

ADB SUPPORT IN  
THE HEALTH SECTOR REFORM IN MONGOLIA

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# RATIONALIZING MONGOLIA'S HOSPITAL SERVICES

EXPERIENCES, LESSONS LEARNED,  
AND FUTURE DIRECTIONS

*Altantuya Jigjidsuren, Bayar Oyun, and Najibullah Habib*

NO. 37

August 2021

ADB EAST ASIA  
WORKING PAPER SERIES



ADB East Asia Working Paper Series

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Altantuya Jigjidsuren, Bayar Oyun,  
and Najibullah Habib

No. 37 | August 2021

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Printed in the Philippines

Publication Stock No. WPS210305-2  
DOI: <http://dx.doi.org/10.22617/WPS210305-2>

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## **ACKNOWLEDGMENT**

The authors would like to thank Claude Bodart, former ADB staff, and currently health, social protection and elderly care specialist and international advisor, Beijing Normal University, for the peer review.

## **ABBREVIATIONS**

ADB	Asian Development Bank
FHSDP	Fourth Health Sector Development Program
HIF	health insurance fund
HSDP	Health Sector Development Program
MOF	Ministry of Finance
MOH	Ministry of Health
RDTC	regional diagnostic and treatment center
SHSDP	Second Health Sector Development Program
TA	technical assistance
THSDP	Third Health Sector Development Program

## EXECUTIVE SUMMARY

Before the 1990s, Mongolia had a health care system that largely depended on curative hospital-based services, even at the primary health care level. The hospital sector was characterized by the extensive use of an excessive number of acute beds, large number of medically unjustified admissions, and lengthy hospital stays. The population developed an attitude that preferred specialist care and inpatient treatment.

The economic collapse in the early 1990s necessitated socioeconomic reforms in the transition to a market economy, and the Government of Mongolia started the reform of the health sector. Since 1997, the Asian Development Bank (ADB) has consistently supported this reform of the hospital sector, which has achieved significant results in rationalizing hospital services by improving the governance and autonomy of public hospitals; promoting a model of multifunctional district general hospitals; building capacity in hospital management; reforming hospital financing; establishing licensing of health care professionals and licensing and accreditation of hospitals; and developing private hospital sector regulations.

The hospital reform has faced challenges, such as frequent changes in national plans and priorities; lack of capacities in implementing reforms that require comprehensive approaches; and opposition from institutions and hospital managers that could potentially lose their power or positions. These challenges generated lessons that illustrated that reforming the hospital sector requires significant time and effort to generate understanding and gain support of all stakeholders, as well as to translate these efforts into binding national legislation and regulations.

There is also a need in Mongolia, and especially in Ulaanbaatar, for a rationalization of the hospital sector through planning and investing into hospital services based on the needs of the population, a significant decrease in the number of acute hospital beds, the merging of public single-profile specialist facilities with multifunctional general hospitals, and better regulation of the private hospital sector. It should be complemented by the optimization of services through the gradual shift of resources from referral hospitals to primary health care.

This paper describes the hospital sector in Mongolia, results of reforms, challenges that remain, and ongoing, as well as future directions in the reform. The experience gained from ADB's support for hospital reforms in Mongolia and the lessons learned could be useful for future programs in Mongolia and other countries.



# I. NEED FOR RATIONALIZATION OF HOSPITALS

## A. Hospital Sector in Mongolia before the 1990s

Before the 1990s, Mongolia had a health care system that largely depended on hospital-based services.<sup>1</sup> It was characterized by the prevalence of curative services even at the primary health care level. For example, hospitals with 15–30 inpatient beds (mostly for noncomplicated medical conditions) operated in rural *soums* (subprovinces) with an average population of 2,000–3,000 people. At the referral level in rural areas, *aimag* (province) general hospitals provided multispecialty outpatient and inpatient services, and mobile services for the rural population. Each *aimag* general hospital had, on average, 200–250 beds that were used to provide inpatient services in internal medicine, general surgery and trauma, pediatrics, obstetrics, neurology, infectious diseases including tuberculosis, and emergency care. These general hospitals covered the entire population of their respective *aimags*, received referrals from all *soum* hospitals, and deployed emergency care teams to remote areas when necessary.<sup>2</sup>

While the overall system in rural areas worked well, the situation in the capital city, Ulaanbaatar, was significantly more complicated. In Ulaanbaatar, medical services were provided by multiple health care facilities such as ambulatories, polyclinics, district hospitals, maternity hospitals, and specialized hospitals. Separate outpatient clinics for adults and children were designed to provide outpatient medical services, and depending on the number of medical specialists, were called ambulatories (up to five specialists) or polyclinics (10–15 specialists and diagnostic services). District hospitals (with 100–200 beds) were designed to provide inpatient medical services; however, their services were limited to internal medicine and pediatrics. Maternity hospitals functioned as separate facilities for childbirth services only. In addition, there were a number of tertiary-level state general hospitals that provided services not available at the *aimag* and district level; and specialized single-profile hospitals that provided services for specific diseases, such as maternal and child health, communicable diseases, including tuberculosis and sexually transmitted diseases, trauma, psychiatry, oncology and dermatology, and other hospitals providing care based on the occupation of patients, such as for high-level government officials, railway workers, or military and special forces.

The hospital budgets were determined by existing bed capacity and staff numbers, and financed through a fixed, line-item allocation for staff salaries, operating costs, medicines, etc. Most hospitals in Mongolia were built in the 1970s–1980s. Some specialized single-profile hospitals were built with external assistance, but most hospitals, such as district and *aimag* hospitals, and *soum* hospitals were built by the Government of Mongolia based on building and construction standards that lacked planning for requirements in the provision of medical services.<sup>3</sup> There was a lack of modern medical equipment and supplies. Coordination between outpatient and inpatient departments of hospitals was inefficient, due to the absence of the system for rotation of doctors between these departments. Day care and palliative care were not practiced, and nursing care was considered only as a supplementary service. That led to the use of acute hospital beds for the care of chronically ill patients. Systems for licensing and accreditation of hospitals and licensing of medical professionals were nonexistent. Monitoring of hygiene standards and infection prevention in hospitals was carried out by a separate network of sanitary–epidemiological stations. Complaints from clients were used as a part of punitive mechanisms for internal and external

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<sup>1</sup> Before 1990, Mongolia established a health care system based on the Semashko model, characterized by strong central planning and responsibility in both financing and delivery of health care at the state level. All health facilities were public-owned and staffed with civil servants on a uniform pay scale.

<sup>2</sup> There are 21 *aimags* in Mongolia. As of 2018, the smallest *aimag* has a population of 17,444. The biggest *aimag* has a population of 133,258.

<sup>3</sup> Mostly with assistance from the former Soviet Union and Czechoslovakia.

control to enforce quality of care and services in hospitals. Mechanisms such as client surveys that would help hospitals in identifying their opinion and satisfaction with services were not practiced.

Overall, the hospital sector was characterized by the extensive use of an excessive number of acute beds, a large number of medically unjustified admissions, and lengthy stays in hospitals. Consequently, the population developed a preference for specialist care and inpatient treatment. The quality of care at all levels was low.

