Ensuring Health Care Services for the Poor During a Financial Crisis
The Medicard Program in Mongolia: Experiences and Lessons Learned

The 2007–2008 global financial crisis severely affected the Mongolian economy. Poverty struck and access to basic services and medical care plummeted, affecting the health of women and children. This paper describes the Medicard program implemented in Mongolia in 2011–2013 to protect the poor by providing free health services. The program was the Mongolian health sector’s first to apply the Proxy Mean Test to target eligible households. It contributed to ensuring government health and social program inclusiveness, and highlighted the critical role of political commitment in ensuring the sustainability of such programs. This paper provides information on the program design and implementation by comparing it with international best practices.

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Ensuring Health Care Services for the Poor During a Financial Crisis: The Medicard Program in Mongolia: Experiences and Lessons Learned

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No. 8 | November 2016

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## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>FIGURE AND CHARTS</td>
<td>iv</td>
</tr>
<tr>
<td>GLOSSARY</td>
<td>v</td>
</tr>
<tr>
<td>ABBREVIATIONS</td>
<td>vi</td>
</tr>
<tr>
<td>ACKNOWLEDGMENTS</td>
<td>vii</td>
</tr>
<tr>
<td>EXECUTIVE SUMMARY</td>
<td>viii</td>
</tr>
<tr>
<td>MEDICARD MONGOLIA</td>
<td>1</td>
</tr>
<tr>
<td>I. THE NEED FOR MEDICARD IN MONGOLIA</td>
<td>1</td>
</tr>
<tr>
<td>II. DESIGNING AND IMPLEMENTING MEDICARD</td>
<td>2</td>
</tr>
<tr>
<td>1. Services Provided and Delivery Mechanism</td>
<td>2</td>
</tr>
<tr>
<td>2. Targeting the Beneficiaries</td>
<td>4</td>
</tr>
<tr>
<td>3. Building Capacity for Medicard</td>
<td>4</td>
</tr>
<tr>
<td>4. Monitoring and Evaluation</td>
<td>4</td>
</tr>
<tr>
<td>5. Results</td>
<td>5</td>
</tr>
<tr>
<td>III. INNOVATIVE FEATURES</td>
<td>6</td>
</tr>
<tr>
<td>1. Pro-Poor Targeting Methodology</td>
<td>6</td>
</tr>
<tr>
<td>2. Addressing Gaps in Universal Health Coverage</td>
<td>7</td>
</tr>
<tr>
<td>IV. INTERNATIONAL BEST PRACTICES IN MEDICARD MONGOLIA</td>
<td>8</td>
</tr>
<tr>
<td>1. Non-Conditionality of the Program</td>
<td>8</td>
</tr>
<tr>
<td>2. Free Access to a Variety of Health Services</td>
<td>8</td>
</tr>
<tr>
<td>3. Use of Existing Institutional Arrangements</td>
<td>8</td>
</tr>
<tr>
<td>4. Geographical Coverage</td>
<td>8</td>
</tr>
<tr>
<td>5. Program Duration</td>
<td>9</td>
</tr>
<tr>
<td>V. LESSONS AND RECOMMENDATIONS</td>
<td>9</td>
</tr>
<tr>
<td>1. Targeting of Program Beneficiaries</td>
<td>9</td>
</tr>
<tr>
<td>2. Information Dissemination</td>
<td>10</td>
</tr>
<tr>
<td>3. Provision of Services</td>
<td>10</td>
</tr>
<tr>
<td>4. Coordination of the Program Implementation at the Local Level</td>
<td>11</td>
</tr>
<tr>
<td>5. Timing and Duration</td>
<td>11</td>
</tr>
<tr>
<td>CONCLUSION</td>
<td>11</td>
</tr>
</tbody>
</table>
FIGURE AND CHARTS

FIGURE
1 Medicard’s Administrative Structure 3

CHART
2 Service Provision of the Medicard Program by Category 5
3 Medicard’s Total Number of Beneficiaries and Expenditure (2011–2013) 6
GLOSSARY

aimag – provincial administrative unit in Mongolia
soum – administrative subdivision below an aimag comparable to a county
bagh – administrative subdivision below a soum comparable to a village
khoroo – administrative subdivision below a district
### ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADB</td>
<td>Asian Development Bank</td>
</tr>
<tr>
<td>FHC</td>
<td>Family Health Care</td>
</tr>
<tr>
<td>JFPR</td>
<td>Japan Fund for Poverty Reduction</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MSWL</td>
<td>Ministry of Social Welfare and Labor</td>
</tr>
<tr>
<td>PMT</td>
<td>Proxy Means Test</td>
</tr>
<tr>
<td>SHC</td>
<td>Soum Health Care</td>
</tr>
</tbody>
</table>
ACKNOWLEDGMENTS

