

ADB SUPPORT IN  
THE HEALTH SECTOR REFORM IN MONGOLIA

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# SUPPORTING PRIMARY HEALTH CARE IN MONGOLIA

EXPERIENCES, LESSONS LEARNED,  
AND FUTURE DIRECTIONS

*Altantuya Jigjidsuren, Bayar Oyun, and Najibullah Habib*

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## Supporting Primary Health Care in Mongolia: Experiences, Lessons Learned, and Future Directions

Altantuya Jigjidsuren, Bayar Oyun,  
and Najibullah Habib

No. 35 | January 2021

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## ABBREVIATIONS

ADB	Asian Development Bank
FGP	family group practice
HSDP	Health Sector Development Program
ICT	information and communication technology
MOH	Ministry of Health
PHC	primary health care
SHC	<i>soum</i> health center
SHSDP	Second Health Sector Development Program
TA	technical assistance
THSDP	Third Health Sector Development Program
WHO	World Health Organization

## CURRENCY EQUIVALENTS

(as of 9 August 2020)

Currency unit – togrog (MNT)

MNT1.00 = \$0.0003513

\$1.00 = MNT2,846.32

## EXECUTIVE SUMMARY

Under the influence of the Soviet Union, in the years up to 1990, Mongolia established a health care system based on the Semashko model, characterized by strong central planning with the state being responsible for both financing and delivery of health care. Primary health care (PHC) at that time was characterized by the dominance of curative outpatient and inpatient services over preventive services. Despite many achievements, including universal access to health care, there were significant weaknesses, such as low efficiency—despite the high number of hospital beds and medical staff—and a lack of responsiveness to patient needs.

The collapse of the Soviet Union saw the withdrawal from Mongolia of its assistance in the beginning of the 1990s, resulting in an economic crisis. Under these circumstances, there was an urgent need for socioeconomic reforms, including substantial reform of the health sector.

The Government of Mongolia commenced reform of the health sector in the early 1990s and requested support from the Asian Development Bank (ADB). Since then, ADB has broadly supported health sector in Mongolia, including PHC reforms through health sector development programs and technical assistance that continue to date. Over the past 3 decades, these programs and technical assistance have contributed to the establishment of family health centers that provide PHC in urban areas. Significant support was provided for strengthening PHC provision in rural *soum* (subprovince administrative units) health centers. The PHC reforms in Mongolia consisted of a shift from hospital-based curative services toward PHC and preventive approaches in the provision of health care services at the primary level. The PHC reforms included restructuring the old system and introducing new management models based on public–private partnerships, increasing the range of services provided, introducing more effective financing methods, building human resources, and creating better infrastructure. Despite several challenges that persist, PHC has become the foundation and an increasingly important part of the provision of health care in the country.

This paper describes PHC in Mongolia and ADB support for its reform, including results achieved, challenges that remain, and the lessons drawn from experience. The experience gained from the support by ADB of PHC reforms in Mongolia and the lessons learned could be useful for similar future programs in Mongolia and other countries. The paper also outlines future directions for ADB support of PHC in Mongolia.



# I. NEED TO SUPPORT PRIMARY HEALTH CARE

## A. Primary Health Care in Mongolia before the 1990s

For centuries, Mongolian traditional medicine, based on the principles of oriental medicine, was the only medical practice in the country. Modern health care and services in Mongolia were introduced in 1921. Under the influence of the Soviet Union, the health care system up to 1990 developed based on the Semashko model, characterized by strong central planning and state responsibility for financing and delivery of health care.<sup>1</sup> All health facilities were publicly owned, and staffed with civil servants on a uniform pay scale.

Primary health care (PHC) in urban areas (capital city and province centers) were obtained through polyclinics. They provided outpatient services for a catchment population within a defined geographic area. Polyclinics had general physicians, some specialized doctors, and diagnostic sections. Separate polyclinics existed for children and the adult population. A more functional PHC system was established in rural areas. Every *soum* (subprovince administrative unit) had a 15–30-bed *soum* hospital that provided outpatient and inpatient services for patients with noncomplicated medical conditions. *Soum* hospitals also provided antenatal and postnatal care, and minor surgery; operated maternity rest homes<sup>2</sup> for mothers from remote areas; and managed uncomplicated deliveries. Ambulance services for people of remote areas, and home visits within *soum* centers were part of the routine duties of *soum* hospitals. Some *soum* hospitals had attached *bagh* (sub*soum* administrative units) feldshers' posts<sup>3</sup> that provide primary care services in remote areas. In general, *soum* hospitals had a good coverage despite vast territories with sparse rural populations and prevalence of nomadic herders. In terms of prevention activities, the immunization program was well-organized and implemented at the PHC level both in urban and rural areas. Other public health-related services such as monitoring hygiene standards, infection prevention, and environmental health were carried out by a separate network of sanitary–epidemiological stations. Overall, PHC was characterized by the dominance of curative outpatient and inpatient services over preventive services.

Despite many achievements, including free universal access to PHC, Mongolia's health sector still had significant weaknesses, including low efficiency—despite the high number of hospital beds and medical staff—and a lack of responsiveness to patient needs. The success of the input-based health system was measured by the number of doctors, nurses, and hospital beds per population. These coverage indicators were impressive and at the time, compared favorably to other countries at a similar level of development (Table 1), but this was not always the case with the main health indicators (Table 2).

Mongolia's health care system was characterized by dominance of an excessive and ineffective hospital sector with extensive use of acute beds even at the *soum* hospital level, emphasis on provision of specialist services, large numbers of medically unjustified admissions, and long length of stay in hospitals. The attitude of the population has developed in a way that prefers specialist care and inpatient treatment. The quality of care at the primary level was perceived to be low.

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<sup>1</sup> I. Sheiman. 2013. Rocky Road from the Semashko to a New Health Model. World Health Organization Bulletin. Geneva: World Health Organization.

<sup>2</sup> Maternity rest homes were designed and equipped to provide for the possibility for mothers from nomadic herder families to stay near *soum* hospitals for a few days before expected delivery.

<sup>3</sup> A feldsher is a PHC worker with 2 years of medical training assigned to work at a remote post in a *bagh* under the supervision of a medical doctor from the *soum* hospital.

**Table 1: Comparative Health Services Coverage, 1994**

Country	GNP per Capita (\$)	Health Expenditures per Capita (\$)	Hospital Beds (per 1,000 population)	Doctors (per 10,000 population)	Nurses (per 10,000 population)
Bangladesh	230	n/a	0.3	1.9	n/a
China, People's Republic of	490	11	2.4	15.5	n/a
Indonesia	810	12	0.7	1.4	3.5
<b>Mongolia</b>	<b>340</b>	<b>40</b>	<b>9.9</b>	<b>25.4</b>	<b>47.8</b>
Sri Lanka	600	18	2.8	2.1	5.7

GNP = gross national product.

Sources: Asian Development Bank. 1996. *Key Indicators*. Volume XXVII. Manila; United Nations Development Program. 1995. *Human Development Report 1995*. New York: Oxford University Press.

