SPOTLIGHT 3

Moving toward universal health insurance coverage in Turkey and the Kyrgyz Republic

The economic consequences of an illness are often devastating in developing countries. About 100 million people fall into poverty annually struggling to cover health care costs. The experiences of Turkey and the Kyrgyz Republic show that countries at all levels of development can improve access to and affordability of medical services by increasing the efficiency of government health spending and protecting the poor through publicly financed health insurance.

Increasing equity in access to health care in Turkey

Turkey has achieved impressive results in access, affordability, and quality of health care. Health insurance covers 95 percent of the population, and 76 percent of Turkish citizens are satisfied with health care services. Before 2003, however, use of health services was very uneven among regions, and health care in rural areas was both hard to obtain and more costly than in cities. Health financing was fragmented among four different insurance schemes. A separate Green Card Program for the poor covered only inpatient services and therefore was not widely used. Most public health resources were allocated to costly hospital-based services, rather than primary care.

To address these problems, the government launched a comprehensive Health Transformation Program in 2003. All health insurance schemes were merged into a universal health insurance program managed by the newly created Social Security Institution. Every insured person, including the poor, has the same benefits package, which covers inpatient and outpatient services, dental care, diagnostic tests, emergency care, and pharmaceuticals. The poor are exempt from co-payments if they use public facilities. The expanded benefits led to greater demand for the Green Card; participation more than tripled from 2003 to 2011, from 2.5 million to 9.1 million. Targeting of the program has also improved substantially: Green Card benefits to those in the lowest income quintile increased from 55 percent in 2003 to 71 percent in 2012.

Premiums are based on household income and increase with wealth. The government pays the premiums for the poor—defined as households with per capita income less than one-third the minimum wage, or about $163 a month. The poor are identified through the national Integrated Social Aid Services System, which is also used to determine eligibility for other social assistance programs. The integrated system helps avoid duplication of information and improves benefits administration. The near-poor (those with per capita income between one-third and the full minimum wage) are also well protected, with premiums set at about $20 a month. The rest of the population pays higher premiums, depending on income.

The government sought to strengthen primary care by promoting family medicine. This decision was in keeping with global evidence that systems oriented to primary care produce better health for the population at lower cost. The government introduced several incentives, including raising salaries of family doctors, introducing performance guidelines, and regularly monitoring the quality of service delivery through facility visits and patient surveys. Providers risk paying up to 20 percent of their base salary in penalties for failure to meet certain performance targets, such as immunizations and antenatal care. The government also introduced monthly bonus payments of up to 40 percent of base salary for doctors who relocate to underserved locations, a step that has reduced the gap in access to health care between rural and urban locations.

These reforms have significantly improved access to services and financial protection against medical costs throughout the country. Use of health services has more than doubled since 2003, satisfaction with the quality of health care has also risen, and key health indicators—life expectancy, and child and maternal mortality—have improved. A World Bank evaluation of the Green Card Program showed that it provided an effective safety net for the poor during the economic crisis of 2008, with beneficiaries less likely than those with no insurance to reduce their use of curative and preventive care. Improvements in access to health care were achieved without excessive public health spending: at 5.1 percent of gross domestic product (GDP), Turkey's public health spending is comparable to that of other countries at similar levels of development. Going forward, it will be important to strengthen mechanisms to contain costs and further increase efficiency of health spending.

Improving affordability of health care in the Kyrgyz Republic

At independence in 1991, the Kyrgyz Republic had a standard Soviet health care system, characterized by a large network of providers, a focus on curative hospital care rather than preventive services, and a centrally planned, input-based financing system. Although inefficiencies plagued this system, every Kyrgyz citizen enjoyed access to free medical services. During the early 1990s, the young state experienced a deep economic crisis, GDP declined by more than half, and the government was unable to maintain the oversized health care system. Informal out-of-pocket payments to health care providers became common to compensate for low salaries. Hospitalized patients often had to help pay for medicine, bed linens, and even

light bulbs. For many of the poor, health care was unaffordable and thus unused.