## **B. Initial Government Initiatives to Reform the Hospital Sector**

In Mongolia, the economic collapse due to the withdrawal of assistance from the Soviet Union in the early 1990s generated reforms in the transition to a market economy. Consequently, the government began the health sector reform by establishing family health centers in urban areas to provide primary health care.<sup>4</sup> This was done to dilute and reallocate the concentration of resources for hospital-based inpatient services in favor of primary and public health services. At the same time, government-initiated reforms in the hospital sector provided opportunities for the private sector to engage in the health care business; use of management contracts and privatization of public district hospitals in Ulaanbaatar; establishment of regional diagnostic and treatment centers (RDTCs) in regional centers; and establishment of governing boards for public hospitals.

The new Constitution of Mongolia (1992) provided a legal basis for establishing private entities, including private hospitals and clinics that were previously nonexistent. The first private health care facilities were mostly small clinics with no beds, and small hospitals with up to 30 beds, mainly in Ulaanbaatar, which rented small premises next to the public hospitals, and were operated by a single specialist who worked simultaneously in the public sector. The first private hospitals had limited diagnostic and treatment capacity, and relied purely on direct payments. Shorter waiting times, flexible working hours, and client-oriented services were the main reasons people preferred private clinics and hospitals. However, private sector participation in health care delivery was not supported by mechanisms that would help the government to properly regulate the private sector.

In 1996, the government began its first reform efforts, one of which was to privatize the social sector, including issuance of pilot management contracts for a few health care facilities, such as a district hospital, a health center, and a sanatorium in Ulaanbaatar. Management functions were transferred to competitively selected management teams, with the expectation of improved operational efficiency and quality of services. The pilot experienced difficulties, since the legal environment and preparations were not complete, and the previous debt of the selected facilities was not sorted out.<sup>5</sup> However, based on the initial promising results of a pilot management contract for one pilot district hospital (Bayanzurkh district hospital), the government privatized the hospital in 2004. This was the first and the last experience of the government to date in privatizing a public hospital. Other facilities in the pilot continued operating under management contracts that had been renewed several times, despite the absence of evidence of positive effects on hospital efficiency, productivity or quality of services, and patient satisfaction.<sup>6</sup>

Another reform, the establishment of hospital boards, was intended to provide more autonomy for public hospitals and ensure community involvement in hospital management and decision-making. In 1998, the Ministry of Health (MOH) established hospital boards in selected public hospitals that were

<sup>4</sup> A. Jigjidsuren, B. Oyun, and N. Habib. 2021. Supporting Primary Health Care in Mongolia: Experiences, Lessons Learned, and Future Directions. *EARD Working Paper Series* No. 35. Manila: Asian Development Bank (ADB). January. <https://dx.doi.org/10.22617/WPS210020-2>.

<sup>5</sup> Open Society Forum. 2004. *Case Study of Health Sector Privatization*. Ulaanbaatar.

<sup>6</sup> Asia Pacific Observatory on Health Systems and Policies. 2013. Mongolia Health System Review. *Health Systems in Transition*. 3 (2).

meant to appoint the hospital executives; guide strategic planning; approve the hospital's organizational structure, staff number, and budget; and to promote improvements in the quality of care.<sup>7</sup> However, the initiative was not backed up by corresponding changes in legislation and regulations. Also, advocacy and capacity building efforts to help implement these changes proved to be insufficient. Several problems immediately arose, such as tensions between the board and hospital executive management due to unclear roles and responsibilities; as well as interference with existing old laws and regulations, which MOH alone was not able to resolve.

In 2001, as part of the policy on decentralization and regional development, another reform initiative established RDTCs in three regional hubs. RDTCs were designed to have more advanced diagnostic and treatment capabilities than *aimag* general hospitals, provide tertiary level services, and serve as regional referral hubs. These RDTCs were provided some advanced diagnostic equipment; however, they did not receive any additional recurrent funding to finance the cost of tertiary care. Neither was there a system for attracting and retaining high-level specialists to staff these centers. Thus, RDTCs were not developed into more advanced institutions, and currently their functions and capabilities do not differ from those of ordinary *aimag* general hospitals.<sup>8</sup> RDTCs receive only a very small number of referrals from neighboring *aimags* and do not serve the intended purpose of being regional referral hubs.

## C. Current Issues in the Hospital Sector

### (i) Public Hospital Sector

The hospital sector consumes the largest portion (61%) of total public health expenditure (Table 1). The public hospital sector accounts for 48% of total hospital beds and 62% of total hospital admissions. Since the 1990s, the general objective in Mongolia has been to reduce the number of hospital beds in the public sector and decrease the length of stay. Although the average length of stay has dropped significantly, from 12.3 days in 1998 to 7.1 days in 2018, there has been no significant reduction in the number of hospital beds.<sup>9</sup> Nationwide, it remains high: 78.8 beds per 10,000 population in 2018, compared to a western model of 35 beds per 10,000 population (Table 2).<sup>10</sup>

**Table 1: 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:			
Primary health care	18,568 (25%)	47,496 (19%)	101,492 (16%)
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 = Mongolian togrog.

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

<sup>7</sup> Boards were established for each of the 11 general hospitals and specialized centers under MOH, and the 21 *aimag* general hospitals. M. O' Rourke et al. 2003. Community Involvement in Health in Mongolia: Hospital Boards and other Participatory Structures. *Australian Health Review*. 26 (1).

<sup>8</sup> Currently, there are five RDTCs in Dornod, Khovd, Orkhon, Umnugobi, and Uvurkhangai *aimags*.

<sup>9</sup> The number of hospital beds in Ulaanbaatar declined from 110 in 1998 to 89.8 in 2018 per 10,000 population. However, the national average increased from 75 hospital beds per 10,000 population in 1998 and 78.8 per 10,000 population in 2018.

<sup>10</sup> Government of Mongolia, Ministry of Health et al. 2010. Framework for the Development of a Strategic Hospital Development Plan for Ulaanbaatar. *Discussion Paper*. Ulaanbaatar.

**Table 2: Selected Indicators of the Public Hospital Sector in Mongolia, 2018**

	Aimags General Hospitals and RDTCs		District Hospitals		State General and Specialized Hospitals	
	Number	Share of Total (%) <sup>a</sup>	Number	Share of Total (%) <sup>a</sup>	Number	Share of Total (%) <sup>a</sup>
Hospitals	21		8		9	
Beds	5,328	21.5	2,528	10.2	3,990	16.0
Outpatient visits	4,126,708	14.5	2,370,864	14.4	1,395,449	8.5
Inpatient admissions	199,396	25.6	125,096	16.1	159,491	20.5
Average length of stay	7.1		6.6		8.3	
Doctors	1,644	14.7	869	7.8	1,258	11.3
Nurses	2,513	20.3	981	7.9	2,035	16.4

RDTC = regional diagnostic and treatment center.

<sup>a</sup> From total public and private hospitals in the country.