**Table 2: Comparative Health Indicators, 1990–1995**

Country	Life Expectancy at Birth (1993)		Infant Mortality Rate (1993)	Under 5 Mortality per 1,000 Births (1990–1995) <sup>a</sup>	Maternal Mortality per 100,000 Live Births (1995) <sup>b</sup>
	Female	Male			
Bangladesh	56	56	106	125.0	479
China, People's Republic of	71	68	30	40.0	72
Indonesia	65	61	56	63.9	326
<b>Mongolia</b>	<b>65</b>	<b>63</b>	<b>58</b>	<b>91.4</b>	<b>205</b>
Sri Lanka	74	70	17	25.6	70
Viet Nam	68	63	41	43.0	107

<sup>a</sup> United Nations. 2013. *World Mortality Report 2013*. New York.

<sup>b</sup> World Health Organization, United Nations Children Fund, United Nations Population Fund, World Bank Group, and United Nations Population Division. 2015. *Trends in Maternal Mortality: 1990 to 2015*. Geneva: World Health Organization.

Source: Asian Development Bank. 1996. *Key Indicators*. Volume XXVII. Manila.

## B. Initial Efforts of the Government to Improve Primary Health Care

The collapse of the Soviet Union saw the end of central planning in the countries under its sphere of influence. The planned economy and the system of centralized governance were not able to guarantee even a minimal improvement in living standards (footnote 1). In Mongolia, the start of socioeconomic reforms in the 1990s was preceded by an economic collapse as a result of withdrawal of Soviet assistance. In those circumstances, there was an urgent need for reforms in society, including the health sector.

In the beginning of the 1990s, the Government of Mongolia started the reform of the health care system. This included the introduction of the compulsory national health insurance scheme to rationalize health care and services, an increase in nontax financing, and improvement of the financial protection of the people.<sup>4</sup> In 1993, the Ministry of Health (MOH) triggered another round of reforms to introduce a family medicine-based PHC in Ulaanbaatar. One doctor and one nurse were appointed to work as a team

<sup>4</sup> In 1995, ADB funded a health technical assistance project that helped the Government of Mongolia build national capacity for improving the policy framework and implementation of the health insurance scheme.

to provide family medicine-based PHC to their assigned catchment population. Family doctors and nurses were located in district polyclinics or district hospitals. In the medical school curriculum, training in general practice and principles of PHC were introduced. However, doctors and nurses assigned for provision of PHC were not trained in family medicine, and they lacked financial incentives and the necessary equipment and supplies. The location of PHC doctors in the secondary hospitals led clients to ignore or bypass them.

In 1992, a health sector review was carried out by the MOH with support from the Asian Development Bank (ADB) and other international partners. The review highlighted past achievements of Mongolia's health care system, particularly universal access to health services, as well as weaknesses. A discrepancy was observed between input indicators and the relatively poor results achieved, clearly demonstrating the low efficiency and low effectiveness of the current health care system.

The health sector required a major overhaul to improve system quality and effectiveness, and to adapt it to a market economy. There was a need for fundamental reforms to develop an efficient health care system based on PHC as the platform, complemented by a well-organized and rational referral system to secondary- and tertiary-level hospitals. Consequently, there was a need for policy advice, management assistance, training, as well as a new infrastructure.

### C. ADB Support to Primary Health Care in Mongolia

The government requested ADB support to help implement two major reforms: shifting the emphasis from hospital-based curative services toward PHC and changing the health care financing system to improve efficiency of health care. Since a well-functioning system of *soum* hospitals provided PHC that suited the needs of the nomadic rural population, and was scattered across vast areas, the main focus was given to reforming PHC in urban areas.

#### (i) Health Sector Development Program, 1997–2003

The first ADB project in Mongolia's health sector was the Health Sector Development Program (HSDP),<sup>5</sup> whose main achievement was to establish family group practices (FGPs) in urban areas, which were intended to provide family medicine services and ensure gatekeeping<sup>6</sup> to reduce expensive hospital care. The HSDP proposed a new PHC model in which FGPs are managed by private entities or partnerships with the primary objective to provide PHC to the population in its catchment.<sup>7</sup> This option was considered best at that time. The partnerships delivered PHC services based on a performance-based contract made with the local government. The funding system was based on per-capita payments, with risk adjustments such as higher payments for the poor and vulnerable. This capitation model was expected to promote "competition" between FGPs to attract more people, not just those living in close proximity, through the good quality of services. FGPs that provided better care and services would have more funds in return for their good performance. In turn, FGPs could further invest in providing better quality services to improve their competitiveness. Other essential elements of the model included registration of populations with family doctors within FGPs (approximately 1,200–1,400 people per doctor) and provision of free health care at the point of the service.

<sup>5</sup> ADB. 1997. *Report and Recommendation of the President to the Board of Directors: Proposed Loans and A Technical Assistance to Mongolia for the Health Sector Development Program*. Manila.

<sup>6</sup> In primary care gatekeeping, the goal of the primary care physician is to reduce patient referrals to specialists and thereby reduce costs.

<sup>7</sup> According to the Law on Partnership, the partnership is a legal entity, with a principle of collective management by its members subject to members' investment size. A partnership consists of 3–5 family doctors as members, and a similar number of nurses on a contract basis.

The HSDP established new FGPs in Ulaanbaatar on a pilot basis through the construction of facilities or buildings, and provision of necessary equipment.<sup>8</sup> These resources included medical equipment and devices.<sup>9</sup> The HSDP conducted workforce planning, established a licensing system, and developed sample job descriptions for FGP medical staff; as well as general principles and criteria for the people in choosing family doctors. The HSDP also supported the development of guidelines and protocols, and training and retraining of staff engaged in FGP in family medicine. A nationwide information campaign aimed at raising public awareness of FGPs was conducted. Based on the successful pilot from the HSDP, the government issued a series of decisions to establish FGPs nationwide in urban areas,<sup>10</sup> and redefined contractual and financial regulations<sup>11</sup> related to the operation of FGPs. The process started in 1999 and resulted in the establishment of FGPs throughout Mongolia by 2002, covering 60% of the population.<sup>12</sup>

The HSDP was implemented for 5 years, after which the newly established FGPs began to face problems associated with the introduction of the new model. Despite their legal status as private entities, FGPs were treated as budgetary entities by local governments, which severely hampered their autonomous status. The FGPs were required to pay salaries to staff based on the civil service salary scheme; at the same time, FGPs were liable for higher private tax, including social insurance contributions, like other private entities. The government staff lacked understanding and capacities in handling, monitoring, and evaluating FGP contracts and the newly introduced capitation payment method. Curative services at FGPs continued to dominate over preventive public health services. Family medicine protocols lacked a system for monitoring quality of services. Essential services that would reflect the needs of the population were not defined, resulting in confusion over referrals, duplication of services, and continuing provision of PHC services at the referral-level hospitals. The absence of subsequent refresher and on-the-job training on family medicine for FGP staff compromised the effectiveness of the capacity-building efforts of HSDP. Facilities built by government resources for newly established FGPs often did not comply with the model set up by the HSDP. Importantly, the information campaign was not sustained; hence, the preexisting public attitudes that favored hospital care were left unchanged. The desired gatekeeping role of FGPs remained largely ineffective and clients continued to bypass them to directly visit hospitals.<sup>13</sup>

The government continued efforts to strengthen FGPs and address unresolved issues, while ADB was requested to support PHC in rural areas.

