Vast territory. Nomadic herders in Mongolia are sparsely dispersed over a territory of 1.5 million square kilometers. The health system must be able to meet their needs.
Mobile health care. A health worker travels to rural communities by motorbike.
Introduction

The 1991 collapse of the Soviet Union and the subsequent withdrawal of its assistance to Mongolia plunged the country into economic crisis. This led to an urgent need for socioeconomic reforms, including a reshaping of the country’s health system. Since then, with support from the Asian Development Bank (ADB), Mongolia has brought about major changes to its health care system, including in hospital and primary health care (PHC), health care financing, and medicines regulation.

Mongolia’s 3.3 million people are better served than ever by the current health system, but much remains to be done. The government’s experiences, including the many challenges it has faced on the road to reform, hold important lessons for other countries, particularly former socialist countries, which are experiencing a similar transition to a market economy. Mongolia’s experiences encompass the challenges of how to organize, finance, and manage a modern health care system, providing equitable access to good quality health care for all.

Since the early 1990s, ADB has been a consistent supporter of the Government of Mongolia on its journey of health system reform. This support has been in the form of a series of multiyear health sector reform programs. These cover all aspects of primary care, hospital care, health care financing reform, and medicines regulation. In addition, ADB has provided targeted technical assistance to address specific issues, such as strengthening health insurance, and improving access to affordable medicines in public hospitals.

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Background

Modern health care was introduced in Mongolia in the early 1920s. Under the influence of the Soviet Union, the country’s health care system followed the Semashko model, considered to be one of the most influential models in health care organization, management, and financing. The Semashko model is based on state responsibility for health care financing and delivery, strong central planning, free and universal access to health care, and communicable disease control. It is a single-payer system, financed from the national budget, and measures success by inputs—the number of doctors, nurses, and hospital beds per population—rather than improvements in key population health indicators. In the Mongolian context, this system had strengths—such as widespread access to basic health care—and weaknesses, including low efficiency, low quality, and a lack of responsiveness to patient needs, despite a high number of hospital beds and medical staff.

Health Care in the Socialist Era

During the time of the socialist state of the Mongolian People’s Republic, from 1924 to 1992, PHC in rural areas was delivered through soum (subprovince administrative unit) hospitals. These were typically 15- to 30-bed facilities providing outpatient and inpatient services for patients with noncomplicated medical conditions; antenatal, uncomplicated delivery and postnatal care; and minor surgery. People in more remote areas were served by bagh (sub-soum administrative unit) posts where a PHC worker with 2 years of medical training, called a feldscher, was assigned to work under the supervision of a medical doctor from the soum hospital.

This system focused on curative services rather than preventive health, but immunization programs were well organized. It was well suited to the needs of the rural population, primarily nomadic herders who were sparsely dispersed over a territory of 1.5 million square kilometers. Aimag (provincial) general hospitals serviced the entire population of the aimag and received referrals from all soum hospitals, deploying emergency care teams to remote areas when necessary.

Socialist era health care in Mongolia was well suited to the needs of the rural population, primarily nomadic herders who were sparsely dispersed over a vast territory.

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Overcoming challenges. A doctor gives a prescription to her patient at a clinic in Mongolia. Primary health care has become the foundation of the provision of health care in the country.
Meanwhile, in the capital, Ulaanbaatar, polyclinics provided outpatient and PHC services within a defined geographic area, and 100- to 200-bed district hospitals provided internal medicine and pediatrics, while maternity care was provided by separate hospitals. Tertiary-level state general hospitals, concentrated in Ulaanbaatar, provided services unavailable at the aimag and district levels.

The system worked relatively well until the 1970s, but was not responsive to improved medical technologies and increasing demand for better health services. Overall, the health care sector was characterized by an excessive number of acute beds, a large number of medically unjustified admissions, and lengthy hospital stays. Consequently, the population developed a preference for specialist care and inpatient treatment. The quality of care at all levels was low.

**Mongolia’s Transition to a Market Economy**

With the collapse of the centrally planned economy and the transition to a market economy, the funding model for Mongolia’s health system, from centrally allocated public funds alone, was no longer viable.

The economic crisis of the 1990s not only caused rising unemployment and poverty, accompanied by high inflation and currency depreciation, but also sharply impacted the ability of the government to finance and deliver health care services. State health expenditure as a proportion of gross domestic product fell from 6.7% in 1990 to 4.0% in 1992, with user fees introduced to bridge the gap. Shortages of most goods, including essential medicines and medical supplies, contributed to a drastic decline in the quality and accessibility of health care services.

In 1992, the Ministry of Health, with support from ADB and other international partners, carried out a health sector review. It was clear that the sector required a major overhaul to improve system quality and effectiveness, and adapt it to a market economy. The Government of Mongolia 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 health care efficiency. The government began the reform of the health care system, including the introduction of the compulsory national health insurance scheme to increase sources of financing for health care and improve the financial protection of its people.