The author acknowledges the valuable comments and support by Claude Bodart, Raushanbek Mamatkulov, Gantuya Ganzorig, Yolanda Fernandez Lommen, and Susann Roth of the Asian Development Bank and Sayanaa Lkhagvasuren.
EXECUTIVE SUMMARY

The 2007–2008 global financial crises badly hit the Mongolian economy. Falling international mineral prices resulted in a sharp reduction in government fiscal revenue that hampered public spending. A plummeting growth rate compounded by a high poverty rate at the time left many households in Mongolia highly exposed. The poor and vulnerable were particularly affected, as shown by the drastic fall in their consumption levels and access to basic services. Against this backdrop, the poor decreased their non-food expenses, including medical care, which affected women’s and children’s long-term health.

In this context, there was an urgent need to ensure essential health services for the poor. Of several programs to protect the poor introduced by the Government of Mongolia, along with financial and technical support from international organizations, the Medicard program aimed to provide them with free health services during the financial crisis. The program was funded by the ADB-administered Japan Fund for Poverty Reduction (JFPR).1

This working paper briefly describes the Medicard program, its design and implementation, the results achieved, and the lessons drawn from the experience in Mongolia. The Medicard benefit package provided various health services to eligible recipients without condition, one of the program’s unique approaches.

The Medicard program was the Mongolian health sector’s first to apply the Proxy Mean Test (PMT) to target eligible households. PMT was implemented nationally over 2.5 years, reaching out to all 329 soums and engaging 221 family health centers, 290 soum health centers, 30 hospitals, and 394 pharmacies. The poorest 5% of the population (92,501) were identified as eligible; by the end of the program, the national cumulative number of beneficiaries reached 249,001.

The Medicard program addressed gaps in universal health coverage by minimizing out-of-pocket expenses for the lower income population. Most importantly, it contributed to ensuring government health and social program inclusiveness.

Medicard produced a number of lessons for similar future projects in Mongolia and in other countries, one of which is that political commitment is critical to ensure these programs’ sustainability. Although the Medicard program made a valuable contribution in protecting those affected by the financial crisis, it lacked sufficient political support to become an integrated part of the national government agenda.

1 ADB. 2009. Proposed Grant Assistance. Mongolia: Protecting the Health Status of the Poor during the Financial Crisis (Financed by the JFPR). Manila.
I. The Need for Medicard in Mongolia

The 2007–2008 global financial crises badly hit the Mongolian economy. Falling international mineral prices resulted in a sharp reduction in government revenue that hampered public spending. A plummeting growth rate compounded by a high poverty rate, which reached 35.2% at the time left many households in Mongolia highly exposed to the financial crisis. The poor and vulnerable were particularly affected, as shown by the drastic fall in their consumption levels and access to basic services. Against this background, the poor decreased their non-food expenses, including medical care, which affected women’s and children’s long-term health.

While primary health care is largely state-funded in Mongolia and hospital services are mostly funded by health insurance, people encounter high out-of-pocket expenditures, especially those who are not insured, have no civil registration, and are poor. In 2009, out-of-pocket payments accounted for more than 41% of total health expenditure in Mongolia. These payments include 10–15% co-payments for hospitalization, the cost of diagnostic services, medical prostheses and other devices that are neither subsidized nor covered by health insurance, and the cost of pharmaceuticals. Health insurance partially covers a limited number of pharmaceuticals. However, due to inadequate allocation of funds, hardly any insured benefited from this. People spent the highest share of their direct payments for medicines (95% of direct payments of the poor and 62% of non-poor) and on outpatient care and hospitalization (5% of the poor and 33% of non-poor). The need to pay out-of-pocket for health services pushed 27,442 households (3.8%) into poverty in 2009.