## (ii) *Second Health Sector Development Program, 2003–2010*

As requested by the government, the Second Health Sector Development Program (SHSDP)<sup>14</sup> focused on integrated improvement of rural health services (component 1), with the focus on PHC provided

<sup>8</sup> The HSDP constructed 69 FGPs and 8 *soum* hospitals, rehabilitated 6 FGPs and 15 *soum* hospitals, upgraded 3 *aimag* general hospitals, and equipped 105 health facilities with essential medical equipment in three project *aimags*.

<sup>9</sup> The HSDP provided sets that included stethoscopes, ophthalmoscopes, suture sets, sterilizers, folding tables, gynecological chairs, refrigerators, and examination lamps.

<sup>10</sup> Government of Mongolia. 1999. Resolution No. 149. About establishment and operations of family hospitals.

<sup>11</sup> Government of Mongolia. 2000. Resolution No. 72. About the program on provision of health care and services on contract basis. [http://mohs.gov.mn/uploads/userfiles/files/TA%20Project%20TA%209386-MON-Technical%20Report\\_1\\_updated\\_Eng.pdf](http://mohs.gov.mn/uploads/userfiles/files/TA%20Project%20TA%209386-MON-Technical%20Report_1_updated_Eng.pdf).

<sup>12</sup> From 1999 to 2002, a total of 234 FGPs were established, including 118 in Ulaanbaatar and 116 in *aimag* centers. As of 2018, there are 219 FGPs in the country, including 135 in Ulaanbaatar and 84 in *aimag* centers.

<sup>13</sup> ADB. 2008. *Performance Evaluation Report: Health Sector Development Program in Mongolia*. Manila.

<sup>14</sup> ADB. 2003. *Report and Recommendation of the President to the Board of Directors: Proposed Loan and Technical Assistance Grant to Mongolia for the Second Health Sector Development Program*. Manila.

at *soums* and *baghs* and institutional capacity development (component 2).<sup>15</sup> During the program's implementation period, the well-established system of *soum* hospitals and *bagh* feldshers faced challenges arising from the overall difficulties that society was experiencing during its transition to a market economy. Internal migration resulted in an acute shortage of physicians and other qualified health workers in rural areas. Lack of financial incentives and opportunities for professional development, such as consultation with colleagues; limited practice due to the small population; limited chances for on-the-job training and continuing education; and difficult transportation and communication conditions were major obstacles for attracting new and retaining existing qualified medical staff in rural areas. *Soum* hospitals lacked resources to maintain facilities, which continued to deteriorate. This was exacerbated by the lack of basic equipment and supplies. As a result, main health indicators such as maternal mortality rates were worsening, especially in rural areas.<sup>16</sup>

The major achievement of the SHSDP was strengthening PHCs at the *soum* and *bagh* levels in five *aimags* (provincial administrative units) selected by MOH. *Soum* hospitals in project *aimags* were upgraded in terms of facilities and equipped with essential medical and nonmedical equipment.<sup>17</sup> All *soum* hospital medical staff and *bagh* feldshers in project *aimags* received clinical training that was evaluated and found to be highly effective.<sup>18</sup> Technical assistance (TA) was implemented to support the SHSDP to improve service provision by introducing basic information and communication technologies (ICT) at the PHC level in rural areas.<sup>19</sup> Provision of personal digital assistant devices at the *bagh* level, hardware, and creation of simple ICT modules supported the information exchange for consultation, referral, and training among *bagh*, *soum*, and *aimag* staff; and improved capacity to diagnose and manage common conditions. In addition, the TA project introduced software (Health Info v1) for entering and processing health statistics data that eased data collection and reporting from *soum* hospitals to their respective health departments.<sup>20</sup> Another TA project that complemented the SHSDP<sup>21</sup> aimed to address the maternal mortality ratio by improving PHC-based antenatal and postnatal care.<sup>22</sup> The TA project focused on improving reproductive health services, targeting mothers with geographic and social barriers to accessing services. It also demonstrated mechanisms for mobilization of social support for vulnerable mothers; improved knowledge, skills, and capacity of doctors, nurses, midwives, and *bagh* feldshers; and strengthened the reproductive health services and antenatal care at the PHC level in SHSDP *aimags*.<sup>23</sup>

The overall successful implementation of the SHSDP coincided with the government initiative to develop a long-term policy document—the Health Sector Master Plan, 2006–2015—a guide for the provision and coordination of the support provided to the health sector. However, frequent changes in the MOH

<sup>15</sup> The health system in rural areas is composed of *bagh* feldsher posts, *soum* hospitals, and *aimag* general hospitals. *Bagh* feldshers and *soum* hospitals provide primary care for the rural population, including health education; and basic health services, such as ambulance and maternal services. *Aimag* general hospitals (250–350 beds) provide first-level referral services. For remote areas, inter-*soum* hospitals are set up as first referral hospitals.

<sup>16</sup> The country average for the maternal mortality ratio per 100,000 live births in 2000 was 161; the average for Bayan-Ulgii, Khovd, and Arkhangai *aimags* were 215–403. MOH. 2001. *Ministerial Order No. 39: Strategy for Reducing Maternal Mortality*. Ulaanbaatar.

<sup>17</sup> The SHSDP built 21 new and upgraded 10 *soum* and inter-*soum* hospitals; improved water supply through construction of wells, upgraded 5 *aimag* general hospitals, and equipped 92 *soum* hospitals and *aimag* general hospitals in 5 project *aimags*.

<sup>18</sup> S. Enhktuya. 2008. *Project Training Report for 2005–2006*. Second Health Sector Development Program. Ulaanbaatar.

<sup>19</sup> ADB. 2004. *Grant Assistance to Mongolia: Information and Communication Technology for Improving Rural Health Services*. Manila.

<sup>20</sup> ADB. 2008. *Mongolia: Information and Communication Technology for Improving Rural Health Services. Implementation Completion Memorandum*. Manila.

<sup>21</sup> ADB. 2005. *Grant Assistance to Mongolia: Maternal Mortality Reduction Project*. Manila.

<sup>22</sup> The MOH and the World Health Organization reports of 2001–2002 indicated that improvements in reducing maternal mortality had deteriorated and many maternal deaths could have been prevented because a significant number of them occurred among those who had never used antenatal care, or had used it in late stages.

<sup>23</sup> ADB. 2008. *Grant Assistance to Mongolia. Maternal Mortality Reduction Project. Implementation Completion Memorandum*. Manila.

leadership caused frequent shifts in policies that were rarely based on the Master Plan and often caused confusion among partners.<sup>24</sup>

By the end of SHSDP, the government requested ADB to continue assistance for the PHC, not only in rural, but in urban areas as well.

