Executive Summary

This Health System Review provides an overview of the health system in Mongolia, a country undergoing rapid economic growth and political changes. These changes can be seen in the rapidly changing picture of the health system as well. Chapter 1 introduces the country and its people, and describes its transition from socialism to a market economy. Since the beginning of the new millennium, the country has seen strong economic growth driven largely by a boom in the mining sector but still remains dependent on herding and agriculture. The changes in Mongolia are reflected in the burden of diseases moving from communicable to noncommunicable diseases (NCDs). Leading causes of mortality are now circulatory system disorders and cancers. In addition, service delivery is hampered by the extremely low population density in an expansive country.

Chapter 2 describes the governance and organization of the health system. With the fall of the Soviet Union in the 1990s, the health system of Mongolia began its transition from the centralized, Semashko model to a more decentralized one. Unfortunately, the move towards decentralization has seen more administrative success than financial. The new 2011 fiscal budget, however, takes concrete steps towards financial decentralization, such as transferring the primary health care budget to the local governor’s office.

As before, services are provided at three types of facilities (primary, secondary and tertiary) and over two administrative divisions (the capital and the provinces or the aimags). Efforts have been made to strengthen the management of the Ministry of Health (MOH) and health departments at aimag levels, and a number of new primary health-care facilities have been established. The Health Act of 2011 further laid out the structure and functions of these various health-care facilities at different levels and also established a governing board of the state central hospitals, specialized centres, and regional diagnostic and treatment centres (RDTCs) that aim to provide organizational autonomy in decision-making.
The planning process for the MOH is based on the government’s Health Sector Strategic Master Plan (HSSMP) for 2006-2015. Recently, the government has also strengthened the intersectoral approach with international partners to support coordination on collaborative activities and planning. The involvement of the private sector has also seen significant increases over the past few years, but the regulatory framework for private health-care providers needs to be strengthened.

Chapter 3 summarizes the financing of health care in Mongolia. The 2008 financial crisis saw a drop in the total government health expenditure, in percentage of spending, from 10.7% to 8.6% where it has stayed since. Total health expenditure, in percentage of gross domestic product (GDP), also fluctuated since 1995 but has been at 5.7% since 2008.

Like many other countries with a Semashko health system, the Mongolian health system is heavily hospital-based. Major parts of both total (53.5% in 2005) and general government expenditure on health (54.8% in 2009) in Mongolia were allocated to inpatient care. However, the expenditure allocated for primary care and public health are underestimated because many of the services of primary health-care facilities are delivered through hospitals.

Newly released WHO data on out-of-pocket payments (OOPs) as a share of the total health expenditure (THE) show a sharp increase from 14.5% in 1995 to 41.4% in 2010. However, these numbers should be treated with caution: they may have risen from a change in methodology used to calculate OOP as well as an actual increase in the OOP. Further analysis is needed. Social Health Insurance (SHI) was implemented in 1994 and has become a stable source of health financing. Population coverage has fluctuated from a low of 82.6% in 2012 when students and herders were not subsidized by the state, to 98.6% in 2011 when a one-time subsidy from mining revenues bumped coverage back up. This initiative is unlikely to be sustainable in the long term. SHI faces many institutional and governance challenges which have prevented it from acting as a strong purchaser. National discussions to move to a pooled purchaser of health services under the social insurance scheme have been dominating the main health-care financing reform agenda in the past few years.

Chapter 4 describes the physical and human resources of the health system. Primary health-care services are delivered at 546 facilities, including family health centre, soum health centres and intersoum
hospitals, and village hospitals. Referrals are sent to 36 secondary care general hospitals owned by local governments. There are 17 tertiary general hospitals and specialized centres, all located in the capital city. Funding allocated for capital investment, which is budgeted separately from recurrent expenditures, has been increasing and the share of the total health expenditure spent on physical infrastructure has increased from 4% in 2006 to 15.4% in 2010. This funding includes investment for medical equipment. The major challenge with medical equipment remains its maintenance at the rural level facilities. Advances in health technology and budgetary pressures have helped shift the focus from hospital-based curative services to outpatient diagnostic services and treatment.

The MOH employs around 41 000 people in the public health workforce, and along with the education sector, accounts for 60% of all civil servants. The health system is overly dependent on doctors with too few allied health staff, especially nurses, making it expensive and inefficient. The MOH is trying to increase the number and quality of nurses but further policy and budgetary changes are needed for any impact. The MOH is also taking numerous steps to improve working conditions of allied health staff and introduce incentives to work in rural areas. In terms of coverage, there are fewer primary care physicians per 1000 population in Ulaanbaatar than in the rural areas, due mostly to the heavy rural-urban migration. This is reversed when talking about secondary care doctors; all tertiary care doctors are in Ulaanbaatar.

Chapter 5 describes the delivery of services. It describes the three main packages of services described in the Health Sector Strategic Master Plan: essential health care, complementary/secondary services, and other/tertiary health services. These services are provided at three different levels.

- Primary health care is delivered by family health centres, soum health centres and intersoum hospitals.
- Secondary health care is provided by district and aimag general hospitals, rural general hospitals and private clinics.
- Tertiary health care is delivered by multispecialty central hospitals and specialized centres in Ulaanbaatar.

There is a mismatch between the planned activities of national public health programmes and the financial resources dedicated to them, which has led to shortcomings in their realization and discrepancies in
programme implementation between urban and rural areas as well as between different aimags.

Chapter 6 describes the principal health reforms in the country. The reforms started in the early 1990s, with the collapse of the Soviet Union. In the 1990s, the government introduced Social Health Insurance, a public health care (PHC) concept, public and private partnership, assurance of equity, and quality and efficiency of improvements. Reforms have focused on strengthening the health regulatory framework, setting strategic objectives, and sustaining previous reforms.

Health care reforms in Mongolia have been notable for their slow speed of implementation, inconsistency and the contradictory nature of processes. The frequent changes in the governmental or ministerial leadership have impeded the progress of policy reforms, and as a result, some of the desired policy reforms have not been achieved.

Chapter 7 provides an overall assessment of the health system. The Mongolian government has been committed to ensuring sustainable funding to the health sector and providing accessible and equitable quality health care to all citizens. As a result of prioritized and targeted efforts, health outcomes and indicators are improving. However, there are still significant problems associated with poor quality of care, inefficiency, and inadequate implementation of reforms and institutional improvements. The main dimensions of health inequity in Mongolia are geographical (urban versus rural), income-related and demographic (nomads versus settled population).

The hospital-oriented system inherited from the socialist period has been the most significant barrier to improving efficiency of the health system in Mongolia even though the legislative environment and policy directions have changed substantially during transition. NCDs and injuries are becoming serious health issues requiring integrated multisectoral coordination, advanced preventive approaches, and adequate management. Some positive actions and regulations are in place due to government initiatives and commitment. However, the lack of accountability and transparency are evident across the government, including the health sector. Comprehensive and committed actions are, therefore, needed to be taken.
Chapter 8 presents an overall assessment of the Mongolian health system. It highlights key gains and achievements, like the declining infant, child and maternal mortality, and high health insurance population coverage. However, it also highlights the challenges that still linger, including the need for the system to evolve from its Semashko model and implement reform in a transparent and accountable manner. The health system needs to be able to adapt to the changing needs of the population as NCDs become more pervasive and more problematic. The government is already aware of these issues. Many reforms, already in process, warrant careful monitoring over the next few years.