

1. Introduction

In 2002, Turkey's health indicators lagged behind those of Organisation for Economic Co-operation and Development (OECD) and other middle-income countries. Life expectancy at 71.9 years was significantly lower than the OECD country average of 78.6 years, and the infant mortality rate and maternal mortality ratio (at 28.5 deaths per 1,000 live births and 61 deaths per 100,000 live births,² respectively) were some of the highest among middle-income countries. Only 64 percent of the population was covered by health insurance, and even those who were insured did not have adequate access to timely health services.

The health financing and delivery system was fragmented, with four separate social insurance schemes and the Green Card for the poor, each with different entitlements and rules for access. System stewardship and governance by the Ministry of Health (MOH) was inadequate; there was little coordination between the MOH and Ministry of Labor and Social Security (MOLSS), which were both providers and financiers of the health system.

Various governments had made considerable efforts to restructure health service delivery and financing, with limited success. In 2003, there was a unique opportunity when the government outlined its reform objectives under a Health Transformation Program (HTP), which highlighted the need for a broad “transformation” in the way health care was financed, delivered, organized, and managed, particularly in extending health coverage to the entire population and reducing the inequalities in access to and utilization of services across the country. A key objective of the HTP was to increase access to services and eliminate fragmentation in financing by merging all health insurance schemes (including the Green Card program) into a Universal Health Insurance (UHI) scheme to be managed by the newly created Social Security Institution (SSI).

As a result, health outcomes have improved significantly. By 2010, life expectancy rose to 74.3 years. The maternal mortality ratio and infant mortality rates fell to 16.4 deaths per 100,000 live births and 10.1 deaths per 1,000, respectively. Furthermore, through the expansion of benefits and improvements in targeting, Turkey has been able to achieve universal coverage. According to official SSI statistics, today over 95 percent of the population is now covered by health insurance.

The last decade has been a period of rapid economic growth and development for Turkey, thanks to sound macroeconomic management and structural reforms implemented since the 2001 banking crisis. As a result, the Turkish economy grew by an average of 5.5 percent between 2002 and 2011, compared to the pre-2001 average of around 4 percent. Per capita income tripled over the period and was US\$10,444 in 2011.

This case study unravels Turkey's path to universal coverage. It outlines both the transformation of the health system and the performance of the “Yesil Kart”—the Green Card—program, a noncontributory health insurance scheme for the poor. Initially launched in 1992, the Green Card program has seen a rapid expansion in the number of beneficiaries and program benefits since the implementation of the HTP in 2003, with the number of beneficiaries more than tripling,

² The maternal mortality ratio is for 2000.

from 2.5 million beneficiaries in 2003 to 9.1 million beneficiaries in 2011. In addition, both the coverage and targeting of the program improved substantially.

While the Green Card program initially began as a separate targeted scheme for the poor, in January 2012 it became part of the UHI scheme managed by SSI. As this study will show, gradual steps were taken over the years to expand coverage, improve targeting, and expand benefits of the Green Card program to align it with the UHI. This, combined with the improvements in service delivery within a comprehensive reform of the health sector, makes Turkey a unique example of universal coverage for quality health services.

The study is organized as follows. Section 2 briefly outlines Turkey's health reform and how health care is currently organized and delivered. Section 3 describes the Green Card Program, its evolution, and its performance. The final section discusses the pending agenda.

2. Transformation of Turkey's Health System

Prior to 2003, health financing in Turkey was fragmented into five independent financing schemes, each with different entitlements and rules of access. The Social Insurance Organization for Blue-collar Workers in the Public and Private Sectors (Sosyal Sigortalar Kurumu, SSK) scheme covered employees in the formal sector; the Social Insurance Agency for Merchants, Artisans and Self-employed (Bag-Kur) covered the self-employed; and the Social Insurance Agency for Active and Retired Civil Servants (Emekli Sandigi) covered active and retired civil servants through two separate schemes. In addition, the Green Card scheme covered the poor and was financed by the Ministry of Finance and operated by the MOH. Service delivery, too, was fragmented, since a large portion of public health facilities belonged to the SSK, while the rest belonged to the MOH.

The HTP aimed to reduce this fragmentation in both service delivery and financing. The HTP reforms focused on improvements in service delivery through the introduction of family medicine, performance-based payments at levels of service, and increased hospital autonomy and quality.