### (iii) *Third Health Sector Development Program, 2007–2014*

The Third Health Sector Development Program (THSDP) had four components: (i) strengthening health services; (ii) improving health care financing and health insurance, (iii) improving human resource development, and (iv) sector capacity development and management.<sup>25</sup> As requested by the government, the first component of the THSDP focused on improving PHC both in rural and urban areas. The major achievement of the THSDP was restructuring and reorganizing PHC to ensure more emphasis on preventive public health services. The proposed concept was reflected in the new Health Law (2011) and government resolutions and ministerial orders<sup>26</sup> that followed the law. Consequently, FGPs were restructured into family health centers. The process was supported by the development of new standards<sup>27</sup> for optimal level of service, service packages and referral arrangements,<sup>28</sup> core indicators for monitoring and evaluating the performance<sup>29</sup> of family health centers, and clinical guidelines for treatment and diagnosis of common conditions at the primary level. Model family health centers with enhanced physical layouts for better patient access, greater services capacity (including basic laboratory diagnostics), and better medical equipment (including rehabilitation) were established in Ulaanbaatar to serve as a reference for other facilities. A similar process was followed for restructuring *soum* hospitals into *soum* health centers (SHCs)<sup>30</sup> based on the THSDP recommendations.<sup>31</sup> The THSDP supported the development of new standards,<sup>32</sup> service packages, and referral guidelines,<sup>33</sup> and made recommendations on medical equipment, medicines, staffing levels, and job descriptions. The formal prioritization of public health services resulted in reducing the number of inpatient beds at SHCs and in using remaining beds mostly for observation of patients with noncomplicated conditions. The program invested in equipping and building new SHCs and family health centers, and equipping and upgrading *aimag* general hospitals in selected project *aimags*.<sup>34</sup>

The implementation of THSDP coincided with the 2007–2008 global financial crisis, which hit the Mongolian economy hard. Therefore, it was complemented by numerous TA projects that aimed to

<sup>24</sup> ADB. 2010. *Completion Report: Second Health Sector Development Project in Mongolia*. Manila.

<sup>25</sup> ADB. 2007. *Report and Recommendation of the President to the Board of Directors: Proposed Grant to Mongolia for the Third Health Sector Development Project*. Manila.

<sup>26</sup> Government of Mongolia. 2011. *Resolution No 364: Bylaw on FHC*. Ulaanbaatar; and Ministry of Health. 2013. *Ministerial Order No. 239: Family Health Center Development Strategy*. Ulaanbaatar.

<sup>27</sup> Mongolian Agency for Standardization and Metrology. 2011. *Structure and Operational Standard for Family Health Center*. MNS5292:2011. Ulaanbaatar.

<sup>28</sup> Government of Mongolia, Ministry of Health. 2013. *Ministerial Order No. 248: Service Package for FHCs and Referral Guidelines*. Ulaanbaatar.

<sup>29</sup> Government of Mongolia, Ministry of Health. 2013. *Ministerial Order No. 266: FHC Performance Contract*. Ulaanbaatar.

<sup>30</sup> Government of Mongolia, Ministry of Health. 2014. *Ministerial Order No. 386: Soum Health Center Development Strategy*. Ulaanbaatar.

<sup>31</sup> Government of Mongolia, Ministry of Health. Third Health Sector Development Program. GVG Consultancy Team. 2009. Technical Report. *The Future of Soum Health Care*. Ulaanbaatar.

<sup>32</sup> Mongolian Agency for Standardization and Metrology. 2011. MNS5081:2013. *Structure and Operational Standard for Soum Health Center*. Ulaanbaatar.

<sup>33</sup> Government of Mongolia, Ministry of Health. 2013. *Ministerial Order No 248. SHC Service Package and Referral Guidelines*. Ulaanbaatar.

<sup>34</sup> The THSDP built 14 new SHCs and FHCs, upgraded 10 SHCs, and improved water supply through construction of wells; upgraded 5 *aimag* general hospitals; and equipped 73 SHCs, FHCs, and *aimag* general hospitals in 5 project *aimags* and 2 districts in Ulaanbaatar.

address difficulties faced by the poor and vulnerable during the crisis.<sup>35</sup> One of them aimed to improve access to health services for people on the periphery of the health and welfare systems,<sup>36</sup> with particular focus on Ulaanbaatar.<sup>37</sup> The TA analyzed the constraints that prevent the disadvantaged from accessing health services, and pilot tested a few models to increase their access. One of the pilot models, engagement of *khoroо* (subdistrict administrative units in a city) social workers to serve as community health service facilitators was particularly appropriate, as it encouraged the local community and family health centers to develop practical solutions to increase service capacity, accessibility, and availability. Consequently, disadvantaged people in project districts had improved access to health services, particularly to PHC.<sup>38</sup> The pilot models were enthusiastically embraced and appreciated by primary beneficiaries and target groups, including local governments, family health centers, and community groups.<sup>39</sup>

Another TA project developed and implemented the Medicaid program that addressed the urgent need to provide essential health services for the poor and vulnerable during the financial crisis.<sup>40</sup> It aimed to fill the gaps of the health insurance scheme, and improve access to referral care especially for the uninsured poor and vulnerable. The Medicaid program targeted the low-income, poor, and vulnerable groups; and applied, for the first time, the proxy means-testing methodology in identifying eligible households. Upon consultation with PHC doctors, Medicaid-eligible households gained access to free medicines prescribed by PHC doctors, free referral medical services at *aimag* and district hospitals, and transportation from *soum* to *aimag* as needed. The Medicaid program played an important role in the enrollment and engagement of the poor and vulnerable, and in increasing recognition of PHC and strengthening its gatekeeping role. Although the Medicaid program made a valuable contribution in protecting the poor affected by the financial crisis, it lacked sufficient political support to become an integrated part of the national government agenda.<sup>41</sup>

Another TA-supported effort<sup>42</sup> was to mitigate the impact of the economic crisis by addressing chronic malnutrition in children<sup>43</sup> through the provision of essential micronutrients, raising public awareness of child malnutrition, and increasing the role of PHC providers in addressing this public health issue.<sup>44</sup> The TA project implemented several cost-effective solutions based on the local situation and specific

<sup>35</sup> This document refers to those TA projects that were focused on or linked with PHC service delivery.

<sup>36</sup> ADB. 2007. *Grant Assistance Report: Access to Health Services for Disadvantaged Groups in Ulaanbaatar*. Manila.

<sup>37</sup> Mongolia's transformation to a market-based economy has been accompanied by an increase in poverty, unemployment, and a surge in rural-urban migration. Poverty has increased markedly, with 35% of the population estimated as poor. Limited social protection, suboptimal social and health insurance, and the lack of access to education, welfare, and health services have significantly impacted the poor. Municipal governments had difficulties in coping with massive migration by the rural poor to the capital city Ulaanbaatar. As result, the poor and vulnerable lacked PHC and pharmacies in remote areas, were unable to pay for treatments and medicines, had no insurance, and lacked knowledge on services available to users.

<sup>38</sup> In the final evaluation, 92% of the participants responded that they benefited from the pilot implemented by FHCs jointly with the local governments. This translates to around 34,000 disadvantaged people benefiting directly and indirectly from the project.

<sup>39</sup> ADB. 2012. *Grant Assistance: Access to Health Services for Disadvantaged Groups in Ulaanbaatar. Implementation Completion Memorandum*. Manila.

<sup>40</sup> ADB. 2009. *Proposed Grant Assistance to Mongolia for Protecting the Health Status of the Poor during the Financial Crisis*. Manila.

<sup>41</sup> A. Jigjidsuren. 2016. Ensuring Health Care Services for the Poor During a Financial Crisis: The Medicaid Program in Mongolia: Experiences and Lessons Learned. *EARD Working Paper Series*. No. 8. Manila: ADB.