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

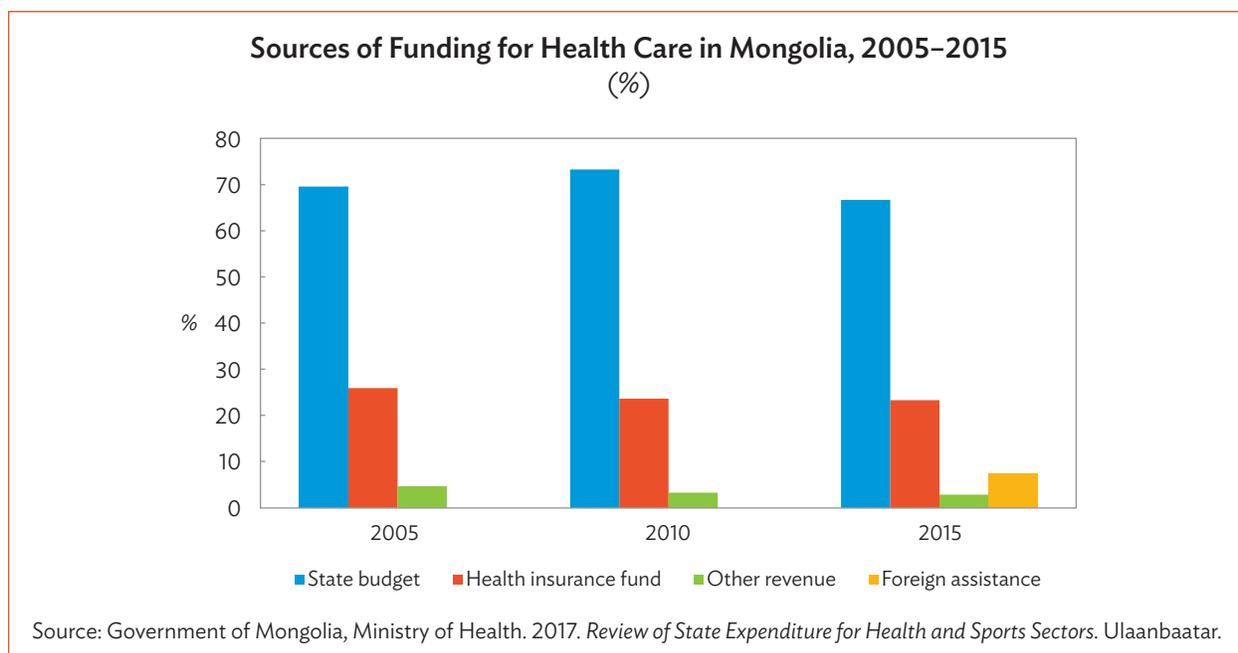
Public hospitals mostly serve poor and low–middle–income people, while higher–income people tend to seek medical services at private hospitals or abroad.<sup>11</sup> The poor quality of health services in public hospitals is considered a major problem.<sup>12</sup> International experience and best practices tend to confirm that the lack of autonomy in decision–making in public hospitals, especially in relation to financing, human resources management, and procurement, is an important determinant of poor health service delivery.<sup>13</sup> After unsuccessful attempts to reform the management of public hospitals, such as the introduction of management contracts and hospital governing boards, they remain fully state–owned public institutions with minimal autonomy with regard to their organization and functions, finances, and human resources. The MOH manages state general and specialized hospitals. District health centers and district hospitals are managed by the Ulaanbaatar City Governor’s office, and *aimag* general hospitals by the *aimag* governor’s offices. The government continues to micromanage public hospitals by defining public hospitals’ plans, and practicing strict control over their finances, investments, and human resources.

The health care financing system for the hospital sector is fragmented and inefficient. The two main sources of funding, the government (state) budget and the health insurance fund (HIF) (Figure), have different systems for coverage, payment, financing, planning, and monitoring. Services such as pediatrics, maternity, infectious diseases, oncology, and mental health services are fully funded from the state budget through a passive and ineffective system of line–item allocations that are not reflective of the actual costs and volume of services. The HIF covers other hospital services and uses a more advanced case–based payment system, but tariffs are poorly related to the actual cost of services;

<sup>11</sup> ADB. 2010. *Technical Assistance to Mongolia for the Fourth Health Sector Project*. Manila.

<sup>12</sup> Ts. Lkhagvasuren. 2016. *Quality and Safety of Hospital Care and Services in Mongolia*. Ulaanbaatar.

<sup>13</sup> The poor performance of public hospitals is explained by the incentive system the hospitals face, in which autonomy of decision–making plays an important role. A 2003 World Bank report stated that incentives result from, first, pressures originating from the external environment; and second, the hospital’s managerial instruments. External pressures are government oversight, organized purchasing (e.g., health insurance), market pressures, and governance from the owners of the hospital. Managerial instruments are reflected in the authority or autonomy given to its managers, the market environment created by the provider payment mechanism and exposure to competition, the extent to which the hospital keeps its surpluses and is responsible for its losses and debts, accountability mechanisms, and the extent to which social functions of the hospital are explicit and fully funded. A. Harding and A. S. Preker, eds. 2003. *Innovations in Health Service Delivery*. Washington, DC: World Bank.



in particular, they do not cover the costs associated with diagnostic services. Besides that, the HIF does not cover most outpatient services including prescription medicines, and therefore encourages inpatient rather than outpatient services. This fragmentation has led to a significant gap in service coverage that is directly shouldered by patients through high out-of-pocket payments.<sup>14</sup> Both the HIF and the state budget use rigid financing and accounting procedures. Accordingly, hospital managers lack autonomy over their finances, and cannot reallocate resources between line items in the budgets without permission from the Ministry of Finance (MOF). Savings generated as results of cost-effective measures are automatically returned to the treasury at the end of the fiscal year. These constraints do not encourage hospital managers to become more efficient.

There is still no system and leading institution for the training and retraining of hospital managers. Management capacity in the hospital sector is low because directors and managers are mostly experienced medical doctors, but not specifically trained in hospital management. The curricula and training programs of the training institutions that offer management courses either focus on general management, financing, and economics. The content of the standard programs is mostly focused on the areas of competency and professional qualifications of the teaching staff, rather than oriented toward the training needs of health managers.<sup>15</sup> There is also no system established for planning and managing health sector human resources. The MOH was unable to control the supply of human resources in the health system, as medical schools are run by the Ministry of Education, and there was a reverse incentive to enroll as many students as possible to collect tuition fees. This has led to a constant oversupply of doctors and a shortage of nurses.<sup>16</sup> Staffing in hospitals is based on national standards that often do not reflect the real needs for health care facilities to provide services. Fixed government salary schemes leave

<sup>14</sup> Out-of-pocket expenses are estimated at 41% of total health expenditure in 2012. WHO. 2012. *Global Health Expenditure Atlas, 2012*. Geneva.

<sup>15</sup> Government of Mongolia, Ministry of Health et al. 2016. *Project Strengthening Hospital Autonomy in Mongolia: Rapid Training Provider Assessment*. Ulaanbaatar.

<sup>16</sup> As of 2018, the shortage of nurses remains the problem, with the ratio of doctors to nurses is 1:1. European Observatory on Health Systems and Policies. 2007. *Mongolia Health System Review. Health Systems in Transition*. 9 (4).

no room for hospital managers to reward staff for good performance. This results in less motivated staff and the low performance of public hospitals, including poor quality of services.<sup>17</sup>

Public hospital infrastructure is outdated and does not meet the standards and requirements for providing modern medical services. While buildings of relatively new state general and some specialized hospitals are still in an acceptable condition, buildings of most *aimag* and district general hospitals are old and outdated. This is a particular issue in Ulaanbaatar, where many hospitals use buildings that were originally planned for offices and purposes other than the provision of medical services. Recently, the government has tried to increase capital investment in the health sector to build new hospitals, and to expand and renovate existing hospital buildings.<sup>18</sup> However, there is no capital investment planning system in place, and hospital construction standards are still based on old Soviet Union codes and norms. This raises questions on the efficiency of investing in new hospital buildings using outdated standards and processes, and spending funds to maintain old, obsolete hospital buildings.