First, in 2005, SSK hospitals were transferred to the MOH hospital system, thus eliminating one major source of fragmentation in the public delivery system. Second, in 2006, the three health insurance schemes (SSK, Bag-Kur, and Emekli Sandigi) were integrated into a single purchaser, the Social Security Institution (SSI). Third, the adoption of the Social Security and Universal Health Insurance Law in 2008 created the legal and institutional basis for a fully harmonized health insurance system, Universal Health Insurance (UHI), the largest social security system in Turkey, under the control of the SSI. Fourth, in January 2010, the Active Civil Servants scheme was transferred to the SSI, and two years later the Green Card program followed. During the same period, significant efforts were made to harmonize the benefits packages of the various schemes. Today, the same benefits package applies to all groups covered under UHI and is guided by a single Health Implementation Guide, which is published annually. Figure 1 provides a timeline of the reforms in health care financing and service delivery in Turkey.

In recent years, there have been radical changes in the level and composition of health funding in Turkey. Total spending on health as a share of gross domestic product (GDP) has increased from 4.9 percent in 2000 to 6.7 percent in 2010, 75.2 percent of which is now publicly funded compared with 62.9 percent in 2000 (table 1). Further decomposition shows the various sources of health spending in Turkey; in 2010, 45.2 percent of funds came from UHI, 30 percent from government sources, 16 percent from out-of-pocket payments, and 8.8 percent from other private sources.

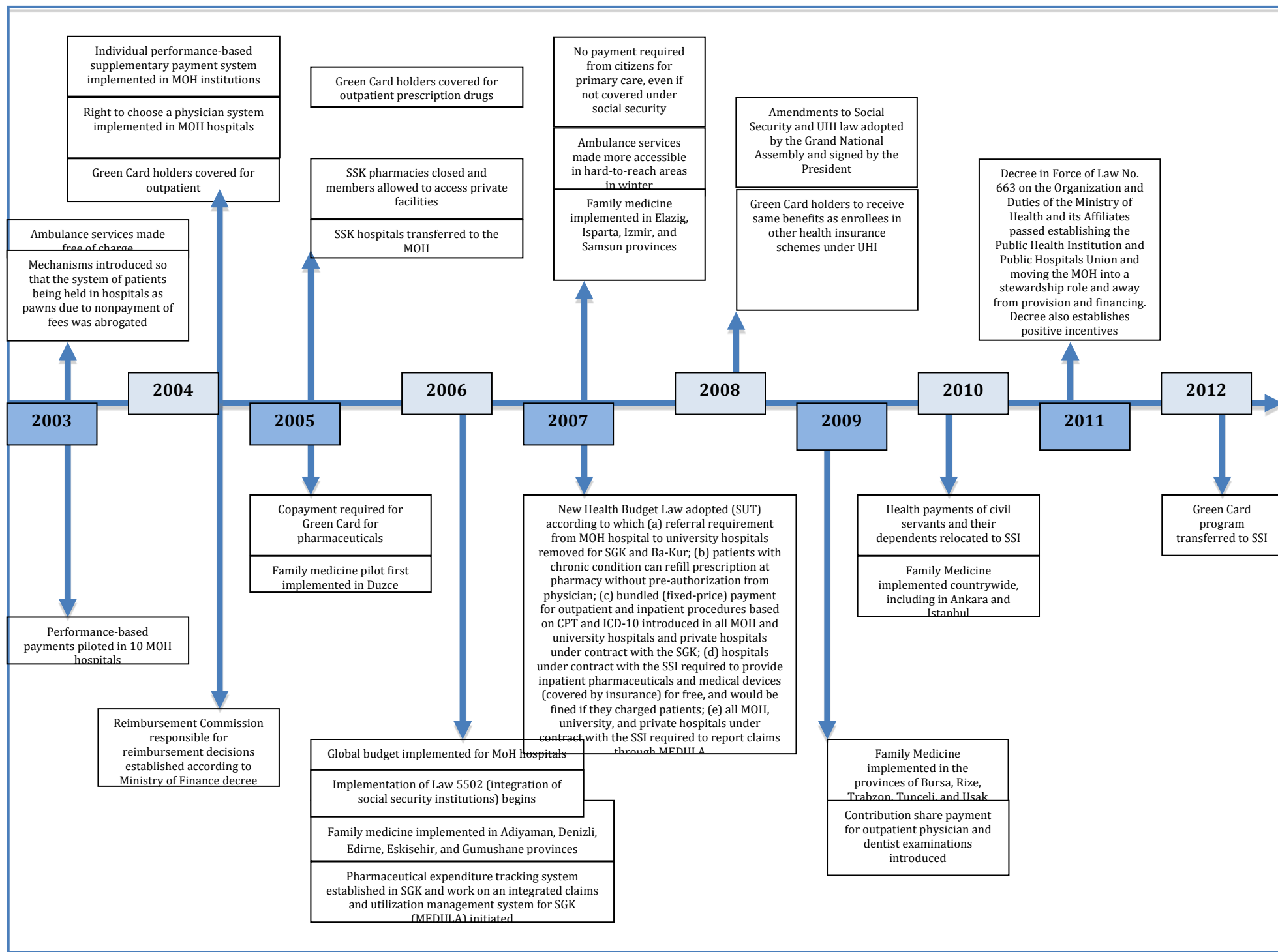
Table 1 Health Expenditures, Turkey, 1995–2010