<sup>42</sup> ADB. 2009. *Grant Assistance Report: Reducing Persistent Chronic Malnutrition in Children in Mongolia*. Manila.

<sup>43</sup> At that time, successive national surveys had shown that persistent chronic malnutrition in infants and young children remained a significant public health issue. This indicated the pressing need to improve PHC participation in public health nutrition.

<sup>44</sup> Micronutrient powder was distributed to 75,900 children under 3 years old in the TA project areas. The end-of-project survey revealed that 77% of surveyed children (6–35 months old) received micronutrient powder from PHC, and 69.4% actually consumed it.

needs, and confirmed that addressing chronic child malnutrition, which mainly affects the poor, is necessary to overcome the poverty cycle and ensure inclusive growth.<sup>45</sup>

Overall, with support from THSDP, PHC in Mongolia has been strengthened and has undergone a significant shift from dominant curative services to a more public health-oriented model through regulatory reforms and changes in operational standards. FGPs were reorganized into family health centers that became the first contact point for health care in urban areas especially for the poor and vulnerable, including the elderly, children, and disabled. *Soum* hospitals that were turned into SHCs under the program substantially evolved in terms of infrastructure and equipment as well as capacity in clinical areas and management. Customer satisfaction increased, and SHCs were firmly embedded and widely used in local rural communities.<sup>46</sup> Improved reproductive health services and public health services to address child malnutrition at the PHC level supported reductions in maternal and child mortalities (Table 3).

#### (iv) Ongoing Health Sector Development Programs

While PHC policies were successfully implemented, governance and financing reforms that were planned by the THSDP, and were expected to support the PHC reforms, were only partially achieved. The following issues remain. Tripartite contractual arrangements between family health centers, local governments, and health authorities remain rigid. Family health centers were unequal partners in the contract, with little influence over frequent changes<sup>47</sup> to contractual arrangements and established indicators. The salaries of family health center employees were based on a government salary scheme applicable to public servants; and partnerships had no right to increase or decrease salaries based on staff performance, which negatively affected staff motivation. PHC funding remained low—the amount paid under a capitation fee could not cover the costs related to primary care and services that family health centers are supposed to provide.<sup>48</sup> Partnerships were funded from the local budget and therefore were required to follow the strict financial reporting system applicable to budgetary organizations. Facility and equipment of family health centers belonged to the local government, which created disincentives for partnership in investing in new equipment and its maintenance. PHC in rural areas lacked equipment and persistently lacked ambulances. The availability and quality of PHC were undermined by neglected laboratory and diagnostic services, emergency services, day and home care, rehabilitation and palliative care, as well as by weak human resources capacity. In addition to inadequate incentive mechanisms to attract and retain skilled and qualified medical professionals at the primary level, the government policy to engage new graduates at the primary level on a mandatory basis have seriously compromised the human resource potential of the family health centers and SHCs. There was a lack of integrated care models, resulting in poor coordination between primary and referral levels of health care.

In addition, other challenges have surfaced as of 2019. Rapid urbanization in Mongolia since the 1990s has increased the burden of provision of health and social services in Ulaanbaatar and other cities. Ulaanbaatar has been the main destination for migrants from rural areas, and now hosts almost 50% of

<sup>45</sup> ADB. 2016. *Reducing Persistent Chronic Malnutrition in Children in Mongolia. Implementation Completion Memorandum*. Manila.

<sup>46</sup> ADB. 2015. *Completion Report: Third Health Sector Development Project in Mongolia*. Manila.

<sup>47</sup> Government of Mongolia. 2011. *Resolution No. 364: About Approving Regulations*. Ulaanbaatar; Government of Mongolia, Ministry of Health. 2012. *Ministerial Order No. 26: About Some Actions to be Implemented on FGPs*. Ulaanbaatar; Government of Mongolia, Ministry of Health. 2013. *Ministerial Order No. 266: About Approving Standardized Contract*. Ulaanbaatar; Government of Mongolia, Ministry of Health. 2017. *Ministerial Order No. A/04: About Approving Regulations*. Ulaanbaatar; Government of Mongolia, Ministry of Health. 2017. *Ministerial Order No. A/05: About Approving Standardized Contract*. Ulaanbaatar; and Government of Mongolia, Ministry of Health. 2017. *Ministerial Order No. A/367: About Approving Regulations on Competitive Selection of FGPs*. Ulaanbaatar.

<sup>48</sup> From 2000 to 2019, the capitation payment rate was equivalent to \$4–\$5 per person per year.

the country's population. This has led to a shortage of human resources, funding, and equipment in urban areas. Obsolete and poorly functioning health facilities limited the accessibility, availability, and quality of health care services. Poor urban infrastructure and weakened government capacity to provide basic social services exacerbated the situation. About 60% of Ulaanbaatar's population lives in *ger*<sup>49</sup> areas, with limited access to running water, sanitation, and social services, including PHC. Access to health care is challenging, especially for the poor who use health services 2.5 times less than the nonpoor.<sup>50</sup> Out-of-pocket expenses are high and account for 41% of total health expenditure.<sup>51</sup> Meanwhile, one-third of household out-of-pocket health expenses are for medicines because of high prices and inappropriate use. Over 90% of the population has health insurance coverage, but the benefit package is limited mostly to hospital services. In 2015, government expenditure on health accounted for just 2.4% of gross domestic product, well below the 5% target set by the World Health Organization (WHO). Addressing behavioral risk factors, such as obesity, alcohol and tobacco use, and gender-based violence and their associated health impacts remains a key challenge.<sup>52</sup>

The Improving Access to Health Services for Disadvantaged Groups Investment Program, continues the focused support of ADB for PHC in Mongolia.<sup>53</sup> The program that currently is at the initial stage of implementation will continue for 10 years (until 2029), and will provide the platform for future ADB support for the health sector of Mongolia. It builds on the results of the previous ADB-funded health sector development programs and TA projects that achieved significant results in supporting the PHC. The program will expand and improve access to quality, gender-sensitive, and friendly PHC services in disadvantaged areas of Ulaanbaatar, where almost half of the population of Mongolia reside. Nationally, integrated primary and referral health care models will be implemented. This will support reform of PHC financing, staffing, contracting, and quality management. The program will support the introduction of new and efficient low-carbon technology, and public-private partnership models for equipment maintenance. The details of these reforms and actions will be further detailed jointly with the government during program implementation, based on the priorities outlined in the State Policy on Health, 2017–2026.<sup>54</sup>

## II. RESULTS ACHIEVED IN PRIMARY HEALTH CARE IN MONGOLIA

Since 1991, Mongolia has achieved significant results in reforming and improving PHC. PHC become a foundation and increasingly important part of delivering health care and services that play an essential role in improving the health status of the population. Over the last 30 years, the health status of the population has improved, with increased life expectancy<sup>55</sup> and sharp declines in child mortality rates and maternal mortality ratios (Table 3).

<sup>49</sup> *Ger* is a traditional Mongolian portable tent, with a wooden frame covered with felt.

<sup>50</sup> Government of Mongolia, Ministry of Health and United Nations Children Fund. 2017. *Nutrition Status of the Population of Mongolia: Fifth National Nutrition Survey Report*. Ulaanbaatar.

