SECTOR ASSESSMENT (SUMMARY): HEALTH AND SOCIAL PROTECTION

Sector Road Map

1. Sector Performance, Problems, and Opportunities

1. Mongolia is making good progress toward improving its national health outcomes. It has achieved Millennium Development Goal (MDG) targets for infant and under-5 mortality, and is on track to achieve its maternal mortality targets by 2015.[1] Cardiovascular diseases, cancers, and injuries and poisoning are the leading causes of death for both sexes and represent over 70% of all deaths in Mongolia. Mongolia is a low prevalence country for HIV (less than 0.1% of the general population) although risk factors such as high incidence of sexually transmitted diseases, low condom use, and increasing mobility are high. The incidence of tuberculosis is high but in steady decrease since 2007 (143 cases per 100,000 population per year in 2011).

2. Total out-of-pocket health expenditures are estimated at 17%–30% of total health expenditures in Mongolia, depending on various sources. About 80% of the population is covered by health insurance; hospitals revenues are sourced from health insurance (average of 40%) and direct state funding (average of 60%); and primary health care is funded almost entirely from the national budget.[2] This contributes to accessibility and affordability. Nevertheless, equity in accessing health care for the poorer segments of the population remains a challenge as some of these individuals are not health insured and copayments are the rule for those who are insured.

3. Geographical, socioeconomic, and gender disparities in health status are a major concern. The effect of rising food prices in 2008, the 2009 financial crisis, and the 2010 *dzud*[3] affected the poor and women and children, in particular. Despite high overall economic growth rates in 2011, 29.8% of Mongolians live under the national poverty line and there are concerns that inequality is rising.[4] Increasing urbanization (67% of the population lives in urban settings), primarily in Ulaanbaatar, has important effects on the lifestyle of communities and results in increasing noncommunicable diseases.[5] Risk factors for noncommunicable diseases are substantial with high tobacco use, heavy alcohol dependency, high consumption of animal fat, low consumption of fruits and vegetables, and low physical activity resulting in over 30% of the population being overweight.

4. Other key issues in the sector are as follows: (i) allocation of funding is biased toward hospitals at the expense of primary health care (PHC); (ii) weak human resources with inadequate training and continuous education, low ratio of nurses to doctors, critical shortages of personnel in rural areas, and poor working conditions and pay; (iii) poor quality of services provided at PHC and hospital levels resulting in safety issues for patients and health care workers; (iv) a poorly regulated drug sector; (v) a quasi-unregulated private health sector concentrated in Ulaanbaatar; and (vi) sector weaknesses in policy, monitoring and evaluation, regulation, and governance.

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[1] Ministry of Health. 2011. *Health Indicators*. Ulaanbaatar. In 2011, maternal mortality stood at 48.2 per 100,000 live births, below the Millennium Development Goal of 50 per 100,000 live births.

[2] Primary care providers are paid through capitation, which covers most services and goods except medicine for outpatients.

[3] A harsh winter with catastrophic economic consequences for herders.

[4] National Statistical Office. 2012. *Mongolian Statistical Yearbook*. Ulaanbaatar.

[5] Nine out of 10 persons die from noncommunicable diseases in Mongolia (Ministry of Health Communication. 2011).

5. The prospects for meaningful health sector reform are greater now than at any time in the past because (i) growing public revenues and health sector budgets will address chronic underfunding of the sector; (ii) public–private partnerships to tap capital and management for the health system are now possible;[6] (iii) public awareness for healthier life styles is emerging, albeit confined to wealthier segments of the population and primarily in Ulaanbaatar; and (iv) political leaders are starting to recognize the urgency of improving the health care system as public demand for reform is mounting. In 2011, the amendment of the health law opened the way to greater autonomy of hospitals and clarity on the status of family group practitioners, with expected improvement of quality and efficiency of care. The draft amended citizen's health insurance law is expected to improve the governance of the health insurance system and the financial protection of insured citizens.