	1995	2000	2005	2010
Total Health Spending as a Share of GDP (%)	2.5	4.9	5.4	6.7
Public Health Spending as a Share of GDP (%)	1.8	3.1	3.7	5.1
Private Health Spending as a Share of GDP (%)	0.7	1.8	1.8	1.7
Public Health Spending as a Share of Total Health Spending (%)	70.3	62.9	67.8	75.2
Private Health Spending as a Share of Total Health Spending (%)	29.7	37.1	32.2	24.8
Out-of-Pocket Health Spending as a Share of Total Health Spending (%)	29.7	27.6	22.8	16.0
Total Expenditure on Health Per Capita (US\$)	95	205	382	678
Total Expenditure on Health Per Capita (PPP)	179	454	621	1029
Public Health Expenditure as a Share of General Government Expenditure (%)	10.7	9.8	11.3	12.8

Note: PPP = purchasing power parity.

Turkey's health spending in 2010 was not excessive, however; it is in line with that of comparable countries at similar levels of income and reflects the prioritization given to health by the government in the last decade. Further, as shown below, increases in public spending have led to significant improvements in service delivery and to improved access for the underserved and rural populations, with a key focus on priority services for mothers and children.

Figure 1 Timeline of Health Sector Reform in Turkey, 2003–12



Provision and Financing of Health Services in Turkey

Prior to implementation of the HTP, primary care was weak, and the majority of the population sought ambulatory care through outpatient services in hospitals. In addition, large regional disparities in quality and access to health care existed, with health outcomes and utilization rates varying significantly by province. Realizing the need to restructure the primary care system, the government decided to implement the Family Medicine Program. The program, piloted in Duzce in 2005, and was rolled out nationwide by the end of 2010. Family medicine providers provide “integrated health services” covering a wide range of primary care services, with an increasing emphasis on prevention of chronic diseases. They have also assumed the responsibility for conducting vaccinations, prenatal care, and infant follow-up, activities that were previously conducted primarily by midwives. Today, primary care and preventive care services are delivered mainly through 6,463 family health centers with 20,243 Family Medicine Practice doctors and 20,243 Family Health Personnel (mainly nurses and midwives) and community health centers.

Secondary and tertiary health care services are provided by MOH-affiliated public hospitals (including SSK hospitals since 2006), university hospitals, and private hospitals. In 2010, there were 1,439 hospitals in Turkey of which 843 were owned by the MOH, 63 were university hospitals, 489 were private facilities, and 45 were owned by other public establishments and local administrations.

In Turkey, primary care and preventive services are financed mainly through the state budget. There are no copayments at the primary-care level. Primary care and preventive services are largely delivered by the Family Medicine Program. Individual doctors and other clinical staff are contracted using performance-based contracts on a capitation basis.

Hospital services are financed through a combination of prospective and retrospective payments. The state budget covers the majority of health personnel expenses for public hospitals and, until 2012, expenses for the Green Card holders. For MOH hospitals, SSI transfers a global budget for services provided to its beneficiaries. These funds go into the revolving fund of each hospital and cover all other expenses, including performance-based bonuses for providers. In addition, salaries and investment costs for MOH hospitals are covered by the general budget. For the private sector and university hospitals, SSI negotiates and concludes contracts with providers, which usually last for up to a year.

University hospitals have a structure similar to MOH hospitals and receive funds from the state to cover salaries and other investments, and have revolving funds from which they generate income from the SSI and patients. Since January 2010, a new classification system for private hospitals has been in place that classifies private hospitals into five categories (from A to E) based on quality indicators such as numbers of beds and patient operations. Private facilities can request extra billing according to their classification. For example, a Category A facility can charge up to an additional 70 percent of the SSI tariff, while category E facilities can bill up to 30 percent.

