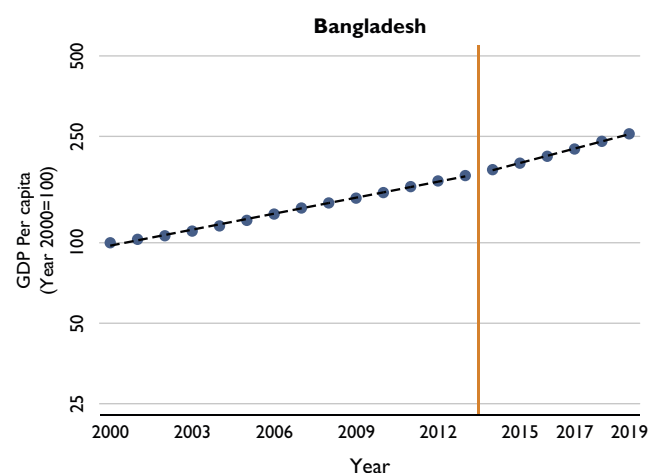
At 15%, total government expenditures as share of GDP is relatively low in Bangladesh (Figure 3 and Table 1) – driven largely by low total government revenues (amounting to only 10% of GDP, amongst the lowest in the world) as well as low tax revenues (only 8% of GDP) – and are financed by a relatively large deficit (5%

Figure 1: Per capita income (US\$) across South Asia Region and East Asia Region



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

Figure 2: Trends in per capita GDP



Source: Estimates are from the IMF World Economic Outlook (WEO) 2019.

¹ Estimate is from the WHO Global Health Expenditure Database (2017).

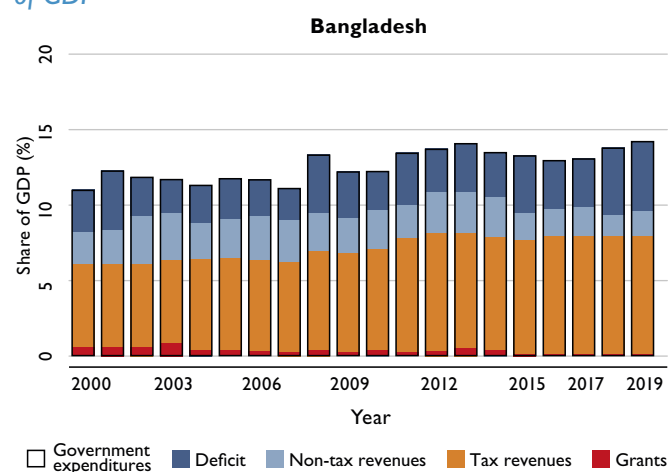
² Pritchett, L. 2000. "Understanding Patterns of Economic Growth: Searching for Hills among Plateaus, Mountains, and Plains." World Bank Economic Review, 14 (2): 221–250.

of GDP). Bangladesh'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.³ Bangladesh's total government expenditure has remained in the 10-15% of GDP range over 2000-2019.

HEALTH SYSTEM

Bangladesh has a mixed model of public-private provision of health care services with the private sector taking a dominant role in service provision, the latter including both for-profit and NGO providers. The health system is centralized and MOHFW sets policy as well as manages a national network of public providers.⁴

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



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

Table 1: Comparison of government expenditures, revenues, deficit, and surplus (as a share of GDP)

Country	Government expenditures	Government revenues		Government deficit/surplus
		Total	Tax	
Afghanistan	28	27	8	-1
Bangladesh	15	10	8	-5
China	35	29	18	-6
India	27	20	18	-7
Indonesia	16	14	11	-2
Malaysia	23	20	14	-3
Myanmar	21	17	3	-3
Nepal	31	26	21	-4
Pakistan	22	13	12	-9
Sri Lanka	19	13	13	-6
SAR	24	20	15	-5
LMI	31	27	17	-4
UMI	35	32	18	-3

Source: Estimates are from the IMF WEO and IMF World Revenue Longitudinal Database. Data is for 2019 with the exception of tax revenue, for which the latest year of available data is used.

With a life expectancy of 72 years and an under-five mortality rate of 30 per 1,000 live births, most population health outcomes in Bangladesh are better than expected for its income level. Fertility rates are at replacement levels. Challenges remain with relatively high levels of maternal mortality and childhood stunting. Geographic and income-related inequalities are also large. Bangladesh scored 0.48 on the WB's human capital index (HCI) indicating that a child born there today would be expected to be only 48% as productive as he/she could have been, and GDP per worker could be double what it is, with full education and health (Table 2).