Of particular concern is the irrational structure of hospital services in Ulaanbaatar, delivered through non-standardized, mono-profile hospitals and centers, as well as district hospitals with limited services. This is compounded by poorly functioning referral services and a lack of service integration between outpatient and inpatient services, as well as between primary and referral levels of care. Alternatives to inpatient services such as day care, home care, and long-term palliative and nursing care are at an early stage of development, as they have not been adequately supported by financial and other incentives.

## (ii) *Private Hospital Sector*

By introducing licensing for private businesses in 1999, the government sought to standardize and regulate the private health care sector and ensure a minimum level of quality. In 2001, when the government adopted a new law on licensing of private businesses, there were already more than 400 private hospitals and clinics established nationwide. The issuance of licenses for health facilities with the services covering specific *aimags* or districts were decentralized to local government offices. The MOH has carried out licensing of hospitals with national coverage of services or those with foreign investment. The licensing criteria and requirements were few and simple, and the licensing process was easy and based only on documentation, without any verification process and subsequent monitoring and evaluation. Licenses issued were neither based on a consideration of the health needs of the population, the planning of services, nor on the numbers and distribution of providers that would be optimal for a given population. The lack of bureaucratic oversight, and the absence of certification of need as a condition for processing applications for the creation of new health facilities, led to a huge increase in the private health sector (Table 3). Government health care facilities have been granted licenses but with no requirements to fulfill, and no requirements for renewal. Health care facility accreditation was created at the same time as the licensing system. The accreditation requirements and regulations were not much different from those related to licensing. Accreditation was voluntary but became a main condition for both public and private hospitals to receive funding from the HIF.

Poor regulation of the private hospital sector has contributed to its unregulated and unplanned growth, while not meeting the actual needs of the population. Government policies to encourage development of the private health care system were intensified by middle- and high-income people, who choose to avoid the public health care system because of its low quality of service, long waiting times, aging facilities, and obsolete medical procedures and technologies. The private health sector, in terms of the number of facilities, is twice as large as the public health sector. However, they account for only 22.8% of hospitalizations and 15.1% of specialist consultations. The private health sector also tends to be focused

<sup>17</sup> Government of Mongolia, Ministry of Health. 2005. *Health Sector Strategic Master Plan 2005–2015*. Ulaanbaatar.

<sup>18</sup> Government of Mongolia, Ministry of Health. 2017. *Review of State Expenditure for Health and Sports Sectors*. Ulaanbaatar.

**Table 3: Selected Indicators of the Private Hospital Sector in Mongolia, 2000–2018**

Indicator	2000	2005	2010	2015	2018
Number of private hospitals with beds	466	160	166	224	243
Number of private clinics (no beds)		523	947	1,006	1,340
Number of beds in private hospitals	964	1,982	2,527	5,262	5,985
Proportion of total (public and private) hospital beds in the country (%)	5.4	10.8	14.2	24.2	24.1
Number of doctors in the private sector	736	1,145	1,549	2,698	3,694
Number of nurses in the private sector	296	682	1,007	1,941	2,480
Number of outpatient visits		1,016,705	1,036,934	1,912,718	2,485,979
Number of inpatient admissions	23,592	63,267	86,117	142,052	177,492
Average length of stay	11.3	9.0	7.9	7.0	7.0

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

on less serious cases due to its smaller-scale facilities, limited services, and lack of emergency and intensive care capacity. The licensing and accreditation systems have not helped to limit the proliferation of private health care facilities or improve the quality of health services. In 2006, a World Bank study cautioned that “the unregulated growth of the private sector is a recipe for a future disaster, as Mongolia already has too many hospitals and health professionals.”<sup>19</sup>

The unregulated growth of the private sector exacerbated the hedge against financial risks associated with a high volume of direct out-of-pocket payments, cost escalation, and unnecessary treatments.<sup>20</sup> The main source of funding for private hospitals is direct user fees. Although the HIF reimburses costs in private hospitals, it used to apply much lower tariffs for the same group of diseases compared to those for public hospitals. The government recently decided to apply similar tariffs for services provided by public and private hospitals from the HIF.<sup>21</sup> This intends to level the playing field for private hospitals, reduce the workload in public hospitals, and reduce the financial burden on people. However, there is still no system for regulating or monitoring the volume of direct payments in the private sector and controlling the overall cost escalation.

The same situation prevails as to quality of services in private hospitals—there is no quality control system. The claim review process system of the HIF is weak and not focused on ensuring the quality of hospital services for the insured. Unnecessary admissions, as well as unnecessary treatments and procedures are still an issue. There is also no strong system for the accurate collection of data from private hospitals. The absence of an efficient, integrated information management system that captures both the private and public sectors is a serious problem that hampers the overall efficiency of the system.

<sup>19</sup> World Bank. 2006. *The Mongolian Health System at Crossroads: An Incomplete Transition to a Post-Semashko Model*. Washington, DC.

<sup>20</sup> J. Dorjdagva 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>21</sup> Government of Mongolia, Health Insurance National Council. 2019. *Resolution No 28: About Approving Tariffs, Lists, Coefficients and Guidelines*. Ulaanbaatar.

## II. ADB SUPPORT FOR RATIONALIZATION OF HOSPITAL SERVICES

Since the start of its support to reform the health sector in Mongolia, ADB has funded various programs and extended technical assistance to support the government in the reform of the hospital sector. ADB's assistance has aimed at rationalization of hospital services, improvement of hospital governance, capacity building in hospital management, improvement of hospital financing systems, and introduction of regulatory mechanisms to improve quality of hospital services.

### A. Rationalization of Hospital Services

ADB's support in the rationalization of hospital services began with the Health Sector Development Program (HSDP), 1997–2003.<sup>22</sup> The HSDP supported mostly primary health care, and its major achievement was the establishment of family group practices in urban (capital city and province centers) areas. Since the smooth operation of primary health care requires support from the hospital sector, the HSDP made initial attempts to streamline hospital services. A plan was developed that was to consolidate public hospitals in Ulaanbaatar. This plan was supported by a human resource management plan to reduce the number of hospital staff in the public sector through redeployment to rural hospitals. However, the HSDP's efforts to rationalize hospitals coincided with the beginning of the rapid growth of the private health sector without prior introduction of appropriate legal and regulatory measures, including licensing and accreditation systems. The rationalization plan was not realized, and toward the end of the program, it became clear that hospital rationalization will not succeed unless the government recognizes the fundamental need to reorient and consolidate hospital services to a level that meets the real needs of the population.<sup>23</sup>

The Second Health Sector Development Program (SHSDP), 2003–2010 along with its major focus on improving health service delivery in rural areas planned to renew previous efforts to reduce the number of doctors in secondary and tertiary level hospitals in Ulaanbaatar, by providing incentives to work in rural areas.<sup>24</sup> However, this again failed to be realized due to the resistance of the MOF and Ulaanbaatar hospital managers to reallocate funds to rural hospitals.