6. Health sector investment contributes to social development through achieving non-income MDGs. A healthier population will be more productive and, therefore, Asian Development Bank (ADB) assistance in the health sector will also contribute, indirectly, to economic development, inclusiveness, and poverty reduction. Improving health systems will contribute to more effective use of scarce government resources. Health interventions provide an opportunity to support gender mainstreaming through awareness raising, support better systems of data collection and monitoring, and improve access to services, particularly for women.

2. Government's Sector Strategy

7. In 2005, the government approved the Health Sector Strategic Master Plan (HSMP), 2006–2015 as a technical long-term planning document to achieve the health-related MDGs. The HSMP was reviewed in 2011 and it will be crucial in guiding future investments and policy reforms in the health sector. Important strategies of the HSMP include (i) increasing the coverage, access, and utilization of health services through promoting quality PHC; (ii) strengthening health human resources skills and management; (iii) strengthening the financial management system to improve the use of resources; (iv) improving the health insurance system; and (v) supporting a sector-wide health care approach to improve coordination of inputs and resource management.

8. Decentralization of the health system was initiated in the mid-1990s, but local governments and health managers lacked the capacity to meet their new responsibilities. The Public Sector Finance and Management Law recentralized the health sector budgeting process in 2003 and mandated the use of performance contracts and the formulation of strategic plans. The 2011 Integrated Budget Law is a limited attempt to decentralize budget authority in the health sector. Medium-term planning is still in the formative stage in the health sector. Government budgeting is still driven by line items, and hospitals have little flexibility to manage financial and human resources. Private hospitals are poorly regulated. The government has little experience in designing suitable regulatory and contractual frameworks to monitor private sector

[6] Parliament approved the public–private partnership policy and the law on concessions in January 2010. The State Property Agency in charge of implementation of the policy selected priority activities in the health sector (outsourcing of hospital services and private management contracts of family group practices) to demonstrate the feasibility of a public–private partnership approach in the sector. Private investors are entering the hospital market intending to offer higher standards of care for more affluent patients. Songdo Hospital, a private Republic of Korea investment, opened in 2007 and provides secondary and partly tertiary medical care. Since early 2011, Gurvan Gal Private Hospital, a 110-bed hospital, provides quality care based exclusively on out-of-pocket expenses. MSC, a private Mongolian group operating in the mining and other sectors, will start operating a 100-bed hospital with international standards from early 2013.

performances, ensure quality of care, and enforce licensing and accreditation requirements.

9. Government commitment to health has been demonstrated by substantial increases in the health budget Government health expenditures increased from MNT211,669 million in 2008 to MNT333,702 million in 2011 but they have not kept pace with the dramatic increase in gross domestic product over the same period. This is reflected by a decrease in the percentage of total government health expenditures to total government expenditures from 8.9% in 2009 to 7.0% in 2011. Total government health expenditures as a proportion of gross domestic product remained constant at about 3.1% during 2008–2011. The recent adoption of the concession law (public–private partnership) and the expected increase in private investment in health (mainly in the hospital sector) present an opportunity to improve the sector using private resources. This requires improving regulation of the private sector and strengthening social health insurance to ensure access to services provided in the private sector.