³ 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

⁴ World Bank. 2016. Fiscal Space for Health in Bangladesh: Towards Universal Health Coverage. Dhaka: World Bank.

Table 2: Comparison of Health Outcomes

Country	Population (millions)	Life expectancy	Fertility	Under-five mortality	Adult survival	Maternal mortality	Childhood stunting
Afghanistan	36	64	4.6	62	64	638	41
Bangladesh	165	72	2.1	30	76	173	36
China	1,410	76	1.7	9	86	29	8
India	1,339	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
Myanmar	53	67	2.2	46	68	250	29
Nepal	29	70	2.0	32	75	186	36
Pakistan	197	67	3.6	69	71	140	38
Sri Lanka	21	77	2.2	7	84	36	17
SAR	1,788	71	2.6	35	75	194	32
LMI	2,965	68	3.1	39	70	196	27

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 (GHED), of which the latest available year for all countries is 2017.

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	
Afghanistan	67	11.8	7	46	0	54	75
Bangladesh	36	2.3	7	90	0	11	7
China	441	5.2	250	51	49	0	36
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
Myanmar	58	4.7	10	83	3	14	76
Nepal	48	5.6	12	89	0	11	58
Pakistan	45	2.9	14	97	3	-	60
Sri Lanka	159	3.8	71	96	1	3	50
SAR	191	5.3	116	87	3	12	52
LMI	130	5.3	71	77	14	10	39

Source: The WHO GHED 2017.

Bangladesh's per capita spending on health (Table 3) is roughly US\$35 per capita, about 2.9% of GDP. Only one-fifth of this is publicly sourced.⁵ Out-of-pocket (OOP) spending stands at 72% of health spending, among the highest shares in the world. External financing for health is 11% of health spending. Table 3 represents the share of external funds that flows through public channels.

DOMESTIC RESOURCE MOBILIZATION FOR HEALTH EFFORTS

In 2015, the government introduced a 'health development surcharge' of 1% on all imported and domestically-produced tobacco products. This is being collected by the National Board of Revenue (NBR). In 2017, the government approved a Health Development Surcharge Management Policy through a government gazette order which specified that these resources are to be spent to finance tobacco control activities and for prevention of tobacco-related non-communicable diseases. Around Taka 2.25 billion (~US\$26 million; per capita ~US\$0.15) is collected every year. However, these resources are yet to be fully injected into the health budget.

⁵ This refers to current health expenditures only and excludes capital expenditures.

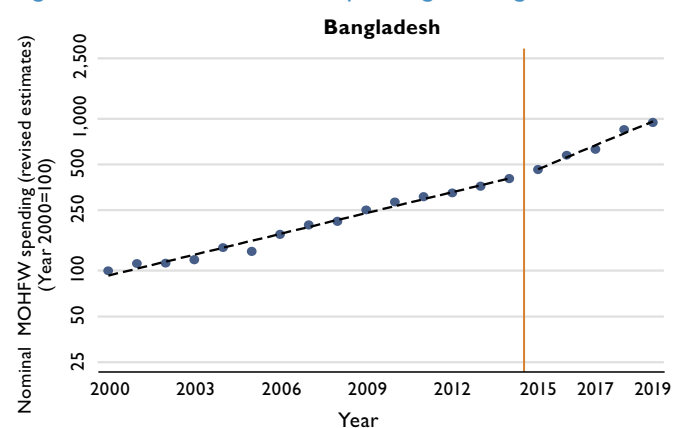
TRENDS IN CENTRAL GOVERNMENT BUDGETARY SPENDING ON HEALTH

As per government data sources, revised estimates of MOHFW budgetary spending amounted to Taka 223.4 billion (~US\$2.6 billion) in 2019, up from Taka 23.6 billion (~US\$0.5 billion) in 2000: representing a ten-fold cumulative nominal increase over 2000-2019 and an average annual increase of 11.8% (see Figure 4).⁶ MOHFW budgetary spending as a share of total health expenditure, however, decline from 5.8% in 2000 to 5.5% in 2019 (see Figure 5).

Bangladesh has faced relatively low levels of inflation and population growth in recent decades. Over 2000-2019, the inflation rate was 5.8%, lower than the average across all LMI countries over the same time period. At 1.2%, population growth was also below the average for all LMI countries (see Figure 6). Nevertheless, these inflation and population growth numbers imply that nominal budgetary increases would need to exceed at least $5.8\% + 1.2\% = 7.0\%$ per year to keep levels the same in per capita constant terms.