The Government of Mongolia generally subsidized the premium contribution for the so-called vulnerable groups that are also exempted from copayments. However, as the premium subsidy and exemptions were not adequately targeted, many poor households were left outside the scheme. Data from the Household Socio-economics Survey 2007–2008 show that the poor most frequently used the free primary health care provider services. The use of specialized medical services at the secondary and tertiary level, and private health facilities increase as quintiles go up. The use of specialized medical care among the poor and very poor is 4–8 times lower than that among the higher-income population. The lack of civil registration, which affects migrants in particular, along with a lack of health insurance, the cost of transportation, and additional charges for basic commodities and food that are not provided by the hospital (i.e., some medicines and medical supplies that the hospital could not afford) are the main factors hampering the poor’s access to health services.

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3 Footnote 1, p. 5.
4 In 2009, the health insurance coverage was 77.6%. (Source: Health Indicators. 2009. Ministry of Health).
6 In 2012, only 3% of the health insurance fund was allocated to “discounted drug program”, and only 8% of potential beneficiaries used it. The discounted drug program covers up to 50% of the price of 300 essential medicines. (Source: Assessment of the Drug Discount Program funded by the Health Insurance Fund. 2013. Ministry of Health).
8 Vulnerable groups include children 0–16 years old, people over 55 (women) and 60 (men) with no income sources other than pension, pregnant women, mothers taking care of children below 2 years old, and people entitled for long-term social welfare services.
Due to the financial crisis, the government was compelled to adopt a fiscal consolidation program to contain the deficit, which reduced social protection and welfare. This limited the fiscal and institutional capacity of the government to cope with the impact of the crisis on households. The poor and vulnerable were particularly affected by these policies, as they are highly dependent on affordable access and social assistance as coping strategy in times of economic stress.\footnote{Footnote 1, p.5.}

In this context, there was an urgent need to ensure free access to essential health services for the poor. The Government of Mongolia, with financial and technical support from international organizations, and in the framework of its poverty alleviation strategy\footnote{Government of Mongolia. 2005. National Development Strategy of Mongolia for 2005-2021. Ulaanbaatar; Government of Mongolia. 2010. National Health program for 2010-2021.Ulaanbaatar; and Government of Mongolia. 2012. National Program to Support Household Development. Ulaanbaatar.}, introduced several programs to protect the poor and address their urgent needs. One of them, the Medicard program (Medicard thereafter), was a component of a project to protect the health status of the poor during the financial crisis, which was launched in 2009 with funding in the amount of $3 million from the ADB-administered JFPR.\footnote{ADB. 2009. Proposed Grant Assistance. Mongolia: Protecting the Health Status of the Poor during the Financial Crisis (Financed by the JFPR). Manila.}

## II. Designing and Implementing Medicard

The design of Medicard was developed through extensive consultations with all relevant stakeholders at the national and local level. Following this participatory approach, the government issued a guideline to regulate service provision, registration, reporting, claim reimbursement, and monitoring procedures for Medicard’s implementation.\footnote{Government of Mongolia. Joint ministerial order No.358/135 of MOH and MSWL. 2010. Guidelines to Implement the Program to Improve Accessibility of Health Services and Assistance for People in Need for Social Welfare Support and Assistance. Ulaanbaatar.} The program was led by the Ministry of Health (MOH), which established a project implementation unit (project unit thereafter) in partnership with the Ministry of Social Welfare and Labor (MSWL) and the Social Insurance General Office. Medicard was implemented nationwide from 2011–2013, in all aimags and cities, including Ulaanbaatar, where about half of the total population resides.

### 1. Services Provided and Delivery Mechanism

Upon consultation with medical doctors at the Family Health Centers (FHCs) and Soum Health Centers (SHCs),\footnote{Family Health Centers and Soum Health Centers are primary healthcare providers in Mongolia. FHCs are located in cities, do not have beds, and comprise 3–4 family medicine practitioners and serve an average of 5,000 to 6,000 people from the surrounding area. SHCs are located in soums, have around 10 beds, comprise 3–4 family medicine practitioners, and serve an average of 3,000 to 5,000 people.} Medicard-eligible households gained access to the following services at no cost: (i) referral medical services, including outpatient, inpatient, and diagnostic services in aimag and district general hospitals; (ii) medicines prescribed by family doctors;\footnote{List comprised of 328 essential medicines.} and (iii) transportation from soum to aimag.\footnote{In November 2012, the benefit package was updated to include the cost of transportation from soum to aimag centers.}
The FHC and SHC medical doctors, who are fully subsidized by the government, were the first points of contact for the program beneficiaries. With FHC/SHC prescriptions, the beneficiaries had access to free medicine, along with services in the aimag/district general hospitals with reference letters from FHC/SHC doctors (see Figure 1). In addition, in Ulaanbaatar, the project also engaged the Enerel hospital, which is dedicated to serving homeless people. In practical terms, eligible households were provided with a Medicard booklet.