<sup>51</sup> Dorjdagva, J. et al. 2016. *Catastrophic Health Expenditure and Impoverishment in Mongolia*. *International Journal for Equity in Health*. 15 (105). <https://doi.org/10.1186/s12939-016-0395-8>.

<sup>52</sup> National Statistics Office of Mongolia. 2018. *Mongolian Statistical Yearbook 2017*. Ulaanbaatar.

<sup>53</sup> ADB. 2019. *Report and Recommendation of the President to the Board of Directors: Proposed Multi-tranche Financing Facility to Mongolia for Improving Access to Health Services for Disadvantaged Groups Investment Program*. Manila.

<sup>54</sup> Government of Mongolia. 2017. *State Policy on Health*. Ulaanbaatar.

<sup>55</sup> Average life expectancies at birth in Mongolia follow (total years): 1990: 60.268; 2000: 62.869; 2005: 65.103; 2010: 67.38; 2015: 69.111; and 2018: 69.689. (Source: World Bank. Life Expectancy at Birth, Total (years)—Mongolia. [https://data.worldbank.org/indicator/SP.DYN.LE00.IN?locations=MN&name\\_desc=true](https://data.worldbank.org/indicator/SP.DYN.LE00.IN?locations=MN&name_desc=true)).

**Table 3: Implementation of the Millennium Development Goals in Mongolia, 2015**

<b>Goal 4: Reduce child mortality</b>				
Target 9: Reduce the under-five mortality rate by 4 times, between 1990 and 2015				
<b>1990</b>	2000	2006	<b>2015</b>	<b>Target for 2015</b>
<b>88.8</b>	44.5	23.2	<b>18.3</b>	<b>21.0</b>
<b>Goal 5: Improve maternal health</b>				
Target 10: Provide access to all individuals to required reproductive health services and reduce the maternal mortality rate ratio by 4 times, between 1990 and 2015				
<b>1990</b>	2000	2006	<b>2015</b>	<b>Target for 2015</b>
<b>200.0</b>	166.3	67.2	<b>26.0</b>	<b>50.0</b>
Target 11: Proportion of births attended by skilled personnel				
<b>1990</b>	2000	2006	<b>2015</b>	<b>Target for 2015</b>
<b>100.0</b>	99.6	82.2	<b>99.8</b>	<b>99.8</b>

Source: Government of Mongolia and United Nations Development Program. 2016. [http://hdr.undp.org/sites/default/files/mongolia\\_human\\_development\\_report\\_2016\\_english\\_full\\_report\\_2016\\_06\\_28.pdf](http://hdr.undp.org/sites/default/files/mongolia_human_development_report_2016_english_full_report_2016_06_28.pdf).

While SHCs continue to serve as an entry point for getting health care in rural areas, newly established family health centers have developed into a sustainable model and contribute the most to provision of PHC in general, and in urban areas in particular. The process of development of PHC witnessed the transformation of family and *soum* hospitals that primarily focused on curative services into family health centers and SHCs with more emphasis on public health services and health promotion, establishing the system as it is today (Table 4).

At family health centers and SHCs, PHC is accessible to everyone, including unregistered and migrant populations. The risk adjusted per-capita financing is sustained and provides incentives to register and serve the poor and vulnerable. Family health center services are mostly utilized by the poor and vulnerable, and individuals who rely on free services.<sup>56</sup>

**Table 4: Selected Primary Health Care Indicators, 2018**

<b>Indicator</b>	<b>Family Health Centers</b>	<b>Soum Health Centers</b>
Total number	219 (135 in Ulaanbaatar, 84 in <i>aimag</i> centers)	273
Number of doctors (% of total)	1,000 (8.9%)	1,034 (9.3%)
Number of nurses (% of total)	940 (7.6%)	1,842 (14.9%)
Number of outpatient visits (% of total)	5,634,491 (38%)	2,171,085 (14.8%)
Proportion of outpatient visits for preventive purposes	41.8%	38.6%
Proportion of pregnant mothers enrolled in early antenatal care	86.9%	89.3%
Number of beds (% of total)	n/a	3,980 (15.9%)
Average length of stay (days)	n/a	6.6

Source: Government of Mongolia, Health Development Center. 2018. *Health Indicators*. Ulaanbaatar.

<sup>56</sup> J. Dorjdagva et al. 2017. Free and Universal, but Unequal Utilization of Primary Health Care in the Rural and Urban Areas of Mongolia. *International Journal of Equity Health*. 16 (73). doi: 10.1186/s12939-017-0572-4.

### III. CHALLENGES THAT REMAIN IN PRIMARY HEALTH CARE IN MONGOLIA

In a well-functioning health system, there are health promotion and prevention activities at the community level, and a patient should go first to the PHC facility. If the PHC facility lacks the skills and equipment to diagnose and treat, the patient goes to the referral level of health care. The system is advantageous for the patient and their families, as PHC facilities are within reasonable traveling distance. This system is also economical, because it should lead to expensive hospital skills and equipment being used only on patients who need it. Although this looks simple on paper, it is not easy to operationalize.

Some countries have been able to achieve significant results in the provision of PHC. The WHO provides several country examples of effective and well-functioning primary care systems. For instance, in France, rural doctors are an integral part of village life, offering personal, one-to-one care that hospitals cannot extend. Empathy, trust, and an intimate knowledge of individual case histories are their stock-in-trade. Addressing people's individual health needs, and treating the whole person, rather than the disease alone, is a core part of their approach to PHC. Treating the patient as a whole person means going beyond a narrow clinical diagnosis to find the answer to the patient's health problems. That involves discussions on diet and other lifestyle issues or health advice on, for example, screening for cancer and regular health checks.<sup>57</sup> Despite such best examples, building up an effective PHC that meets the needs of people has not yet been achieved, as planned and desired, in many countries.

Despite significant achievements, challenges remain in the PHC system of Mongolia. According to international best practices, up to 80% of patients could be treated in PHC settings, if they are functioning effectively.<sup>58</sup> Currently, the PHC system in Mongolia is not properly functioning as a gatekeeper, as exemplified by the existing high rates of bypass and self-referrals to hospital care.<sup>59</sup> Public awareness campaigns, conducted during the initial stages of establishing family health centers, was an important but unsustainable initiative. Therefore, the attitude of the population, which prefers hospital care and inpatient treatment, combined with the lower quality of PHC, has persisted.

It does not help that family health centers do not deliver the expected range of essential services, and that the quality of services leaves much to be desired. A recent study revealed that availability of PHC services within health facilities is low. The family health centers contribute the most to providing PHC, but readiness is mostly hampered by a lack of diagnostic capacity and essential medicines.<sup>60</sup> Important services that could invite and retain more people at the PHC level, such as basic laboratory and imaging diagnostics, emergency care, day care and provision of minor surgical procedures, family planning, rehabilitation, and home and palliative care are not sufficiently delivered. Until recently, the priority essential services package that should be provided primarily at the PHC level was not defined.

Initial advances in retraining and specializing PHC doctors and nurses in family medicine have waned, since in family health centers and SHCs, there is no strong requirement to specialize in family medicine.

<sup>57</sup> World Health Organization. 2008. Country Examples. France: Primary Health Care in Action. In *The World Health Report 2008*. Geneva.