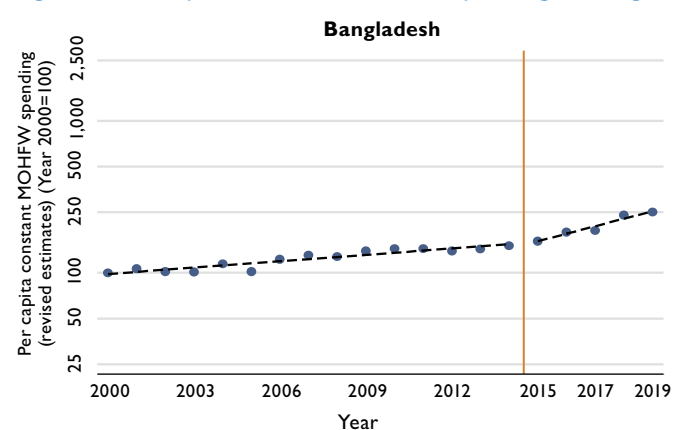
Adjusting for inflation and population growth shows that, in per capita constant terms, MOHFW budgetary spending in Bangladesh has more than doubled since 2000: averaging an annual growth rate of 4.8% per year and almost the same as the cumulative increase in the size of the economy over the same period (see Figure 6). In terms of its 'Pritchett Landscape', Bangladesh remains a 'hill' country with growth in per capita MOHFW spending exceeding 3% before and after its break point of 2017. In 2019, per capita MOHFW budgetary spending on health amounted to Taka 1,201 (~US\$15 per capita), up from only Taka 479 (~US\$6 per capita) in 2000.⁷ Per capita MOHFW spending is the product of three things: MOHFW's share of total government spending, total government spending share of GDP, and per capita GDP. In 2019, Bangladesh's per

Figure 4: Nominal MOHFW Spending in Bangladesh



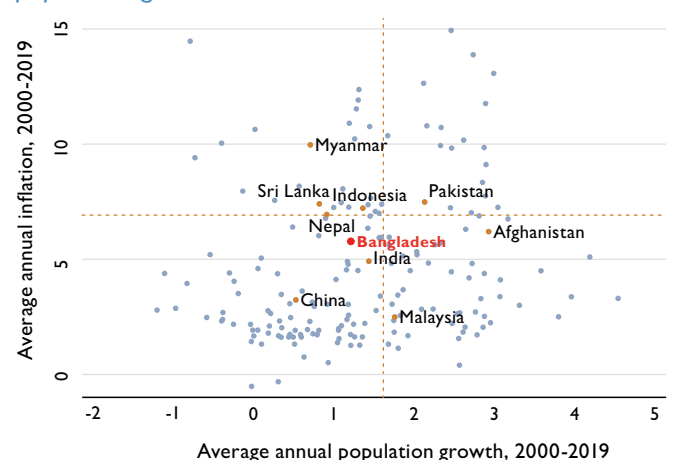
Source: The WHO GHED 2017.

Figure 5: Per capita constant MOHFW spending in Bangladesh



Source: Authors' estimates using data from the Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh and the IMF World Economic Outlook.

Figure 6: Average annual inflation against average annual population growth in select countries



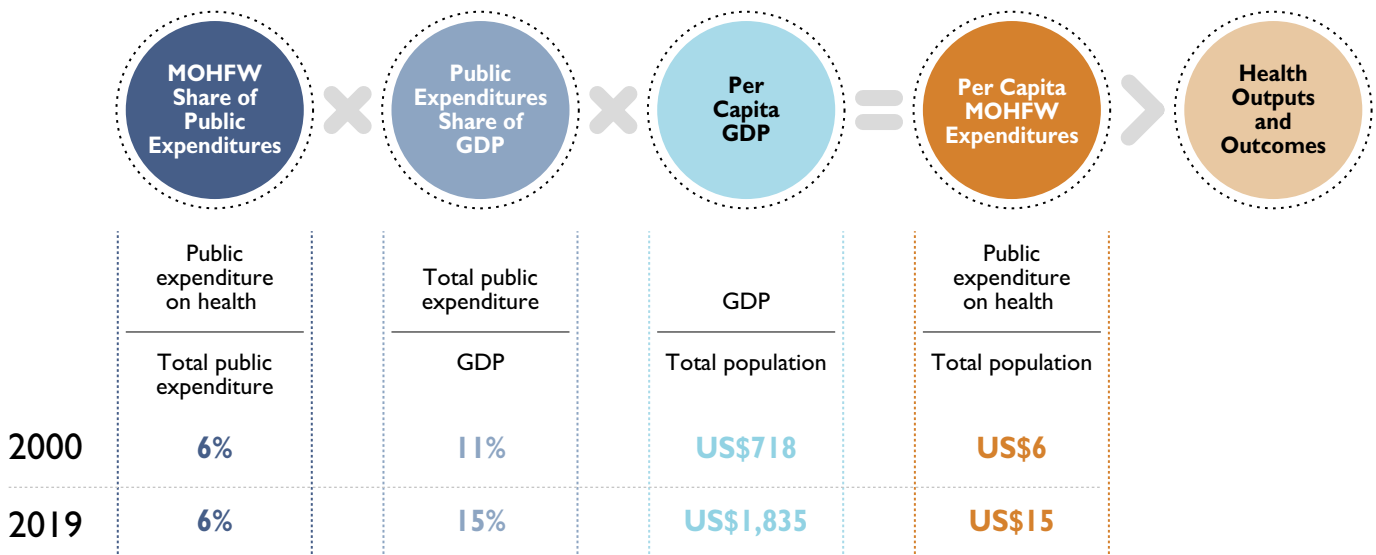
Note: Dotted red lines indicate LMIC averages
Source: Authors' estimates using data from the IMF WEO.