Cost sharing through copayments has been introduced both as a revenue generation mechanism and to encourage appropriate use of care, and applies to all beneficiaries. Outpatient visits to university and MOH hospitals incur a charge of 8 Turkish Lira (TL), while visits to private hospitals incur a copayment of 15 TL. To reduce overprescription, a 3 TL discount is provided if no medicine is prescribed during a visit to a university, MOH, or private hospital. Copayments for pharmaceuticals are usually 20 percent except for retirees who pay 10 percent.

Figure 2 diagrams the flow of funds prior to 2012. As mentioned, on January 1, 2012, the Green Card program was transferred to the SSI. Thus, today, health services for all five schemes are financed through the UHI scheme housed in the SSI (figure 3).

Figure 2 Flow of Funds before 2012

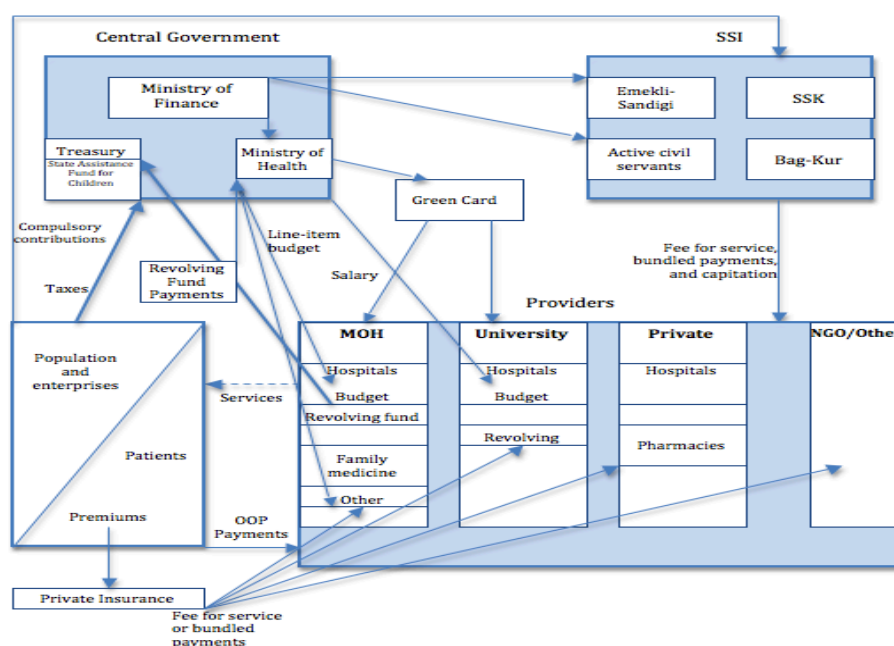
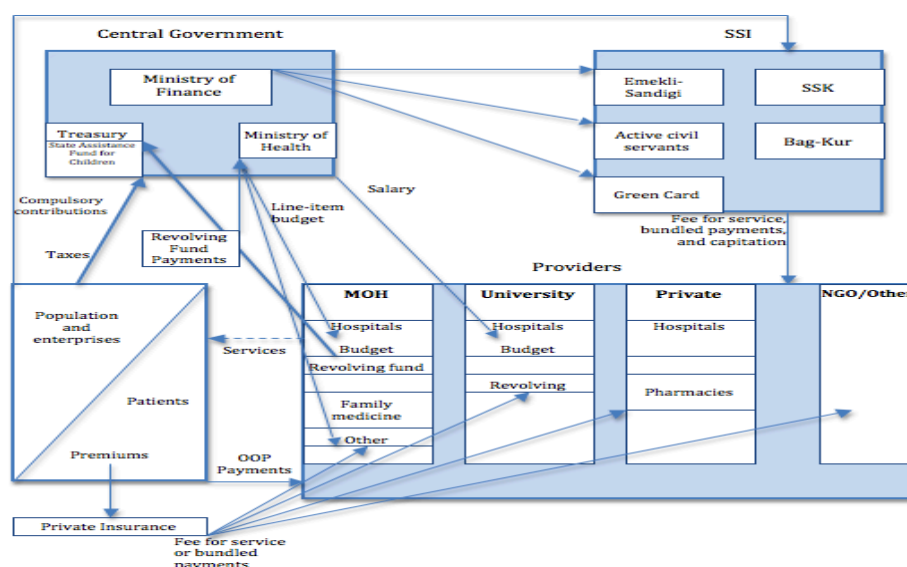


Figure 3 Flow of Funds after 2012



3. The Green Card Program for the Poor

The reforms in the health sector that focused on expanding access to services for the poor and underserved were also accompanied by a significant increase in financial protection for the poor under the HTP. The Green Card Program for the Poor, the main flagship social protection program of the Turkish government, played a key role in this aspect.