3. ADB Sector Experience and Assistance Program

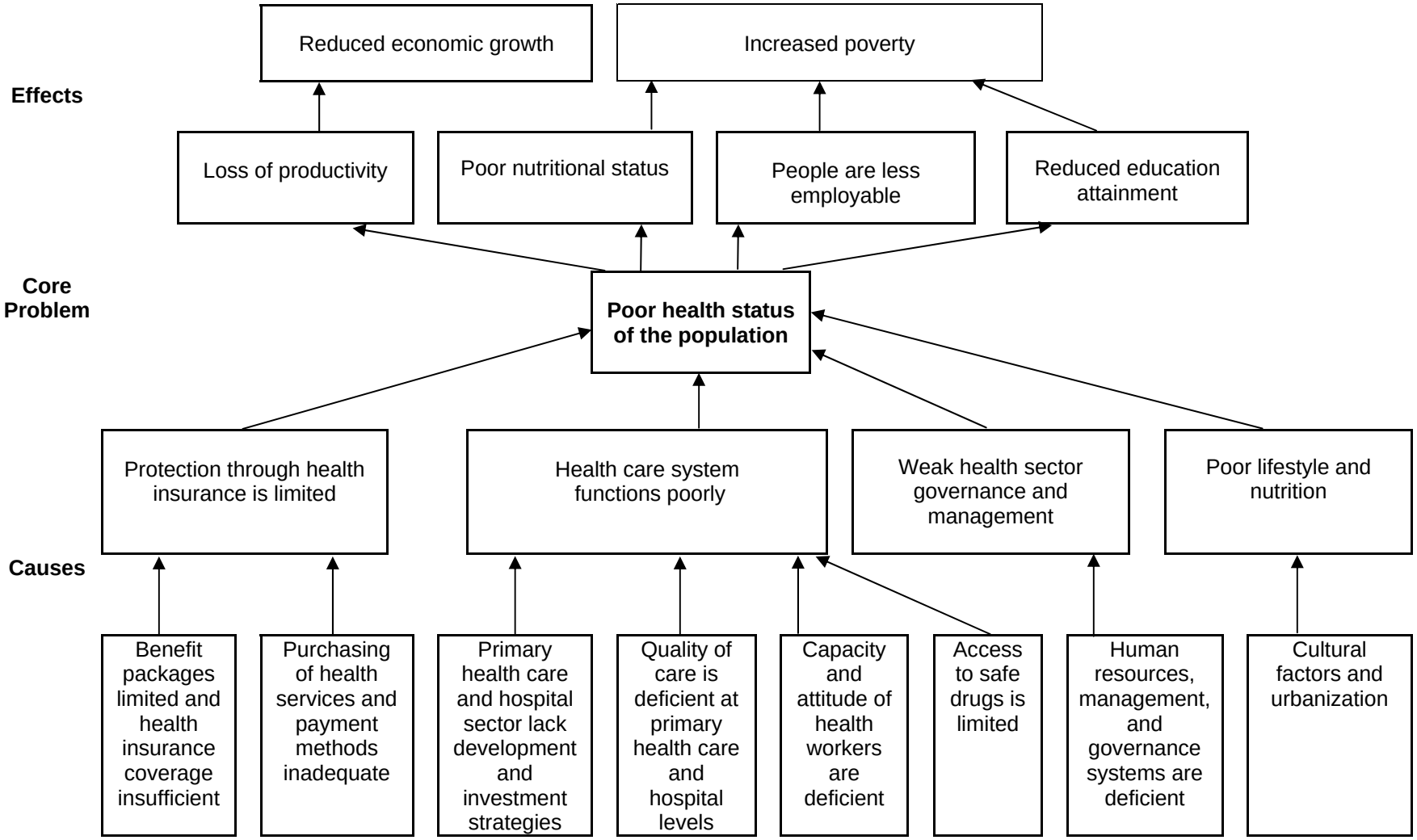
10. ADB has been a major partner in the government's efforts to reform the health sector since the early 1990s. As of June 2012, ADB has provided three loans for two projects totaling $29.9 million, grant financing of $28.0 million for two projects, 10 technical assistance operations amounting to about $5.7 million, and three grant projects for $7.0 million for the sector. ADB's sector assistance was consistent with its sector strategies, responsive to critical needs in the sector, and in line with the government's priorities. ADB supported significant changes in the health system, notably the introduction of family group practices to provide PHC in urban areas. However, family group practices continue to face significant challenges of inadequate funding, resulting in unsatisfactory quality of services.