Structurally, a tripartite agreement was concluded among the project unit, the health care providers, and the concerned social insurance departments in each soum, khoroo, district, and aimag, assigning specific responsibilities to each party. As such, health providers serve program beneficiaries, and report and submit claims to the project unit and/or the social insurance departments. The program was embedded in existing health insurance reimbursement mechanisms to mitigate transaction costs and delays. Social insurance departments were to review claims received from service providers, verify beneficiaries, and report to the project unit, which reimbursed hospitals and the health insurance fund.

Figure 1: Medicard’s Administrative Structure

Source: ADB staff.

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18 The Enerel hospital was established by the Ulaanbaatar City Mayor’s office with support from the Fraternity Notre Dame Charity organization of France, with the sole purpose of providing healthcare services to homeless people in Ulaanbaatar.

19 The Medicard booklet included personal information of each household member, rights and responsibilities of program beneficiaries, a list of offered services, and detailed instructions how to obtain the program’s services.

20 Footnote 1, p. 5.
Targeting the Beneficiaries

One of the strengths of Medicard was the targeting of beneficiaries, first by using the list of homeless people in Ulaanbaatar, which was developed by a nongovernmental organization, and second through the use of a PMT, which was conducted by the MSWL. The PMT scores applicant households based on such characteristics as the location of residence, dwelling quality, ownership of durable goods, demographics, education level, and occupation of adult members. The target population was identified in four phases from April 2011 to November 2012. The survey resulted in a detailed intersectorial database of low-income households that was first used for the Government of Mongolia Food Stamp program that was originally implemented in 2009 with support from ADB. The PMT database was shared with MOH for use for the Medicard program and with relevant government agencies for other programs under other ministries (e.g., free textbook distribution).

According to the government’s decision, all households under the PMT cut-off threshold (the 5% poorest) were designated Medicard beneficiaries. As a result, a total of 15,107 registered households (92,501 individuals) and 2,719 homeless people received the benefits.

Building Capacity for Medicard

To ensure the implementation of Medicard, capacity building was provided, and relevant information disseminated. These included (i) training for social workers of local governments at aimag, soum, district and khoroo levels on its features, including implementation arrangements, and procedures to enroll the eligible poor; (ii) training for Medicard’s health care providers; and (iii) training for social insurance inspectors in charge of claims review and reimbursement arrangements.

In addition, face-to-face briefing sessions with eligible households were organized by soum and khoroo social workers to explain the features of Medicard. Publicly owned mass media channels raised awareness about the program at the start of its implementation.

Monitoring and Evaluation

In cooperation with the aimag and city health departments and the social insurance departments, the project unit conducted a number of Medicard spot-checks to identify and discuss difficulties, and to provide guidance on problem solving. Interviews and meetings with the program beneficiaries sought feedback about health service availability and accessibility. All health service providers and government agencies shared in the findings of the spot checks to improve local performance. The project unit also assessed Medicard’s performance of randomly selected tripartite agreements made among health service providers, social insurance departments, and the project unit, and shared the results with relevant stakeholders.

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21 The Life Skills and Training Specialized Center, a nongovernmental organization, provides social services to homeless people in the capital, including civil registration, shelter, food, training, and basic first aid.

22 The food stamp program was launched in 2008 as a response to the high food prices during the financial crisis in 2008–2009. The MSWL distributed food stamps for an average amount of MNT45,000 per household per month. Food stamps were and still are redeemed in specified shops in every soum, khoroo and district. The food stamp program was supported by ADB’s Food and Nutrition Social Welfare Programme and Project (ADB. 2008. Report and Recommendation of the President to the Board of Directors: Proposed Asian Development Fund Grants to Mongolia for the Food and Nutrition Social Welfare Program and Project. Manila).
5. Results