Established in 1992, this program aimed to provide health benefits to the poor who are not covered through formal means of health insurance and are unable to pay for health services. The main legal instrument for its establishment was the Law on Funding Treatment Costs of the Non-Affording Citizens from the Government Budget by Issuing the Green Card Numbered 3816 and Dated 1992. Turkish citizens living within the borders of the Republic of Turkey who were not covered by any social security schemes and who have a per capita household income of less than one-third of the minimum wage threshold (except for taxes and social security premiums), could be eligible for coverage under the Green Card program. In addition, pensioners over 65 years of age and people with chronic illnesses (those employed but who have diabetes or are on dialysis) were eligible even if their household's per capita income was greater than one-third the minimum wage.

How is it Funded?

The Green Card program is funded through the national budget. In 2002, the budget allocated toward the program represented only 0.15 percent of GDP and 4.05 percent of public health expenditures. As shown in table 3, the budget expanded significantly, and by 2009 it accounted for 0.40 percent of GDP and 8.43 percent of public health expenditures.

**Table 2 Green Card Expenditures
as Percent of Public Health Expenditures and GDP, Turkey**

Year	Total Expenditure (Thousand liras)	Percent of Public Health Expenditures	Percent of Total Public Expenditures	Percent of GDP
2002	537,937	4.05	0.36	0.15
2003	665,000	3.81	0.39	0.15
2004	756,000	3.53	1.11	0.14
2005	2,340,211	9.76	1.07	0.36
2006	2,651,239	8.80	1.33	0.35
2007	3,722,207	10.78	1.33	0.44
2008	3,746,203	8.98	1.20	0.39
2009	3,845,820	8.43	0.95	0.40
2010	3,390,083			
2011	3,174,639			

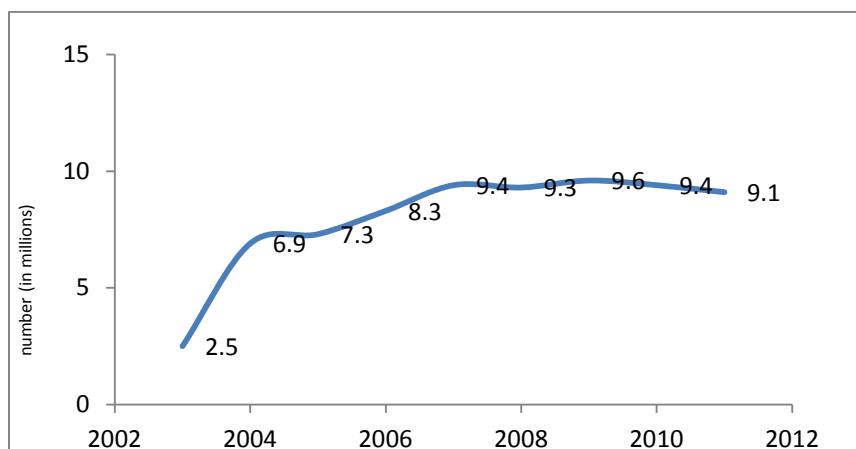
To pay for Green Card beneficiaries, the Ministry of Finance allocated funds in the MOH budget and these were transferred to hospitals by the MOH in lieu of services used by Green Card

beneficiaries (see figure 2). In this case, the MOH was both provider and purchaser, except for when Green Card recipients sought care in university hospitals.

What are the Entitlements?

Until 2004, the Green Card program covered only inpatient treatment costs, and uptake was low. In 2003, only 2.5 million people were registered under the program and targeting was poor—only 20 percent of the beneficiaries belonged to the lowest income quintile. The budget allocated toward the program represented only 0.33 percent of total health spending. In 2004, benefits under the program were expanded to cover both outpatient and inpatient services at MOH and university hospitals, and as of January 2005, outpatient prescription drugs were included in the benefits package. This induced a higher demand for the Green Card and, by 2006, 8.3 million people were under the scheme. Over the years, the benefits package has been expanded to align itself with the rest of the Universal Health Insurance Program. By 2011, the number of beneficiaries reached 9.1 million or 12.7 percent of the total population of Turkey. Figure 4 illustrates the expansion in beneficiaries under the program between 2003 and 2011.