11. ADB is the single largest external financier providing assistance to the health sector and plays a pivotal role in assisting the government to formulate and implement health sector reforms. Support from other international agencies—the Global Fund to Fight AIDS, Tuberculosis and Malaria; United Nations agencies (World Health Organization, United Nations Children's Fund, United Nations Population Fund); German development cooperation through GIZ; and Luxembourg Development—is disease- or program-oriented. The United States Millennium Challenge Account includes a health component to address Mongolia's rapidly increasing rates of noncommunicable diseases and injuries.

12. **Major lessons learned**. The complex and changing social, political, cultural, and economic contexts in which health reforms take place require a long-term partner commitment to see reforms come to fruition. Policy reform objectives should not be too numerous and should be well integrated into an overall project. A stakeholder analysis should be conducted for all proposed policy reforms, and a strategy developed for moving systematically to the desired policy reform. Collection of baseline data and monitoring of well-defined indicators and targets should be a priority to ensure that project achievements can be measured. Continuous capacity development of the executing agency on ADB's procurement and financial management policies is critical to successful project implementation.

13. ADB support in the health sector will focus on policy reforms, capacity development, and investments in (i) primary health care and health insurance (Third Health Sector Development Project, 2008–2013); (ii) hospital sector reform and drug safety (Fourth Health Sector Development Project, 2011–2016); and (iii) blood safety, medical waste management, and hospitals hygiene (Fifth Health Sector Development Project, 2013–2018).

Problem Tree for the Health Sector



Source: Asian Development Bank estimates.

Sector Results Framework (Health), 2012–2016)

Country Sector Outcomes		Country Sector Outputs		ADB Sector Operations	
Outcomes with ADB Contributions	**Indicators with Targets and Baselines**	**Outputs with ADB Contribution**	**Indicators with Incremental Targets**	**Planned and Ongoing ADB Interventions**	**Main Outputs Expected from ADB Interventions**
Quality and financial accessibility of health services improved	Universal coverage of citizens' health insurance in 2015 (2010 baseline: 80%) Proportion of government health sector budget allocated to PHC increased to 25% in 2015 (2010 baseline: 20.2%) Percent of illegal or substandard drugs in the market reduced to 13% in 2016 (2007 baseline: 26%) Prevalence of hepatitis B and C among health workers is reduced to 12% in 2015 (anecdotal baseline measurement in 2010: above 15%)	Health and health insurance infrastructure and systems expanded	Health insurance coverage of the poor (identified through proxy means test) increases to 100% in 2015 (2010 baseline: 30%) Annual per capita expenditure on PHC increased from $14.8 in 2009 to $20.0 in 2015 (real terms) A drug regulatory agency is established by 2015 A new transfusiology center is in operation by 2016 The central medical waste facility in Ulaanbaatar meets international standards by 2015 Hospital-acquired infections are monitored in line with international standards by 2015 The cabinet approves a hospital development policy and strategic plan by 2013	**Planned key activity areas:** Health insurance strengthening (15%) PHC strengthening (30%) Hospital services improvement (30%) Drug safety (15%) and Institutional and human resources capacity development (10%) **Pipeline projects with estimated amounts:** Fifth Health Sector Development Project ($30 million) **Ongoing projects with approved amounts:** Third Health Sector Development Project ($14 million) and Fourth Health Sector Development Project ($14 million) Protecting the Health Status of the Poor (JFPR, $3 million); Reducing Persistent Malnutrition (JFPR, $2 million); and Improving Access to Health Services for the Vulnerable in Ulaanbaatar (JFPR, $2 million)	**Planned key activity areas:** Health insurance coverage and benefits increased, and governance improved Legal status of PHC clarified and implemented Hospital development in Ulaanbaatar regulated Drugs regulatory functions implemented Two knowledge products on health insurance and access to health care Blood transfusion, medical waste, and acquired infection improved Health insurance reformed Legal status of PHC clarified Hospital sector rationalized Drugs better regulated Level of funding of social programs maintained Household micronutrients available to mother and children Access to health services for vulnerable groups increased

ADB = Asian Development Bank, JFPR = Japan Fund for Poverty Reduction, PHC = primary health care.
Source: Asian Development Bank estimates.