<sup>58</sup> ADB. 2010. *Fourth Health Sector Development Project: Improving Sector Governance*. Consultant's report. Ulaanbaatar.

<sup>59</sup> The percentage of inappropriate admission to some tertiary hospitals is reported to be 45%. Percentage of admissions referred by PHCs is 20% out of total admissions. R. Byamba et al. 2006. Inappropriate Admissions of Tertiary and Secondary Level of Care in Ulaanbaatar. Second Health Sector Development Project. Ulaanbaatar.

<sup>60</sup> A. Jigjidsuren et al. 2019. Free and Universal Access to Primary Healthcare in Mongolia: The Service Availability and Readiness Assessment. *BMC Health Services Research*. 19. 129. <https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-019-3932-5>.

The government policy required inexperienced new graduates of medical schools to work for at least 2 years at the PHC level as a condition for application to residency training,<sup>61</sup> which contributed to neglecting specialization in family medicine. In addition, this has undermined the reputation of family health centers and SHCs, especially among those who are better-off and can afford paid services in specialized public hospitals or private hospitals. In general, PHC staff lack the skills to provide quality family medicine services. Relevant PHC staff do not have the appropriate skills to manage and make optimal use of financial, human, and other resources.

The proportion of funding allocated for PHC continues to decrease, and remains low compared to hospitals, which account for the lion's share of the total government spending on health (Table 5).

**Table 5: Government Health Expenditure by Level of Care, 2005–2015**

	2005	2010	2015
Total state expenditure (million MNT)	764,597	3,080,685	7,137,974
State expenditure on health (million MNT)	74,990	251,071	632,521
Of which:			
<b>Primary health care</b>	<b>18,568 (25%)</b>	<b>47,496 (19%)</b>	<b>101,492 (16%)</b>
Secondary-level health care	27,433 (37%)	83,707 (33%)	196,954 (31%)
Tertiary-level health care	19,080 (25%)	54,162 (22%)	187,378 (30%)

MNT = togrog.

Source: Government of Mongolia, Ministry of Health. 2017. *Review of State Expenditure for Health and Sports Sectors*. Ulaanbaatar.

The government recently doubled the per-capita payment rates for family health centers in 2019<sup>62</sup> and reimbursed basic diagnostic services, day care, rehabilitation, and home care from the health insurance fund.<sup>63</sup> However, PHC funding remains low compared to per-capita payments for PHC in other countries at a similar level of development,<sup>64</sup> and is insufficient for provision of good quality basic services. The capitation fees are also not sufficient in creating adequate incentives to motivate performance and competition among family health centers. Attempts to introduce costing of PHC are still in their initial stages and should be continued to ensure that the proposed basic services meet with the required resources. PHC facilities, especially in rural areas, still use low-efficiency technologies for heating, which add significant amounts to already high utility costs. This leaves almost no resources for investment in improving the quality of services through better medical equipment, medicines and supplies, and infrastructure and their maintenance. The major disadvantage of the capitation method, which creates a perverse incentive for family health centers to increase the rate of referrals since they can save with less work and less responsibility, has not been addressed. There are no enforcement mechanisms such as penalties for bypassing the primary level providers, or increased copayments in hospitals. This, in

<sup>61</sup> Government of Mongolia, Ministry of Health. 2012. *Ministerial Order No. 168: About Renewing Model and Mapping for Development of Medical Professionals*. Ulaanbaatar.

<sup>62</sup> The current average annual per capita payment for FHCs is MNT30,000—approximately \$11 as of April 2020. Government of Mongolia, Ministry of Health and Ministry of Finance. 2019. *Joint Order of the Minister of Finance and Minister of Health No. A257/562. About approving methodology for estimating budget and guidelines for financing and monitoring family, soum and village health centers*.

<sup>63</sup> Parliament of Mongolia. 2015. *Law of Mongolia on Social Health Insurance*. Ulaanbaatar.

<sup>64</sup> On average, PHC expenditure in 36 low- and middle-income countries ranged from \$15 to \$60 per capita. N. V. Maele et al. 2019. *Measuring Primary Healthcare Expenditure in Low-income and Lower Middle-income Countries*. *BMJ Global Health*. 4. e001497.

addition to the lack of basic services and integrated models of care, as well as the poor quality of services, have led to a nonfunctioning referral system.

Regulatory restrictions imposed on family health centers have diluted their private nature and resulted in the deterioration of the whole concept of public–private partnerships. Frequent and insignificant changes in the rules initiated by the government, conducted with little participation of family health centers, bring uncertainty and mistrust to the sustainability of the tripartite treaty. Performance-based contracts and systems for their monitoring and evaluation contribute little in improving the quality of services of family health centers. One of the key elements of the new model of family practices, strengthening the participation of people by encouraging them to register with a family doctor of their choice, was abandoned at the onset of the establishment of family health centers.

#### IV. LESSONS LEARNED

There are several key lessons and recommendations to be considered.

The timing of ADB support for the health sector and reform of PHC was well-justified and defined. The support, once started, continued through Mongolia’s difficult transition period, when the previous health system was not able to properly function, health services for people were deteriorating, and there was a need for fundamental reform to improve the quality and effectiveness of the health system, and to adapt it to a market economy. ADB support was based on and coincided with the initial efforts and understanding of the importance of establishing and promoting family medicine practices in PHC by the government. Through its technical and financial support to government reforms, ADB has been the main international partner for the development of the health sector in Mongolia.<sup>65</sup>

ADB support in the health sector was aligned with the national priorities and guided by international practices, which were considered as best at the time of implementation of the programs and TA projects. These ADB-funded health sector development programs and TA projects helped develop national policies and strategies on PHC, and ensured their sustainability through incorporation in national laws and other binding legal regulations. However, many of these policy reforms are yet to be properly implemented by the government. For example, PHC is accorded high priority in all national development policy documents, but government allocation has never prioritized it.

Frequent changes in the government seriously hampered the consistency and continuity of PHC reforms and related long- and medium-term plans, as well as their timely implementation. High turnover of government staff and loss of institutional memory and capacities<sup>66</sup> frequently led to the lack of government leadership, misunderstanding, and underutilization of useful recommendations and proposed actions, which had been formulated through extensive consultation and agreement processes involving all relevant stakeholders.

<sup>65</sup> As of 31 December 2016, the total amount of funding provided as grants and loans for the health sector of Mongolia was \$132.55 million. ADB. 2017. *Mongolia: Health Sector Fact Sheet*. Manila.

<sup>66</sup> Government of Mongolia, Ministry of Health and ADB. 2018. *Technical Report I: Rapid Assessment of the Implementation of the Health Sector Strategic Master Plan (2006–2015) and Review of the Major Health Sector Reforms Conducted since 1990s in Mongolia*. Ulaanbaatar.

In such an unstable and frequently changing political environment, the PHC reforms require longer and more consistent TA, resources, and advocacy efforts. Interruptions that occurred in ADB support underline the importance of continued and consistent assistance. The resumption of ADB support should focus on assisting the government and other stakeholders in implementing the future directions.

As an essential part of the overall health system, PHC development should be strongly linked and coordinated with the development of other areas of the health system. Challenges that remain in areas such as health system governance, human resources, financing, and referrals must be addressed so that they do not hamper efforts to improve PHC.