Figure 4 Number of Green Card Beneficiaries, (in millions), Turkey, 2003–11



Today, the basic benefits package is comprehensive and covers health service expenditures for the following:

- Personal preventive health care including preventive care for addictive substances harmful to health
- Outpatient and inpatient services, medical consultations, diagnostic tests, treatment, dressing, tooth extraction, dental prosthesis, and eyeglasses
- Outpatient and inpatient maternal health care, medical examinations, diagnostic tests and procedures, delivery, treatment and emergency care costs of newborns after delivery, and follow-up services
- Hospitalization for emergency cases and treatment
- In-vitro fertilization, up to two attempts
- Blood and blood products, vaccines, medicines, prosthesis, medical goods, and equipment
- Pharmaceuticals and medical devices
- Free health care provision for children under 18 regardless of their insurance status.

Green Card beneficiaries are only covered for services received in public facilities at all three levels of care and can only use private facilities in emergency cases or if public facilities are fully occupied. The same copayments apply for the Green Card beneficiaries as for UHI other beneficiaries. In addition, Green Card beneficiaries also share the cost of dental care, prosthetics, and orthotics.

How are Beneficiaries Identified and Enrolled?

Until 2012, a hybrid targeting scheme was used to identify individuals eligible for the Green Card. Centrally appointed kaymakams (district officers) were given discretion for the distribution of the card following eligibility rules determined by the central government. Enrolment was voluntary and applications were collected at the district-level Green Card offices, which usually reported directly to centrally appointed district or provincial officers (kaymakams or vail's). The ultimate decisions on the distribution of the cards were made by local committees chaired by the kaymakam (in districts) and the deputy governor in charge of the Green Card in the province center.

The application and card allocation process was as follows:

Step 1: For districts and provinces with population exceeding 50,000, the initial application process was handled through a one-stop service center. The one-stop service center checked whether the applicant was registered with any of the social security institutions (Bagkur, Emekli Sandigi, or SSK) or whether the person owned a motor vehicle (ownership of a car prevented the person from getting a Green Card).

Step 2: The reported income of the person was added to any income estimated from agricultural landholdings. Total household income was then divided by the number of people in the household. If the estimated income per capita was less than one-third of the net minimum wage (less than 295 TL), then all household members were eligible for the Green Card.

Step 3: The local committee then decided whether the individual should receive a Green Card. Even if the person was formally eligible for the card, the committee could use discretion (if they thought the person was not poor) and not provide the card. Once qualified, each household member received his or her own green booklet, which registered all interactions with the health system from that point on.

Eligibility lasted for a year, and beneficiaries had to be recertified annually.

Integrating the Green Card Program into the UHI – What are the Changes?

Beginning on January 1, 2012, the Green Card program was integrated into the UHI scheme. This resulted in changes in the flow of funds and in the identification and enrolment process. In terms of financing, since January 2012, funds for Green Card holders (who are gradually being transferred into the national system for identification of the poor) are transferred from the Ministry of Finance to the SSI (figure 3).

The identification of the poor to be covered by the state budget is now based on a national system called the “Integrated Social Aid Services System,” which is managed by the Ministry of Family Affairs and Social Policies. The system is also used to determine beneficiaries of scholarships, homecare for the elderly, and conditional cash transfers (CCTs), and disabled benefits.

Under the new system, individuals are classified into one of four groups (G0–G3) depending on their income, as follows:

- G0: Households with per-capita income less than one-third the minimum wage (0 TL to 295 TL) do not pay premiums. Their premiums are covered by the state.
- G1: Households with per-capita income between one-third the minimum wage and the minimum wage (295.50 TL to 886.50 TL) pay a premium of 35.46 TL (12 percent of one-third the minimum wage).
- G2: Households whose per-capita income falls between the minimum wage and twice the minimum wage (886.50 TL to 1,773 TL) pay a premium of 106.38 TL (12 percent of minimum wage).
- G3: Households whose income is more than twice the minimum wage (>1,773 TL) pay a premium of 212.76 TL (12 percent of twice the minimum wage).

Green Card beneficiaries are now identified based on an income measurement test and fall into the G0 category. Eligibility is described on the basis of per-capita income of a household, and a household member is regarded as poor if the household’s per-capita income is less than one-third the minimum wage (<295 TL). If these criteria are met, the health expenditures of each member are covered by the government budget.

The identification, certification, and monitoring of Green Card holders is regulated by the Regulation on the Rules and Principles of Identifying, Certifying, and Monitoring Income Under the Universal Health Insurance. People whose premiums are paid from the government budget are visited every year for reassessment. The system is also updated under the following conditions:

- People whose income varies over the year must apply monthly so that the amount of their premiums can be adjusted accordingly.
- The system uses data from various databases to compile information on a family’s income. If changes in income are identified before an insuree provides a self-statement, then the system reruns and re-identifies the household income and sets new, more appropriate premium levels.
- If the system notes that the number of household members has changed due to births, deaths, marriages, divorces, and so forth, and is recorded in the public databases, the per-capita household income is revised automatically to reflect this, and appropriate premium levels are set.