The Third Health Sector Development Program (THSDP), 2007–2014 contributed, through advocacy and capacity building, to consolidating policy views in several areas of health system reform, including hospital rationalization.<sup>25</sup> The advocacy efforts of the THSDP helped decision makers understand the importance of making the public hospital sector more effective through rationalization. As a result, the government requested ADB to support hospital rationalization as the major and focused component of the Fourth Health Sector Development Program (FHSDP), 2012–2020.<sup>26</sup>

<sup>22</sup> ADB.1997. *Report and Recommendation of the President to the Board of Directors: Proposed Loans and Technical Assistance Grant to Mongolia for the Health Sector Development Program*. Manila.

<sup>23</sup> Operations Evaluation Department. 2008. *Performance Evaluation Report: Health Sector Development Program in Mongolia*. Manila: ADB.

<sup>24</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.

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

<sup>26</sup> ADB. 2010. *Report and Recommendation of the President to the Board of Directors: Proposed Grant to Mongolia for the Fourth Health Sector Development Project*. Manila. The FHSDP's component on hospital rationalization continues with the construction of a demonstration hospital in Songinokhairkhan district of Ulaanbaatar. All the technical tasks under this component were accomplished. The other two components on hospital management training and safety of medicines are being completed.

The FHSDP assisted the MOH in developing the National Hospital Development Policy, 2014–2023 and its medium-term implementation plan.<sup>27</sup> Subsequently, the main policies outlined in these documents

were integrated into the State Policy on Health, 2017.<sup>28</sup> Main policy directions include rationalizing hospital services in accordance with the actual needs of the population, as well as trends in morbidity and mortality, granting autonomy to improve management in public hospitals, and pursuing better regulation for the private hospitals.

To develop a much-needed capital planning system that would enable the MOH to make evidence-based decisions on capital and equipment investments, the FHSDP helped the MOH in assessing the infrastructure and equipment inventory in the public health sector. Based on the results of the assessment, the FSHDP developed an equipment inventory database and equipment planning software for medical and information technology equipment, and translated the Universal Medical Device Nomenclature. The MOH issued regulations on the use of the medical inventory database for prioritization and planning of investments in medical equipment. The database was not regularly updated though, and is no longer used by the MOH.

The major output of the FHSDP is to turn the Songinokhairkhan district hospital in Ulaanbaatar into a multifunctional general hospital to demonstrate the new concept of hospital care at the district level. During construction of the hospital, new processes in concept design, functional planning, and construction were used for the first time in the Mongolian public hospital setting. The new Songinokhairkhan district hospital will provide outpatient and inpatient services (200 beds) in at least seven basic specialties and have an integrated obstetrics and gynecology, general surgery and traumatology, cancer, infectious disease services, and dental care services for the district population. It will pilot concepts and practice of day care and surgery, ensure rotation of doctors between outpatient and inpatient services, and establish better linkages with available long-term health care facilities. The hospital will also be a reference for innovative hospital infrastructure and clinical and management systems.<sup>29</sup> It is expected that this model will be gradually rolled out to other districts of Ulaanbaatar.

The multitranche Improving Access to Health Services for Disadvantaged Groups Investment Program, 2019–2029 or Sixth HSDP intends to improve access to quality primary and district level health services in Ulaanbaatar.<sup>30</sup> The project will further support the hospital rationalization by restructuring general hospitals in Chingeltei and Khan-Uul districts, which will be similar to the demonstration hospital built in Songinokhairkhan district by the FHSDP. In addition, low-carbon technology energy resources will be piloted in a new Khan-Uul district hospital. The program will also assist in reforming the emergency care system linked with general hospitals, integrating secondary and primary level services.

## **B. Hospital Governance and Autonomy**

ADB began supporting reforms to improve the management of public hospitals in 1997 through the HSDP (footnote 22). At that time, the overall concept of decentralization of decision-making was a key concern in Mongolia. The HSDP recommended introducing a new model of governance of public

<sup>27</sup> Government of Mongolia, Ministry of Health. 2014. *Order of the Minister of Health No. 55: About Approving National Hospital Development Policy*. Ulaanbaatar; and Government of Mongolia, Ministry of Health. 2015. *Order of the Minister of Health No. 181: About Approving Plan 2015–2019 to Implement the National Hospital Development Policy*. Ulaanbaatar.

<sup>28</sup> With the approval of the Law on Development Policy Planning and the resulting policy on consolidating different level policy documents, the program was abolished in 2017 by the Order of the Minister of Health A/81. About Abolishing the Orders. Government of Mongolia. 2017. *State Policy on Health*. Ulaanbaatar.

<sup>29</sup> Completion of construction works and commencement of services is expected in 2021.

<sup>30</sup> ADB. 2019. *Report and Recommendation of the President to the Board of Directors: Proposed Multitranchise Financing Facility to Mongolia for Improving Access to Health Services for Disadvantaged Groups Investment Program*. Manila.

hospitals through management boards, in order to provide some autonomy for public hospitals in managing their operations. Consequently, in 1999, the MOH established several such management boards in public hospitals, including the eight pilot *aimag* general hospitals of the HSDP. Such boards comprised representatives of local government, hospitals, and communities, and were appointed for 4 years. Hospital boards faced several challenges, including difficulties in selecting board members (vague selection criteria); poor understanding of the boards' roles, responsibilities, and functions; and problems with funding the operations of the board. Hospital management teams perceived boards as an unnecessary and unwelcome innovation that took away their power; and consequently, they did not support the boards. Most importantly, the concept of empowering hospital boards was not backed up by appropriate legal reforms, and ran contrary to many laws and regulations in force at that time. The hospital management board's pilot failed to assimilate in the health system, and the concept was discontinued soon after the HSDP (footnote 23).

In 2007, the THSDP renewed efforts to introduce a new model of governance for public hospitals (footnote 25). The THSDP organized study tours and other capacity building activities to consolidate the thinking of policymakers on hospital governance and autonomy.<sup>31</sup> The THSDP assisted in the development of hospital board bylaws reflecting the principle of corporate governance, by involving the community and professionals in the management of public hospitals. This concept was reflected in the 2011 revision of the Health Law. However, the MOH did not receive support from relevant government agencies in providing the public hospitals some autonomy in managing financial and human resources. Although the MOH had planned to retry piloting the concept of hospital boards in a few hospitals, this stalled due to changing priorities and lack of regulations and operational tools to facilitate empowerment of financial and human resources management. The MOH ceased this attempt in 2013.

The FHSDP continued to build at different levels, including parliament and government, understanding that granting more autonomy to public hospitals can generate more funds for hospitals, increase efficient utilization of resources, and improve access to and quality of services (footnote 26). The FHSDP supported the development of the new Medical Care and Services Law, 2016; and relevant revisions to the Health Law, Budget Law, and state and local Property Law, to enable hospital boards to make decisions on the structure, functions, and finances of public hospitals.

ADB also implemented the technical assistance (TA) on Strengthening Hospital Autonomy in Mongolia.<sup>32</sup> This TA project was designed to support the MOH in developing additional regulations, build capacity, and pilot implementation of the semi-autonomous model of hospital governance envisioned in the abovementioned laws. The TA supported the MOH in reviewing all policy and regulatory documents that govern operations of public hospitals, human resources, and financial management; and in developing a conceptual framework and plan for a phased implementation of hospital autonomy in Mongolia. The TA project assisted in the development of several practical guidelines and templates to facilitate implementation and pilot testing through practical advice and tailored training in four hospitals that MOH selected.<sup>33</sup>

As of the writing of this report, piloting of hospital autonomy in three of the selected hospitals continues. It is clear that changing mindsets requires substantial time and effort, as does granting hospital managers more decision-making rights, balanced with the appropriate monitoring mechanisms.<sup>34</sup> Currently,

<sup>31</sup> ADB. 2015. *Completion Report: Third Health Sector Development Program in Mongolia*. Manila.