## V. FUTURE DIRECTIONS

The Declaration of Alma-Ata of 1978 serves as a global guidance for development of PHC in countries, including Mongolia.<sup>67</sup> The Global Conference on Primary Health Care held in Astana in 2018 reaffirmed the commitments expressed in the Declaration of Alma-Ata and the 2030 Agenda for Sustainable Development.<sup>68</sup> The Astana Declaration serves as the most recent global and updated guide on PHC for all countries and stakeholders involved.

The Astana Declaration envisions that PHC should be of “high quality, safe, comprehensive, integrated, accessible, available and affordable for everyone and everywhere, provided by the health professionals who are well-trained, skilled, motivated and committed.” It highlights that “strengthening PHC is the most inclusive, effective and efficient approach to enhance people’s physical and mental health, as well as social well-being,” and that PHC is a cornerstone of a sustainable health system for universal health coverage and the health-related Sustainable Development Goals.

The Astana Declaration prioritizes addressing inequity in health and ensuring access of all to PHC, particularly the poor and vulnerable. It gives importance to addressing the growing burden of noncommunicable diseases and aging of the population; including preparedness for public health emergencies both in the global and local contexts. The Astana Declaration continues to emphasize the importance of health promotion and disease prevention, and confirms commitments of the PHC to deliver a comprehensive range of continuous and interlinked preventive, promotive, curative, rehabilitative services, and palliative care, and with a functional referral system between primary and other levels of care.

High priority is given to appropriate allocation and retention of human resources, ensuring their motivation through knowledge and capacity building and proper compensation mechanisms. The importance of using high-quality, safe, effective, and affordable medicines, vaccines, diagnostics, and other technologies, including ICT in PHC, are specifically stated. The declaration urges countries to continue to invest in PHC, provide adequate financing, and use appropriate reimbursement systems, based on the national context. It advises involvement and participation of individuals, families, communities, and civil society to ensure that the health needs of the various population groups are fully met. The declaration reaffirms the primary role and responsibility of governments at all levels, and calls for multisector action involving all stakeholders, including international partners, agencies, and funds, to

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<sup>67</sup> International Conference on Primary Health Care. 1978. *Declaration of Alma-Ata*. Alma-Ata.

<sup>68</sup> Global Conference on Primary Health Care. 2018. *Declaration of Astana*. Astana.

align with national policies, strategies, and plans to take joint actions to build stronger and sustainable PHC toward achieving universal health coverage.

At the national level, the Government of Mongolia recently developed the State Policy on Health, 2017–2026; and the Action Plan for Implementation of the State Policy on Health (or the Health Sector Master Plan), 2020–2026.<sup>69</sup> The Health Sector Master Plan was developed with TA from ADB and the Japan Fund for Poverty Reduction. The Health Sector Master Plan is meant to provide the health sector of Mongolia with medium-term guidance, and serves as a platform for a coordinated response, involving all stakeholders to ensure effective use of public, private, and international investments.

The Health Sector Master Plan foresees immediate and longer-term goals and actions to further strengthen and improve PHC. These include improving delivery of essential services provided at the PHC level through strengthening laboratory diagnostics, day care, rehabilitation, and home care, as well as mobile services for remote population and emergency trauma care provided along the main roads and railway. The PHC will play an integral part and serve as an entry point in national plans to increase the coverage of target populations by expanding current programs and introducing new programs into the system for nationwide screening, early detection, and follow-up of most common communicable and noncommunicable diseases. Integration of primary and referral levels of care in Ulaanbaatar is planned as part of the integrated delivery of services through coordinated networks, and supported by establishing nationwide standardized systems for appointment, referral, and clinical handover. Special attention should be given to further improve access for the poor and vulnerable groups in close collaboration with the social welfare system.

The government intends to back up planned expansion of PHC and services in relation to resources by increasing funding for PHC and achieving the WHO recommendation for per-capita spending. The government also plans to improve financing mechanisms by regularly reviewing and implementing recommendations to prevent perverse incentives and improve the performance of health organizations based on an assessment of the effectiveness of payment methods. Better definition of directions of works and services that should be implemented within the framework of public–private partnerships will contribute to improving the governance of partnership-managed family health centers. Coordinated and comprehensive information and communication campaigns to further promote PHC will play a crucial role in the success of efforts to improve PHC in Mongolia.

## VI. CONCLUSIONS

The establishment of PHC as a fundamental platform of the health system continues to be a difficult task globally. It remains a challenge for Mongolia as well, with its long-standing culture that prefers hospital care and inpatient services.

Over the past 3 decades, the government has achieved significant results such as the establishment of family health centers that provide PHC in urban areas, and strengthening the provision of PHC in rural SHCs. The PHC reforms in Mongolia directed the shift from the hospital-based curative services toward PHC and preventive approaches in the provision of health care services as a first step. Mongolia's PHC reforms included restructuring the old system and introducing new management models based

<sup>69</sup> Government of Mongolia, Ministry of Health. 2020. *Order of the Minister of Health A/103*. Ulaanbaatar.

on public–private partnerships, increasing the range of services provided, introducing more effective financing methods, building human resources, and creating better infrastructure.

Extending the significant results achieved during the last 30 years with ADB support will depend on providing high-quality essential services that address the needs of and ensure participation of people, which are delivered from well-equipped and comfortable facilities. Consequently, there is a need to regularly ensure presence and retention of capable staff motivated by appropriate incentives, sufficient funding and investments in services and infrastructure, effective governance and management systems, and a tightened referral system, which encourage the use of PHC as a gatekeeper. Likewise, the concept of family medicine should be effectively and continuously marketed to the general public.

Primary health care is an essential and integral component of an interlinked health care system. Therefore, further assistance from ADB in supporting PHC reform in line with consolidated efforts to reform and improve the entire health care system in Mongolia will be important.

## GLOSSARY

<i>aimag</i>	provincial administrative unit in Mongolia
<i>soum</i>	administrative subdivision below an <i>aimag</i> , comparable to a county
<i>bagh</i>	administrative subdivision below a <i>soum</i> , comparable to a village
<i>khoroо</i>	administrative subdivision below a district

## **Supporting Primary Health Care in Mongolia**

*Experiences, Lessons Learned, and Future Directions*

Since the early 1990s, the Asian Development Bank (ADB) has broadly supported health sector reforms in Mongolia. This paper describes primary health care (PHC) in Mongolia and ADB support in its reform. It highlights results achieved and the lessons drawn that could be useful for future programs in Mongolia and other countries. PHC reform in Mongolia aimed at facilitating a shift from hospital-based curative services toward preventive approaches. It included introducing new management models based on public–private partnerships, increasing the range of services, applying more effective financing methods, building human resources, and creating better infrastructure. The paper outlines remaining challenges and future directions for ADB support to PHC reform in the country.

### **About the Asian Development Bank**

ADB is committed to achieving a prosperous, inclusive, resilient, and sustainable Asia and the Pacific, while sustaining its efforts to eradicate extreme poverty. Established in 1966, it is owned by 68 members—49 from the region. Its main instruments for helping its developing member countries are policy dialogue, loans, equity investments, guarantees, grants, and technical assistance.



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