Monitoring and Evaluation

There is no separate monitoring and evaluation system to monitor service use and outcomes of Green Card program recipients. Health indicators in Turkey are monitored on the national level through a web-based integrated health information system called “SAGLIK-NET,” which is used to share electronic health records of individuals among health institutions. Separate information systems exist for human resources, decision support, family medicine (the Family Medicine Information System), and hospitals (the Hospital Information System), but these are all connected within the “SAGLIK-NET.” Performance indicators for productivity measurements, utilization management, and quality management are slowly being introduced in this system.

The MEDULA system is the main UHI claims processing engine at SSI. The claims process includes identifying beneficiaries; authorizing services; managing referrals; and receiving, adjudicating, and paying claims. Beginning in January 2012, services use by Green Card beneficiaries are also being monitored by the MEDULA system. Prior to January 1, 2012, only information about medicines procured at pharmacies by Green Card beneficiaries was available in the MEDULA system. This system, however, is yet to evolve into an effective tool for policy implementation since there is a lack of real-time micro data available on health spending.

In addition, as noted above, since 2012, state budget coverage for health insurance is being done under the national system for identification of the poor database called the “Integrated Social Aid Services System.”

Performance of the Green Card Program

A 2012 World Bank study (Aran and Hentschel 2012), which analyzes the impact of the Green Card program using the latest Household Budget Surveys from 2003 to 2008, provides further insights into the financial protection and equity engendered by the HTP. These latest data both attest to the effective targeting of the Green Card program and highlight the high and improving levels of financial protection and equity in the Turkish health system.

In terms of targeting, despite the rapid rollout of the Green Card program from 2003 to 2008, analysis of Household Budget Surveys from 2003 to 2008 (Aran and Hentschel 2012) shows that there was no deterioration in the targeting performance of the program and, in fact, targeting performance of the Green Card has improved over time in this expansion period. While, in 2003, 55 percent of benefits accrued to the bottom quintile (33 percent to the poorest decile and 22 percent to the second decile), this targeting performance has improved over time, with 64 percent of benefits reaching this group in 2005, 68 percent in 2007, and 71 percent of benefits reaching the bottom quintile in 2008 (table 4). The targeting performance of the Green Card scheme in Turkey compared well internationally; 60 percent of Chile’s Family Subsidy cash transfers, 39 percent of Brazil’s Bolsa Escola CCT program, 34 percent of Mexico’s Oportunidades CCT program, and 34 percent of Indonesia’s Kartu Sehat health insurance program benefit the bottom quintile of the population in those countries (Castañeda and Lindert 2005).

Although there are scant data on the impact of the Green Card program on utilization of health services, to assess the protective impact, a unique household survey, the Turkey Welfare Monitoring Survey, fielded during the financial crisis in Turkey, assessed the impact of the

Green Card in times of economic hardship. Three different methodologies were used to establish the impact of the Green Card on health care utilization during the crisis. Both nonparametric and parametric estimates using the Turkey Welfare Monitoring Survey established that the Green Card program was an effective and functional safety net, protecting the health care utilization of the poor during the crisis period. Propensity score matching estimates and robustness checks using four different matching techniques—as well as trimming to increase common support—confirm that access to the Green Card was associated with a positive and significant impact on protecting the health care utilization of poor households through the beginning of the financial crisis (Aran and Hentschel 2012).

Table 3 Targeting and Coverage of the Green Card, Turkey, 2003–08

Per Capita Expenditure Deciles	Targeting: Percent of People with Green Card Access in this Decile						Coverage: Percent of this Decile Covered by the Green Card					
	2003	2004	2005	2006	2007	2008	2003	2004	2005	2006	2007	2008
1 (Poorest)	33	40	37	38	43	46	12	26	43	54	64	62
2	22	25	27	24	25	25	8	17	31	34	36	34
3	14	14	13	15	12	13	5	9	15	22	17	17
4	12	9	9	8	7	6	4	6	10	11	10	8
5	9	6	5	5	5	5	3	4	6	7	7	6
6	5	3	4	3	4	4	2	2	4	5	5	5
7	3	2	2	2	2	2	1	1	2	3	4	2
8	1	0	2	2	1	1	0	0	2	2	2	1
9	1	0	1	1	1	0	0	0	1	1	1	0
10	1	1	1	1	0	0	0	0	1	1	0	0
TOTAL	100	100	100	100	100	100	4	7	12	14	15	14

Source: Aran and Hentschel 2012 (estimations using the Household Budget Surveys).