<sup>32</sup> ADB. 2015. *Technical Assistance to Mongolia for Strengthening Hospital Autonomy*. Manila.

<sup>33</sup> Includes hospital board by-laws, selection procedures, and criteria for the hospital director and for community representatives in the hospital board; sample contract between the hospital board and hospital director; job description of the hospital director; and framework to facilitate monitoring and evaluation of the operations of the pilot hospitals.

<sup>34</sup> Government of Mongolia, Ministry of Health; Asian Development Bank; and GFA Consulting Group. 2019. *Technical Assistance to Mongolia for Strengthening Hospital Autonomy: Final Report*. Ulaanbaatar.

ADB continues to support the introduction of the semi-autonomous model of governance in public hospitals. The ongoing TA on Improving Health Care Financing for Universal Health Coverage, which started in late 2018, is continuing the pilot initiated under the previous TA project by providing support for operations, capacity building of the boards of selected hospitals<sup>35</sup> in management of financial and human resources.<sup>36</sup> Based on the pilot, it is planned that the semi-autonomous governance model will be expanded to all public hospitals in Mongolia.

### C. Capacity Building in Hospital Management

Traditionally, most managers of public hospitals in Mongolia are medical doctors with no special training in management. This was not of much importance during the socialist period, when the main role of the manager was simply to implement policies and instructions received from the central management, and to spend funds within rigid line-item budgets. However, with greater autonomy, hospital managers and management teams will need planning and management skills to efficiently manage hospital operations. The lack of managerial skills and experience has negatively affected hospital performance, as well as the quality of services and cost efficiency.

Recognizing this, the FHSDP assisted in the development of a competency-based hospital management training module for senior and middle-level public hospital managers in 2014–2015 (footnote 26).<sup>37</sup> There was a plan to integrate this training into the curriculum; however, it was not institutionalized due to the lack of coordination from the MOH and leadership from the training institutions.

The TA on Strengthening Hospital Autonomy in Mongolia resumed efforts to address the issue of building capacity among hospital managers (footnote 32). A training needs assessment and assessment of providers was conducted under this TA project. TA also supported the development of the training concept, training program, and materials, grouped into 10 modules in 6 areas: strategic management and hospital management, human resource management, service quality management, performance and finance management, process management, and training of trainers. They were used for capacity building activities, not limited to hospitals in which hospital autonomy was piloted, but also covering key management staff of all secondary and tertiary level hospitals across the country.<sup>38</sup> However, issues related to institutionalization of the hospital management training remain unresolved due to a continuing lack of coordination and leadership on the part of MOH, and the lack of interest on the part of the respective training institutions. Building the capacity of hospital managers and management teams remains the challenge for Mongolia.

### D. Hospital Financing

ADB's first TA in support of Mongolia's health sector reforms in 1994 assisted the government in introducing a new social health insurance system.<sup>39</sup> This was patterned after the Bismarck model used in different parts of Europe. At that time, direct funding from the state budget had become insufficient for financing health care. The new compulsory social health insurance system aimed to ensure sustainable nontax financing for health care and increase the financial protection of people. The HIF was based

<sup>35</sup> First State Central Hospital, Shastin's Third State Central Hospital, National Dermatology Center.

<sup>36</sup> ADB. 2018. *Technical Assistance to Mongolia for Improving Health Care Financing for Universal Health Coverage*. Manila.

<sup>37</sup> The hospital management training module was developed jointly by the School of Public Health of the National Medical Sciences University, Association of Public Health Specialists, and Academy of Management. A total of 50 public hospital managers have been trained.

<sup>38</sup> In total, some 1,032 managers were trained including hospital directors, human resource and finance managers, quality managers, members of hospital board, and staff of health departments.

<sup>39</sup> ADB. 1994. *Mongolia: Strengthening the Health Insurance System*. Manila. The TA was funded by the Japan Fund for Poverty Reduction.

on compulsory contributions from employees and employers, and on government contributions for vulnerable groups, including children, elderly, disabled, and mothers with children under 2 years old. The HIF began covering hospital services, mostly inpatient hospital care. The government continued to fully subsidize primary health care through the tax-based state budget, and critical hospital services such as pediatric, maternity, infectious diseases, cancer, and mental health services.

Several ADB-funded health sector development programs continued to support the reform of hospital care financing. The TA for Health Sector Reform accompanied the SHSDP and assisted in improving the understanding of output- and performance-based budgeting to support implementation of the Public Sector Finance and Management Law (2002), and in raising effectiveness of the HIF by shifting the health insurance payment system from retrospective payments based on the number of inpatient days, to case-based payments. Intensive work was done on cost analysis and estimation of unit cost of various services at both the hospital and primary level.<sup>40</sup>

The THSDP developed the Health Financing Model for Mongolia that provided recommendations for a new health care financing model that advocated the creation of a single purchaser model through pooling of funds, i.e., combining government and health insurance funds and introducing a universal benefits package (footnote 25).<sup>41</sup> The aim of THSDP was to address issues related to fragmentation in health care financing. Despite the achievement of a relatively high consensus among relevant ministries and the government's approval of the proposed health financing strategy for 2010–2015, its implementation has been suspended due to frequent changes in government officials and shifting priorities.

The THSDP efforts were continued by the TA on Strengthening the Health Insurance System, which focused on improving the financial protection of people by increasing the capacity and performance of the health insurance organization.<sup>42</sup> Although the health insurance coverage had reached 90.4% by 2013, insured people were increasingly dissatisfied with health insurance because of the limited service coverage, poor quality of hospital service and increased out-of-pocket expenditure. The TA project assisted in the establishment of an independent and autonomous health insurance organization, updated the claim review and contracting processes, improved the capacity of the health insurance organization to monitor the quality of hospital services, analyzed the cost of basic health interventions, and increased HIF reimbursement levels and levels of government subsidies.<sup>43</sup>

The TA on Strengthening Hospital Autonomy in Mongolia assisted in defining and costing new diagnostic-related groups (DRGs) for hospital services that are funded from the government budget (footnote 32).<sup>44</sup> Accordingly, in 2019, the MOH and MOF redesigned the current line-item-based financing from the state budget into a case-based payment system and revised the payment tariffs, which became equal for public and private hospitals. The new DRGs are also being used by the MOF to test prospective payments and global budgeting in pilot hospitals (footnote 35).

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<sup>40</sup> ADB. 2004. *Technical Assistance to Mongolia for Health Sector Reform*. Manila.

<sup>41</sup> Government of Mongolia, Ministry of Health. 2010. *Third Health Sector Development Program. Health Financing Model for Mongolia*. Ulaanbaatar. Single purchasing is pooling of funds from different sources, such as government budgets and insurance funds, under one funding agency to allow greater efficiency in contracting, financing, and monitoring services delivery.

<sup>42</sup> ADB. 2013. *Technical Assistance to Mongolia for Strengthening the Health Insurance System*. Manila.