⁶ Estimates until 2015 are from the Public Expenditure Review, Health Economics Unit, Ministry of Health & Family Welfare (1997-2014), and from the Budget Brief, Ministry of Finance (2016-2019). Actual expenditure is from 2000-2017 while revised estimates are included for 2018-2019.

⁷ These expenditures include both capital and current spending and are reported in constant 2017 terms.

capita GDP amounted to US\$1,835. Of this, 15% was total government spending (representing spending across all sectors, including for health) and 6% of total government spending represented health's share (amounting to ~US\$15 per capita, as noted above). In 2000, Bangladesh's per capita GDP was US\$718 with 11% representing total government spending of which 6% was the share of MOHFW (amounting to ~US\$6 per capita) (Figure 7).

Figure 7: Calculation of Per Capita MOHFW Expenditure in Bangladesh



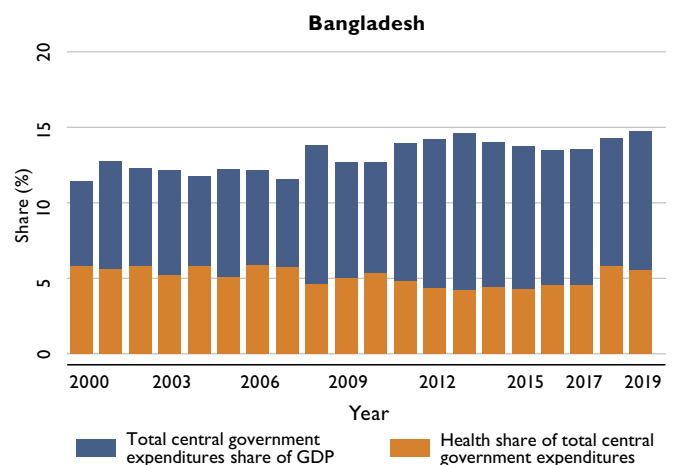
Source: Rounded estimates are from the WHO GHED 2019, the World Development Indicators (WDI) 2020, and the IMF WEO 2020.

Over 2000-2019, the 4.8% increase in per capita MOHFW spending was primarily due to economic growth (4.9%) followed by an increase in the share of total government expenditure in the economy (1.4%); MOHFW's share of total government spending has declined (-1.5%) over this time period (Hence: 4.8%=4.9%+1.4%-1.5%).

BROADER TRENDS IN HEALTH FINANCING AND UHC

More generally, the pace of increase in per capita MOHFW spending has been slower than that in per capita OOP spending on health; as a result, the OOP share of health spending has increased slowly as MOHFW share of GDP has declined over time, indicating that Bangladesh's 'health financing transition'— where countries are observed to reduce external and OOP financing for health with domestic public sources as they grow and develop -- is in reverse gear.⁸

Figure 8: Total government expenditure as a share of GDP compared to the MOHFW share of total government expenditures in Bangladesh, 2000-2019



Source: Authors' estimates using data from the Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh, the WHO GHED, and the IMF WEO.

⁸ Fan, VY, and WD Savedoff. 2014. "The Health Financing Transition: A Conceptual Framework and Empirical Evidence." *Social Science and Medicine* 105: 112–121.