4. The Pending Agenda

As noted, over the last decade, Turkey has achieved significant success in expanding health insurance to a majority of its population, while at the same time undertaking the needed capacity building and implementation of incentive structures to assure access and financial protection, and to promote efficient use of resources. Moving forward, maintaining the sustainability of financing the UHI while ensuring continued access to quality health services will be important.

While health spending in Turkey, including funds allocated for Green Card recipients, has increased over the last decade, the Government of Turkey has already been taking the necessary measures to ensure improved efficiency in health spending, that is, “value for money,” and to contain costs. A key focus in the future will be on the extensiveness of the benefits package. Work is ongoing to define services that would be best covered under a complementary health insurance scheme in the near future. In addition, evaluating the use of new and existing

medicines and treatments financed by SSI, including medicines, medical devices, diagnostic techniques, surgical procedures, and health promotion activities, can help improve decision making on the scope of the basic benefits package, and assist in the decision on expanding to new services.

The introduction of expenditure caps for MOH, private, and university hospitals and for pharmaceuticals in recent years has been a positive step toward ensuring the fiscal sustainability of the universal health insurance system. In 2007, a fixed global budget for all MOH hospitals was implemented, and to date this has been successful in containing further spending growth in these hospitals. In 2010, the government successfully imposed spending limits for university and private hospitals. While pharmaceutical spending declined between 2009 and 2010, maintaining the pharmaceutical spending limit has not been particularly successful. The SSI is currently working together with pharmaceutical companies to develop mechanisms that can help maintain the spending limit.

While Turkey is developing and implementing modern payment methods and efficient service delivery mechanisms, what is missing is the transfer of the financial risk to providers. This would involve implementing utilization management and review processes to assure and monitor appropriate behavior.

Effective policy implementation by SSI is constrained by lack of real-time micro data on health spending. The MEDULA data system was designed specifically for this purpose, but four years after its inception it is still not fully operational. Having individual-level claims information is critical for a modern health insurance system to function.

There also needs to be better policy coordination between UHI and the MOH in a number of areas including the development of payment systems, determination and application of expenditure caps, medical effectiveness criteria, and a number of pharmaceutical issues.

The introduction of a national system to monitor poverty and determine eligibility for all social protection programs is a major step forward. The new system aims to build on the strengths of the old one for determining eligibility by using a hybrid mechanism combining central criteria with local knowledge and assessment. While the system currently has been fairly successful in integrating information from several central databases, use of home visits to countercheck information provided in applications has been more difficult for the new Ministry of Family and Social Affairs. It would, therefore, be crucial to continue monitoring the new identification and enrolment mechanism using Household Budget Surveys to ensure that the program continues to maintain and even improve targeting.

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The World Bank supports the efforts of countries to share prosperity by transitioning toward universal health coverage (UHC) with the objectives of improving health outcomes, reducing the financial risks associated with ill health, and increasing equity. The Bank recognizes that there are many paths toward UHC and does not endorse a particular path or set of organizational or financial arrangements to reach it. Regardless of the path chosen, the quality of the instruments and institutions countries establish to implement UHC are essential to its success. Countries will face a variety of challenges during the implementation phase as they strive to expand health coverage. With that in mind, the World Bank launched the Universal Health Coverage Studies Series (UNICO Studies Series) to develop knowledge and operational tools designed to help countries tackle these implementation challenges in ways that are fiscally sustainable and that enhance equity and efficiency. The UNICO Studies Series consists of technical papers and country case studies that analyze different issues related to the challenges of UHC policy implementation.

The case studies in the series are based on the use of a standardized protocol to analyze the nuts and bolts of 27 programs in 25 countries that have expanded coverage from the bottom up, starting with the poor and vulnerable. The protocol consists of 300 questions designed to elicit a detailed understanding of how countries are implementing five sets of policies to accomplish the following:

- Manage the benefits package
- Manage processes to include the poor and vulnerable
- Nudge efficiency reforms to the provision of care
- Address new challenges in primary care
- Tweak financing mechanisms to align the incentives of different stakeholders in the health sector

The UNICO Studies Series aims to provide UHC implementers with an expanded toolbox. The protocol, case studies and technical papers are being published as part of the Series. A comparative analysis of the case studies will be available in 2013.



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