<sup>43</sup> In 2018, health insurance was separated from social insurance under the Ministry of Labor and Social Protection and established as an independent agency under the MOH. ADB. 2018. *Technical Assistance Completion Report: Strengthening the Health Insurance System in Mongolia*. Manila.

<sup>44</sup> Diagnostic-related groups are payment categories that are used to classify patients for the purpose of reimbursing hospitals for each case in a given category with a fixed fee regardless of the actual costs incurred.

The development of a more efficient financing system for public hospitals through an effective service purchasing model and related policy and institutional reforms is being pursued as part of the ongoing TA on Improving Health Care Financing for Universal Health Coverage, started in 2018 (footnote 36). Recent decisions of the MOF to channel the government budget resources through the health insurance organization for better purchasing of hospital services, use global budgeting in combination with the case-based payment system, and introducing performance-based financing were an important value-added output in ensuring the financial autonomy of hospitals. Support for the government's efforts to improve hospital financing systems will continue through the Sixth HSDP, which began in 2019 (footnote 30).

## E. Licensing and Accreditation

The government's first initiatives to establish licensing and accreditation systems were supported by the HSDP (footnote 22). The program supported the creation of a legal environment for licensing health care professionals, and the licensing and accreditation of health care facilities, as reflected in the Health Law (1998). This law supported the creation of a licensing and accreditation unit in 1999, and the development of regulations, such as the Guidelines for Licensing of Health Professionals, 1999; and the Guidelines for Accreditation of Health Care Facilities, 2002.<sup>45</sup> By 2003, most state health care facilities and a dozen private facilities had undergone accreditation.<sup>46</sup> However, the new accreditation was assessed as having little impact on the quality of services, and did not serve to compel service providers to improve diagnostic and treatment processes, pursue better results, and participate in continuous quality improvement.<sup>47</sup> The situation was aggravated by the government's decision in 2003 to make accreditation a condition for receiving health insurance funding, which in the absence of alternative and competing health care providers, made the accreditation process even more formal and undermined the main purpose of accreditation, which is to improve quality of services. The voluntary status of accreditation was reversed in 2006; however, the licensing and accreditation processes still continued without significant changes using the system developed during the HSDP.<sup>48</sup>

The THSDP attempted to review the licensing and accreditation systems as part of its rigorous assessments of private health care regulation and public-private partnerships in the health sector (footnote 25).<sup>49</sup> The THSDP has provided a number of recommendations, including revising the licensing process and procedures to move from a documentary to an outcome-oriented approach, mandatory application of certification of need, and license renewal to open or expand a health facility. It also recommended that accreditation be entrusted to an independent body; and that the revision of accreditation norms related to infrastructure, engineering, water and sanitation, and clinical dependencies be conducted in a unified manner, to ensure coordination and harmonization of licensing and accreditation. Despite THSDP's efforts, implementation of its recommendations stalled, as the

<sup>45</sup> Government of Mongolia, Ministry of Health, Social Welfare and Labor. 1999. Licensing and Accreditation Unit was Established at the Health Information and Education Center (current Health Development Center). *Ministerial Order No. A/42*. Ulaanbaatar.

<sup>46</sup> As of 2000, a database with 3,360 tests for 10 medical specialties was established for the licensing examination of health care professionals. As of December 2003, 741 public and private health care facilities were accredited. G. Ganchimeg. 2011. *Improving System for Management of Quality of Medical Care and Services in Mongolia*. Ulaanbaatar: Health Sciences University of Mongolia. PhD Dissertation.

<sup>47</sup> Government of Mongolia, Ministry of Health et al. 2003. *Health Sector Development Program: Assessment of the Impact and Achievements of the HSDP*. Ulaanbaatar.

<sup>48</sup> ADB. 2010. *Technical Assistance Completion Report. Second Health Sector Development Program in Mongolia*. Manila.

<sup>49</sup> Government of Mongolia, Ministry of Health; ADB, and GVG. 2009. *Third Health Sector Development Program. Private Health Care Delivery and PPP Assessment in Mongolia*. Ulaanbaatar; and Government of Mongolia, Ministry of Health and ADB. 2011. *Third Health Sector Development Program: Private Health Care Regulation and Financing, and PPP in the Health Sector of Mongolia*. Ulaanbaatar.

government moved away from the Health Sector Master Plan, 2006–2015 and diluted THSDP’s plans and reforms.<sup>50</sup> However, THSDP’s efforts have contributed to the development and adoption of the Medical Care and Services Law, 2016 and the Health Law, 2012 with the support of FHSDP, which regulates the hospital sector as a whole.

### **III. RESULTS ACHIEVED IN THE RATIONALIZATION OF MONGOLIA’S HOSPITAL SECTOR**

Overall, Mongolia has developed a legal and policy environment to improve governance and management, and to rationalize services of public hospitals. Continuous efforts were made to advocate advantages of the new model of hospital governance for decision makers and hospital managers. The package of legislation developed in 2016, including the Medical Care and Services Law, relevant revisions to the Health Law, Budget Law, state and local Property Law, and Civil Service Law aim to improve governance (enhanced decision-making power) and management of public hospitals in a comprehensive way. These policies and actions are confirmed and outlined in the State Policy on Health, 2017 and aim to ensure transparency, accountability, autonomy, appropriate delegation of authority in public hospitals, and rationalization of their services.

The new model of governance of public hospitals with more autonomy in decision-making has been promoted and is currently being piloted in selected public hospitals. Prior to that, additional regulations and practical guidelines to support implementation of aforementioned laws were developed. These are guiding the pilot, which is expected to be replicated in all public hospitals. Capacity building efforts serve to improve the skills and capacities of hospital managers.

The Songinokharkhan District Hospital in Ulaanbaatar is expected to start operations in 2021. It will serve as a model for an efficient multifunctional general hospital to be replicated in other districts, thereby laying the foundation for rationalization of public hospital services in Ulaanbaatar. Songinokharkhan District Hospital will promote effective practices such as day care and surgery, rotation of doctors between outpatient and inpatient departments, and better linkages with long-term health care. It is piloting modern processes in the concept design, functional planning, and construction of hospital buildings that will be used for other public hospitals.

Along with the state budget, the HIF is firmly established as a major funding source for hospital services. The HIF continues to evolve and improve its performance and efficiency, moving away from the bed-day payment model to a more efficient case-based payment system to fund hospital services, and enlarge purchasing capacities. New developments such as introducing equal reimbursement tariffs for services provided by public and private hospitals, switching to a case-based payment method for services financed from the state budget, and channeling of the state budget financing through health insurance will certainly have a positive effect on the quality of hospital services.<sup>51</sup>

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<sup>50</sup> ADB. 2015. *Technical Assistance Completion Report: Third Health Sector Development Program in Mongolia*. Manila: ADB.

<sup>51</sup> In 2018, due to capacity shortages in public hospitals, the government attempted to redirect the state budget funding for renal dialysis through health insurance to involve the private sector for the first time. The health insurance organization selected and contracted private hospitals based on their performance.

The licensing of health care professionals, and the licensing and accreditation of hospitals, which were nonexistent in Mongolia before the 1990s, have been established. Even though these systems need updates, they contribute significantly to the continuous education of health care professionals and ensuring safety of hospital services.