Medicard was implemented at the national level, reaching all 329 soums in 21 aimags, and all cities in Mongolia. The program engaged 221 FHCs, 290 SHCs, 31 aimag/district general hospitals, and 394 pharmacies at soum, khoroo, aimag and district level. By the end of the program’s implementation, the number of beneficiaries who received health services nationwide, including homeless people, reached 249,001 (59.3% female and 40.7% male). The majority of the beneficiaries received drug provision services (97.32%). The top 10 medicines prescribed were for cardiovascular diseases, respiratory, and gastrointestinal diseases. Less than 3% of the beneficiaries received referral medical services, such as ambulatory outpatient services (1.01%), diagnosis tests (0.73%), and inpatient services (0.91%) at the aimag/district general hospitals. The most common diagnoses for referrals were pyelonephritis, pneumonia, hepatitis, hypertension, and radiculitis. Only 0.02% of the beneficiaries used the round-trip transport cost reimbursement between soum and aimag as this service was added into the benefit package late in 2012 (see Chart 2). Chart 3 shows a low number of beneficiaries in 2011–2012. This is explained by Medicard being implemented in only four aimags and one district in the capital city during that period due to delayed identification of the poor. However, in 2012–2013, the program was expanded to cover all aimags and nine districts of Ulaanbaatar, successfully leading to the disbursement of the funds among a many more program beneficiaries.

![Chart 2: Service Provision of the Medicard Program by Category](image)

Source: ADB. 2015. Implementation Completion Memorandum: Protecting the Health Status of the Poor during the Financial Crisis (Financed by the JFPR). Manila.

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23 Top 10 prescribed medicines were amlodipine, enalapril, amoxicillin, ibuprofen, vitamin syrups for children, omeprazole, diclofenac, ciprofloxacin, nifedipine, and metronidazole.
III. Innovative Features

Medicare introduced innovative approaches to providing essential health services, including a pro-poor targeting methodology and a vehicle to address gaps in universal health coverage.

1. Pro-Poor Targeting Methodology

The adoption of PMT stands as the most innovative feature of the program. This represented an important deviation from the less-effective categorical targeting of social welfare benefits in Mongolia (i.e., disability, pregnancy, elderly people or young children), that did not factor in income status. In contrast, the PMT survey was needs-based, using simple, observable characteristics, such as household location, quality of dwelling, ownership of durable goods, demographic structure, education and occupation of the household adult members, etc.

For this purpose, the government surveyed 70% of the total population and created a inter-sectorial database of 437,615 middle- and low-income households in Mongolia. The database was shared with relevant government agencies to be used for any other social programs that would target the poor. The revised Social Welfare Law mandates that the identification of the poor shall be done using the PMT

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**Chart 3: Medicare’s Total Number of Beneficiaries and Expenditure (2011–2013)**

- **Number of beneficiaries**
- **Expenditure (000’ ¥)**
- **Expon. (Number of beneficiaries)**
- **Expon. (Expenditure (000’ ¥))**

Source: ADB. 2015. *Implementation Completion Memorandum: Protecting the Health Status of the Poor during the Financial Crisis (Financed by the JFPR).* Manila.
According to the law, the poor are entitled to a number of benefits, such as allowances and in-kind support for education, health, and food. However, the PMT database is not yet widely used, and the majority of programs, including cash transfers, allowances, and services, still use categorical targeting.

2. Addressing Gaps in Universal Health Coverage

Mongolia’s policy framework supports universal health coverage. The mandatory social health insurance deploys various financial sources to cover different population groups. Public and private sector employees are covered by payroll-financed contributory schemes, while vulnerable groups are subsidized by the government and their premiums are covered by the state budget. In addition, a number of services, including primary health services, delivery, antenatal, emergency, cancer treatment, are provided at no cost in public health facilities, funded by the state and local budgets. As such, most of the population is covered, and most of the essential services are free.

However, in practice, there are significant gaps in services, coverage, and financial protection. A number of services that lack coverage, such as medicines or high-cost diagnostics and treatments, are burdensome for low-income households. In addition, some population groups, like herders or the self-employed and unemployed, are not able to contribute to the social health insurance, and, hence, lack support. Even those availing themselves of health insurance sometimes face difficulties accessing key services due to such factors as system inefficiencies, unregulated competition among private providers, and inaccessibility and unavailability of services in public hospitals. The gaps are illustrated by the relatively low utilization of health services among the poorest, the still-significant out-of-pocket expenses, and the high level of catastrophic payments.