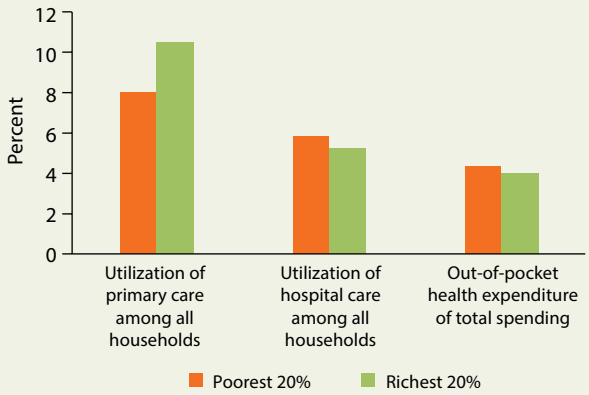
Starting in 2001, the government introduced a series of reforms to improve the efficiency of health sector spending and decrease out-of-pocket costs. The sequencing of reforms was important to the success of the approach. First, the Mandatory Health Insurance Fund (MHIF) was introduced, funded by a 2 percent payroll tax paid by employers. The government makes contributions for the retired and the unemployed, and the self-employed can purchase health insurance for about $10 a year. Significant efficiency gains were obtained by consolidating separate pools of public health care funding at the district and regional levels into a single pool managed by the MHIF. This arrangement has reduced overhead costs and resulted in more equitable allocation of resources across administrative units. Second, purchase of health services was centralized under the MHIF, which contracts with providers across the country under output-based payment mechanisms. This approach has enhanced efficiency, giving facility managers some flexibility in how to use the funds. Third, primary care was made a priority. The oversized hospital sector was reduced by about 40 percent, and savings were allocated to medical supplies and salaries of health providers.

A major outcome of the reforms was the explicit definition of benefits and regulation of entitlements. The State Guaranteed Benefit Package establishes free primary and emergency care for all citizens and subsidized secondary care with exemptions from co-payments for vulnerable groups: children under age 5, retirees older than 70, the disabled, pregnant women, and those with medical conditions with high expected use of health care (diabetes, cancer, tuberculosis, and asthma). These groups also benefit from access to subsidized medications.

The impact of the reforms has been very positive. Use of health care is now roughly the same at all income levels (figure S3.1). Households are less likely to fall into poverty as a result of illness. Out-of-pocket health expenditures have declined among all income groups since the start of reforms and constituted only 4.4 percent of total household spending among the poorest quintile in 2009 (see figure S3.1). The incidence of catastrophic health spending (more than 20 percent of total household expenditures) declined from 8 percent in 2000 to 5 percent in 2009. Several health indicators, such as infant and under-five mortality rates, have improved, and the country has much better health outcomes than the average low-income nation. Public health spending constitutes about 3.5 percent of GDP, which is somewhat higher than the average for low-income countries and reflects the government's prioritization of health spending.

The experience in the Kyrgyz Republic shows that more efficient use of public resources can reduce the patient financial burden in a low-income country. This experience can be particularly valuable for other transition economies with limited fiscal space and overcapacity in the health sector. The positive outcomes were achieved thanks to a comprehensive approach rather than reliance on a single instrument. Introduction of strategic purchasing through the MHIF, giving providers greater autonomy and allowing them to manage some of the savings, downsizing the hospital sector, and increasing investments in primary care have resulted in significant efficiency gains that were directed toward greater financial protection of the population. The

FIGURE S3.1 *Use of health care and out-of-pocket health expenditure by income status, the Kyrgyz Republic, 2009*



Source: WDR 2014 team based on data from Giuffrida, Jakab, and Dale 2013.

Kyrgyz Republic also has a rather developed health information system for a low-income country, which allows the government to forecast income from co-payments, plan annual expenditures, and monitor the impact of new policies.

Future reforms should focus on improving sustainability of health care financing. Further rationalization of health care financing will entail introducing targeting of co-payment exemptions by poverty status, as is done in Turkey and many other countries. Additional efficiency gains could be realized by reducing hospitalization rates and overuse of medication, cutting utility costs of health facilities, and streamlining funding on drug procurement.

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