## IV. CHALLENGES AND LESSONS LEARNED

The implementation of health sector development programs and technical assistance from ADB to support the rationalization of Mongolia's hospital sector has faced challenges and lessons. The most significant challenge is the frequent change of governments, resulting in the high turnover of key staff, loss of institutional memory, shifting priorities, and inconsistencies in policies.<sup>52</sup> Another challenge is the lack of strong leadership, experience, and capacity from MOH and relevant central and local government agencies in implementing reforms that require comprehensive approaches to address the complexities of hospital care, multisector involvement, and large-scale construction projects. Efforts to gain more autonomy for public hospitals faced opposition from government institutions that could lose power over the appointment of hospital executives and managers, and potential resistance from public hospital managers who stand to lose their positions.

These challenges hamper the consistency and continuity of long- and medium-term plans and their timely implementation, and often lead to underutilization of useful recommendations formulated through extensive consultation and agreement processes.

It is evident that hospital sector reforms require significant time and effort to generate understanding and gain support among all stakeholders on the need to plan and match hospital services with the needs of the population. It is also important to translate the understanding that emerged from these efforts into the binding legislation and regulations that will require the government to implement them.

All of the above challenges required long-term commitment and assistance from ADB through consistent health sector development programs and TA projects to achieve results in improving hospital-based services in Mongolia.

## V. FUTURE DIRECTIONS

Clearly, in the long term, there is a need in Mongolia, and especially in Ulaanbaatar, for the rationalization of the hospital sector through planning and investing in hospital services based on the needs of the population, significantly decreasing the number of acute hospital beds, merging of public single-profile specialist facilities with multifunctional general hospitals, and better regulation of the private hospital sector that would result in the closure of excessive hospital facilities. These should be complemented

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<sup>52</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 the 1990s in Mongolia*. Ulaanbaatar.

with the optimization of services through the gradual shift of resources from referral hospital to primary health care, and improvements in coordination between these two layers of the health care system. These long-term goals should be supported by appropriate changes in national legislation and regulations; strengthening capacities of relevant institutions and human resources; and patient efforts to explain the benefits of rationalization and optimization reforms to decision makers, health professionals, and the general population. Long-term goals need to be achieved through clearly defined medium-term objectives and actions that were recently outlined by the MOH.

The Action Plan for Implementation of the State Policy on Health (Health Sector Master Plan), 2020–2026, developed with assistance from ADB and the Japan Fund for Poverty Reduction, defines immediate and medium-term priorities for the health sector.<sup>53</sup> The Health Sector Master Plan proposes to increase the range of services provided at district general hospitals, which would help in retaining and serving more patients who currently are bypassing state general hospitals and national centers. *Aimag* general hospitals are expected to improve their diagnostic and treatment capacities for stroke and myocardial infarction—the main causes of mortality—for which diagnostics and treatments are currently centralized in state general hospitals. All public hospitals are expected to expand day care and surgery, improve links between outpatient and inpatient services, and expand modern technologies such as minimal invasive surgeries.

There will be a focus on hospital rationalization in Ulaanbaatar through the establishment of integrated networks for the delivery of medical services that coordinate primary health care and hospital services provided at district and state general hospitals. Private general hospitals will also be assisted to join these networks. Defining works and services to be implemented within public–private partnerships in the medium term in the health sector can better enroll the private sector in the delivery of services most needed by the population. Specialized centers that provide rehabilitation, and palliative and nursing care, will be established in *aimags* and districts. Strengthening primary health care services is expected to decrease the use of acute hospital beds for chronic patients and cut down on medically unjustified admissions.

Establishing independent accreditation systems is expected to improve the quality of services provided in public and private hospitals. A shift to centralized licensing of health facilities will improve and tighten the regulation of the private health sector. It will be aided by the introduction of strict procedures for applying certificates of need for establishing new hospital facilities or upgrading the capacity of existing facilities. The procedures will be based on criteria that consider health service needs and demand, as well as medium- and long-term policies and plans on hospital rationalization. Health technology assessments that would provide reviews of the needs of hospital facilities in terms of infrastructure and equipment will serve as the basis for the development of the medium-term investment plan. This plan is expected to serve as guidance for coordinated, effective, and rational investments in hospital infrastructure. Hospital infrastructure standards and planning processes will be aligned with international standards. Efforts to improve governance in public hospitals and introduce a semi-autonomous model will be continued by developing and implementing a conceptual framework, establishing and building the capacity of management boards, and strengthening the capacities of management teams of public hospitals.

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<sup>53</sup> Government of Mongolia, Ministry of Health. 2020. *Order of the Minister of Health A/103. About Approving the Action Plan for Implementation of the State Policy on Health*. Ulaanbaatar.

## VI. CONCLUSIONS

Mongolia is making steady progress toward modernizing its health facilities and health technologies, and in developing patient-centered services. However, much more remains to be done to rationalize services and improve governance and management of public hospitals, to improve the quality of services and performance efficiency. The need for more rationalized and coordinated hospital services is particularly pressing in Ulaanbaatar, where too many public and private hospitals are concentrated. The new model of governance of public hospitals, including semi-autonomous and autonomous management, should be scaled up nationally in public hospitals, while addressing the current issues and challenges described above. The capacities of hospital managers and management teams should be strengthened to ensure the success of the autonomy model, and to improve the overall quality and performance of the hospital sector.

It is widely accepted that general hospitals providing a broad range of specialist care are the preferred option for a majority of hospital services. These hospitals should enhance the quality of services, continue to expand efficient services such as day care and surgery, introduce modern and efficient medical technologies, better integrate outpatient and inpatient services, and ensure smooth linkages with the primary health care and long-term health care facilities. District general hospitals with a broad range of services and the above elements could initiate the overall rationalization process necessary to deliver good patient-centered hospital service in Ulaanbaatar. Better integration of delivery of services through planned coordinated networks would further promote consolidation, reduce duplication, and support rationalization. Key to the success of the new model will be the quality of services provided by the staff of hospitals, and the financing systems to encourage new, improved practices and efficiency. Staff will need to acquire new skills and work together as teams. The finance regime should reward those who are best at delivering quality health services.

Hospital rationalization is a difficult task. It requires a unified vision, as well as the commitment and coordinated efforts of all stakeholders to implement policies and actions within the framework of current laws, policies, and plans. Another requirement is a transparent and well-justified process for the planning, implementation, and monitoring of investments in the hospital estate and staff. Such investments are expected to respond to existing needs for and improve quality of current hospital care, but will also shape future services. Therefore, decision-making on investments needs flexibility to respond to future developments that will have an impact on health services.

Hospital rationalization cannot be viewed in isolation from the larger health service environment that intersects the broader aspects of society. Therefore, further improvements in primary health care and long-term care, better regulation of the private sector, and understanding and cooperation from different groups of society are required for the success of hospital rationalization reform.

## **Rationalizing Mongolia's Hospital Services**

### *Experiences, Lessons Learned, and Future Directions*

Before the 1990s, Mongolia had a health care system that largely depended on hospital-based services. The country's hospital sector was characterized by the extensive use of an excessive number of acute beds, a large number of medically unjustified admissions, and lengthy hospital stays. In the early 1990s, the Government of Mongolia started socioeconomic reforms as part of the transition to a market economy. It requested the Asian Development Bank (ADB) to support health sector reforms in the country. This paper describes the hospital sector in Mongolia along with the reforms and results achieved, challenges that remain, and ongoing and future directions for ADB support to better respond to the needs of the people.

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

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