Against this background, Medicard was the first program with a focus to address the gaps. Thanks to the program, low-income households, the poor, and the homeless had access to healthcare services through substantial reduction of out-of-pocket payments. Medicard showed that a key measure for protecting the poor from out-of-pocket payments is to finance essential medicine. Moreover, Medicard contributed to improving legislation to ensure the inclusion of the poor and homeless in the government’s health and social programs.

24 The passage of the amended Social Welfare Law in January 2012 was supported by ADB. Source: ADB. 2001. Report and Recommendation of the President to the Board of Directors: Proposed Loans and Technical Assistance Grant to Mongolia for the Social Security Sector Development Program. Manila.

25 Mongolia has an extensive social welfare system, consisting of 71 types of benefits, covering 41% of the population and amounting to 2.8% of country’s 2013 GDP. Source: World Bank. 2015. Social Welfare Programs of Mongolia: Design and Beneficiary Assessment. Washington.

26 Footnote 7, p.7.

27 The revisions of the Social Welfare Law in 2012 and of the Social Health Insurance Law in 2015 mandate that the government provides a full or partial health insurance premium subsidy for those identified as social welfare beneficiaries, the poor, and the homeless. The passage of the two revised laws was assisted by ADB. Sources: ADB. 2001. Report and Recommendation of the President to the Board of Directors: Proposed Loans and Technical Assistance Grant to Mongolia for the Social Security Sector Development Program. Manila; ADB. 2007. Report and Recommendation of the President to the Board of Directors: Proposed Asian Development Fund Grant to Mongolia for the Third Health Sector Development Project. Manila.
IV. INTERNATIONAL BEST PRACTICES IN MEDICARD MONGOLIA

Medicard was developed by national health experts in Mongolia based on the best available international practices. However, Medicard Mongolia contained the following specific features.

1. Non-Conditionality of the Program

Most of the globally available in-kind transfer programs impose conditionality on services and subsidies to ensure mandatory participation of the eligible beneficiaries. Specific conditions, such as children’s school attendance, or regular vaccination of children, are common worldwide. Medicard Mongolia differs as there are no conditions imposed on eligible beneficiaries, who, once informed about the program, are free to access the services as needed when they became sick. Absence of conditionality is one of the unique features of Medicard Mongolia which indeed increased the program efficiency, as funds were disbursed only for those in need or sick, and free access was secured for all eligible.

2. Free Access to a Variety of Health Services

In-kind transfer programs implemented in the health sector typically focus on one or two services (e.g., vaccination or monitoring of women’s pregnancy). In Medicard Mongolia, beneficiaries are given access to comprehensive health services upon the recommendation of a family doctor. These include medicines, and various types of referral medical services available at the secondary level general hospitals. Although beneficiaries mostly accessed medicines, the most attractive feature of Medicard Mongolia was free access to marginal medical services.

3. Use of Existing Institutional Arrangements

Medicard Mongolia was designed to conform to the existing institutional arrangements in the country rather than to consume time and resources creating a new framework. This pragmatic approach aimed to both simplify program implementation and further strengthen the existing systems in the country. The program engaged family doctors at the FHCs/SHCs as an entry point to the program benefits, reinforcing the gate-keeping function of the family doctors. The program also relied on the official referral arrangement between FHCs/SHCs and aimag/district general hospitals without creating additional steps and forms other than the Medicard booklet. On the provision of medicines, the program offered those included in the list of Essential Medicines. In addition, the program directly reimbursed service providers (pharmacies and hospitals) through the existing health insurance fund. This pragmatic design allowed the program beneficiaries to access health services without concerns over cash payments, simplifying participation, and ensuring payments to the service providers.

4. Geographical Coverage

Wide geographical coverage of in-kind transfer programs is among the key factors to ensure the effective targeting of beneficiaries. However, some international programs limit services to certain geographic locations. In contrast, Medicard Mongolia was an ambitious program that aimed at reaching out to the poor in each of the 329 soums and in all the cities scattered in the country’s vast territory. It should be noted, however, that despite its nationwide coverage, Medicard targeted only

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28 The List of Essential Medicines consists of over 300 of the more commonly used and most efficacious, safe and cost-effective medicines. The list is regularly updated by the MOH.
2,719 homeless and 92,501 individuals, the poorest of the poor. Use of the existing healthcare system to provide Medicard services allowed the program to remain efficient despite its wide geographical coverage and relatively low number of beneficiaries.