Bangladesh's 3% share of health in total government expenditure is similar to that of India and less than the average for LMI countries and countries in the South Asia Region (SAR) (Table 4). Education's share of total government expenditures is five times more than the share of health's, while the health's share is far lower than the share of debt service payments (14%).

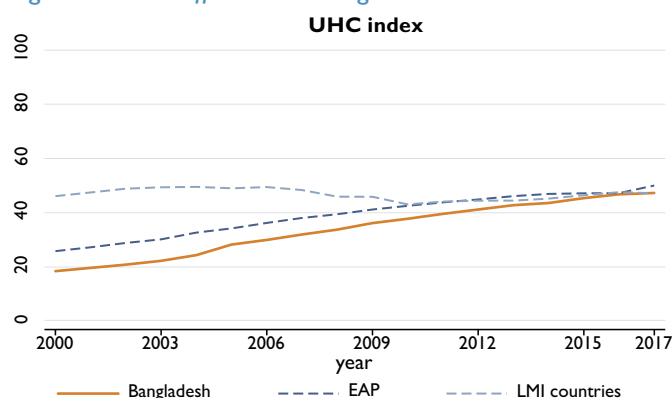
Despite health financing challenges, Bangladesh has made steady progress on its UHC index of essential service coverage over 2000-2017, having improved faster than the average for SAR countries and reaching the average for LMI countries recently (Figure 9).^{9,10} In the last few years, however, the rate of increase in the UHC index of essential services coverage has decreased. Low spending on health has led to under-utilization and perceptions of low quality provision at the facility level.¹¹ Most gains in improved health outcomes were a result of public and community health interventions. With regard to financial protection, preliminary indications are that the proportion of households for whom OOP spending was 10% or higher of consumption has increased in recent years, although more recent analysis of data is needed to confirm this^{12,13} (Figure 10).

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
SAR	8	15	10	11
LMI	9	15	7	8
UMI	12	15	7	8

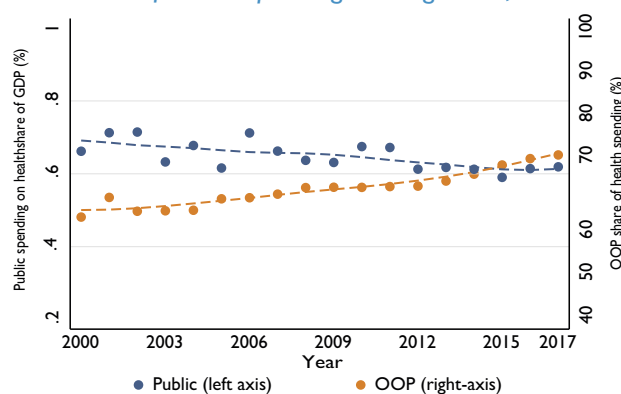
Source: Authors' estimates using data from the Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh, the WDI, the WHO GHED, and the IMF WEO.

Figure 9: UHC Effective Coverage Index



Source: Global Burden of Disease Collaborative Network 2020.

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



Source: WHO GHED 2019.

⁹ 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.

¹⁰ WHO 2019. Global Monitoring Report 2019: Primary Health Care on the Road to Universal Health Coverage. Geneva: World Health Organization.

¹¹ Ahmed, S., Begum, T., and D. Cotlear. 2019. Bangladesh – Unravelling the 'Good Health at Low Cost' Story (English). Universal Health Coverage (UNICO) studies series, 41. Washington, D.C.: World Bank Group.

¹² Ministry of Health and Family Welfare, Government of Bangladesh and The World Bank Group. Pathways to Reduce Household Out-of-Pocket Expenditure.

¹³ Global monitoring report on financial protection in health 2019. Geneva: World Health Organization and International Bank for Reconstruction and Development / The World Bank; 2020.

GLOSSARY & METHODS

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 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.¹

¹ 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.

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.² 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.³ 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). 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.⁴

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

² 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-Accountingfor-Fiscal-Space-Across-Countries>

³ World Bank Group. 2018. The Human Capital Project. Washington DC: International Bank for Reconstruction and Development.

⁴ World Bank Group Data Catalog. <https://datacatalog.worldbank.org/gdp-deflator-index-2000100-us-series>

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).⁵ 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

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.

⁵ 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.

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,⁶ 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.⁷

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.

⁶ World Health Organization 2019. "Universal Health Coverage" Accessed September 2020. Last updated January 2021.

⁷ World Health Organization 2021. WHO Universal Health Coverage data portal. Accessed September 2020. Last updated January 2021.

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