5. **Program Duration**

International experiences show that in-kind transfer programs in the social sector are best implemented as national programs on a long-term basis. Medicard Mongolia was implemented from 2011 to 2013 only, as it was intended as a crisis response program. It should be mentioned that the actual implementation period in 15 out of 21 total aimags was shortened from the originally planned three years to about one-and-a-half years, as the identification of the target population using the PMT method took longer than expected.

Despite the crisis response nature of the program, the encouraging results prompted the MOH in 2013 to propose continuing the Medicard program as a long-term national program. However, the initiative did not receive full government support at the time, and the program was closed.

**V. LESSONS AND RECOMMENDATIONS**

The implementation of Medicard Mongolia offers the following lessons:

1. **Targeting of Program Beneficiaries**

The identification of the most vulnerable groups using PMT was successful and was deemed an innovative approach. However, the methodology faced shortcomings that led to the omission of some vulnerable groups and the inclusion of others whose living standards were better off than the definition of poor. In retrospect, the target population identification process would have substantially benefited from the inclusion of a grievance redress mechanism engaging the local authorities, police, pharmacies and local doctors at the district, soum and aimag levels, given their knowledge of local communities, especially at the microlevel.

In addition, while the use of PMT was an efficient tool to target the eligible poor under the Food Stamp program in Mongolia, the questionnaires created confusion when applied to the health sector. This is because providers tend to interpret the definition of vulnerability as individuals with poor health status rather than those unable to afford services. The PMT questionnaires should have been modified to reflect the health needs of people, their insurance coverage, and/or access to and availability of basic health services as these factors also contribute to vulnerability.

Instituting PMT in Mongolia was a complex process; indeed, visiting and questioning 437,615 households (or 70% of all households) in all soums in a country with low population density after having designed and adapted the methodology and developed the survey questionnaire was challenging. The MSWL had to engage more than 2,000 people to process the survey, who spent two-and-a-half years collecting data, and another six months developing the database. This understandably delayed the implementation of the Medicard program nationwide. Therefore, it is important to start the preparation of the targeting methodology in advance, and coordinate with social protection programs, in particular in countries with limited financial and institutional capacity.
2. **Information Dissemination**

Medicard Mongolia’s information dissemination and education of the target population was less successful. The evaluation of Medicard showed that the eligible beneficiaries did not avail themselves of the full program due to their poor understanding of the benefits and services provided. The information dissemination sessions conducted by the project unit and later by the local authorities did not reach all the eligible beneficiaries. This could be also due to the outreach not fully considering the limited ability of the poor and homeless to understand or sometimes even attend the one-time, face-to-face briefing sessions provided under the program. Another factor that was not given due consideration is awareness of specific behavioral aspects of the poor and homeless, who are not accustomed to approaching institutions, such as hospitals for a variety of reasons, including their poor personal hygiene, poor clothes, and a fear of being neglected or judged. A solid information communication and education campaign, based on a detailed analysis of the needs of the poorest beneficiaries and homeless, would have further enhanced the program.

3. **Provision of Services**

Medicard covered the diagnostic, ambulatory, and inpatient services in secondary-level hospitals, medicines prescribed by family doctors, and the cost for transportation from soums to aimags. The FHC/SHC consultation was the prerequisite for obtaining drug prescriptions or any other medical services needed. The most utilized service among the beneficiaries was the provision of essential medicines, which amounted to 87% of the total disbursement and 97% of service provided under Medicard. This clearly demonstrates that the most pressing health need for the poor was the need to buy medicines, which are not funded by the health insurance and the state budget. The result suggests that when designing similar programs to mitigate the impact of severe economic crisis, narrowing the focus of the program to this particular need of the poor will simplify and accelerate implementation.

The Medicard program offered medical services at no cost in secondary-level hospitals through the full reimbursement of the cost or when the beneficiary had health insurance coverage, by reimbursing the co-payments (the insured in Mongolia bear 10% of the costs). However, the utilization of hospital-based medical services among beneficiaries was minimal, leading to the conclusion that, besides the purely financial barriers, there are important socioeconomic barriers to medical services. Long geographical distance between soums and aimag centers, the need to be accompanied by a family member in order to travel, lack of transportation means, and the impossibility of leaving family or cattle unattended prevent people from seeking health care in aimag hospitals. The poor in urban areas encounter other difficulties, in particular their unregistered status, which implies that they cannot be identified as beneficiaries, as well as poor infrastructure in the city suburbs, and behavioral issues when it comes to seeking health care.

In this regard, during the course of the program’s implementation, the government revised the benefit package to include the cost of transportation from soums to aimag centers to support the poor in accessing medical services. However, this action came late in the project and was not supported by an information and communication campaign. This lesson suggests that the selection of services to be provided should be based on a detailed analysis of the system’s limitations and inefficiencies and on

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the target population’s health needs. It should also fully reflect the factors limiting access to and availability of the services for the target population in each country.

4. **Coordination of the Program Implementation at the Local Level**

The evaluation of Medicard Mongolia revealed a key impediment to local implementation, which is the absence of an integrated oversight mechanism. At the start of the program, representatives of social welfare and health departments, hospitals and pharmacies, along with social workers, were provided with training and information dissemination sessions. This laid out good grounds for the launching of the program locally. However, it was unclear which agency was actually in charge of ensuring the proper implementation. It should be noted that in the onset of the program implementation there was confusion at the central level. The MOH hesitated to consider the program as a social protection, while the MSWL considered the program as a means for the provision of health care services. In this context, the project unit concluded a tripartite agreement with the health service providers and the social insurance departments, but no binding obligations were imposed on health and social welfare departments at the aimag and district level. The role of health departments under Medicard was limited to data collection on beneficiaries receiving health services that were submitted to the project unit. The role of the social welfare departments was limited to the identification of the eligible poor. With hindsight, it would have been more productive to have one of the two departments as the leading agency in charge of the coordination, supervision, and monitoring of the program’s efficiency.

5. **Timing and Duration**

Medicard was planned to be implemented from 2011–2013. However, due to the lengthy PMT process, the actual implementation was shortened to about half of the intended period in most aimags and soums. This undermined the program’s impact. However, Medicard succeeded in reaching the most vulnerable individuals in the country, and helped many poor and homeless people to reduce out-of-pocket payments. Medicard’s success in Mongolia calls for the continuity of the program in the longer term.

Although the MOH acknowledged the importance of this program, and developed guidelines for its national implementation, it failed to gather sufficient political support. The PMT methodology showed that there is a substantial portion of the population of Mongolia in real need for government’s support to improve their health and socioeconomic status. The program has shown that the needs of the poor and homeless require greater efforts and concrete, needs-based measures from the government, and, in particular, strong political will.

**V. CONCLUSION**

Medicard was implemented by the Government of Mongolia with the technical and financial assistance of the ADB and the JFPR in 2011–2013. It was the first targeted program in the health sector of Mongolia to facilitate access to health services for the socially most vulnerable population, including the poor and the homeless.

Medicard was developed by Mongolian health experts based on the review of the best international practices. The program was implemented nationally, reaching out to 329 soums, 21 aimags and nine districts in the capital of Mongolia, serving about 250,000 beneficiaries. The program made a valuable contribution to the overarching government goal to protect the poorest during financial crises through reducing their direct payment for health services.
The program incorporated an innovative approach to identify the target population, the PMT methodology, pioneering its use in health programs in Mongolia. The PMT produced positive results, offering a relevant lesson for future programs seeking to identify beneficiaries from the target population considering their health status.

The implementation of Medicard in Mongolia underlined the need for a multi-sectorial approach and stakeholders’ cooperation and coordination as critical elements to enhance the effectiveness and accessibility of health services for socially vulnerable groups. It also highlighted the importance of having strong political will to implement this type of program nationwide to achieve tangible improvements in the health status of the poor and homeless.

Medicard was designed as a short-term program to mitigate the impact of the 2007–2008 global financial crises on the poor and vulnerable in Mongolia. The lessons learned from the program implementation are useful to strengthen government policies for poverty alleviation, and could also be replicated in other countries seeking similar social goals and objectives.
Ensuring Health Care Services for the Poor During a Financial Crisis
The Medicard Program in Mongolia: Experiences and Lessons Learned

The 2007–2008 global financial crisis severely affected the Mongolian economy. Poverty struck and access to basic services and medical care plummeted, affecting the health of women and children. This paper describes the Medicard program implemented in Mongolia in 2011–2013 to protect the poor by providing free health services. The program was the Mongolian health sector’s first to apply the Proxy Mean Test to target eligible households. It contributed to ensuring government health and social program inclusiveness, and highlighted the critical role of political commitment in ensuring the sustainability of such programs. This paper provides information on the program design and implementation by comparing it with international best practices.

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