**The Government of Mongolia 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 health care efficiency.**

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Health Services Reform in the Early 1990s

Along with reforms to health care financing in the early 1990s, the delivery of care also underwent reform. The government began these reforms by establishing family health centers in urban areas to provide PHC. This was in a bid to address the overconcentration of resources in hospital-based inpatient care in favor of primary and public health services. In 1993, the Ministry of Health introduced family medicine-based PHC in Ulaanbaatar, whereby a doctor and nurse were appointed to work as a team to provide family medicine-based care to their assigned catchment population. However, the assigned doctors and nurses were not trained in family medicine, and lacked financial incentives and the necessary equipment and supplies. The location of PHC doctors in the secondary hospitals led clients to bypass them.

The reforms also created opportunities for private sector involvement in health care. The first private health care facilities were mostly small clinics with no beds, and small hospitals with up to 30 beds, mainly in Ulaanbaatar, and operated by a single specialist who worked simultaneously in the public sector. These private hospitals had limited diagnostic and treatment capacity, but were more client-oriented, offering fee-for-service health care and shorter waiting times, as well as flexible working hours for staff. However, the mechanisms for proper government regulation of the private sector had not yet been put in place. The government also privatized and liberalized the pharmaceutical sector, in an effort to eliminate the acute shortages of medicines in the 1990s. As a result of these initial reforms, by the mid-2000s, the production and wholesale and retail distribution of medicines and medical devices was entirely in the hands of the private sector.

From Early Reform to the Present Day

Since the 1990s, Mongolia has been on a journey to create a sustainable financing model, strengthen standards and governance, improve the provision of PHC, and rationalize hospital services (Figure 1).

Figure 1: ADB Support to Mongolia

Health Care Financing

Mongolia’s health care financing reforms have taken the health system from an exclusively input-oriented financing model to the current output-oriented model. The four major reforms were (i) the introduction of the mandatory national social health insurance scheme; (ii) capitation for PHC and case-based payments for hospital services; (iii) most recently, the pooling of the state budget and the health insurance fund; and (iv) the establishment of the single-purchaser system for health services.

The Ministry of Health adopted the Citizen’s Law on Health Insurance, which came into effect in 1994 with the aim of improving the entire population’s access to necessary health services. All employees in the public sector, and in the newly established private sector, were required to contribute 6% of their monthly salary, with employees and employers equally sharing the burden. The contribution was reduced to 4% in 1998.

To ensure that the social health insurance scheme also covered the low-income population, the government identified vulnerable categories (Figure 2), including children under 16 years old, pensioners, women taking care of children under 2 years old, and citizens needing social assistance (people with disabilities, orphans, single old people, and others). People in these categories constituted approximately 70% of the population, and the government fully subsidized their contribution. Informal workers, the self-employed, and the unemployed were asked to pay a flat rate contribution, which was one-twentieth of the average contribution of salaried workers.

Figure 2: Low-Income Categories Whose Social Health Insurance is Fully Government Subsidized

Protection for Vulnerable Groups

The scheme covered hospital care and, from 2003, PHC, but this was transferred back under state budget financing in 2006 due to concerns over vulnerable groups not being able to access essential PHC services.

By 1996, the scheme covered 95% of the population, but a decade later, participation had dropped to 80%. This reflected dissatisfaction with the quality of services and unacceptably high levels of out-of-pocket payments. Herders, the self-employed, and the unemployed who did not fall under the vulnerable populations categories left the scheme.

Pooled Funding

By 2008, 24% of those insured under the scheme were from the formal sector, but they contributed over 80% of revenue and consumed only 13% of the expenditure. In contrast, the government subsidy accounted for 13% of revenue, and subsidized 60% of the enrollees, who consumed 50% of expenditure. The social health insurance scheme also operated alongside the state health budget, with separate benefit packages and fund flows to hospitals. Then, in 2021, the government pooled the two funding streams to create a single-purchaser model. The National Council of the Health Insurance Fund unified the decision-making process to define the benefits, contracting, purchasing, and quality control under its jurisdiction. The state budget began transferring funds for purchasing services under government responsibility to the health insurance fund, with the Health Insurance General Office acting as a purchaser on behalf of both funding sources.

This was one of the reforms supported by ADB through several projects. Under the most recent technical assistance project, the benefit package was also streamlined to focus on promoting day care and outpatient care, and reducing the extensive use of acute hospital beds for unjustified admissions. Other reforms include improvements to the provider selection, contracting, and payment processes.

Despite the intention of the social health insurance scheme to protect vulnerable groups, and historically high levels of population coverage, these groups have also borne the brunt of out-of-pocket payments, even leading to catastrophic health expenditure, spending that exceeds a household’s capacity to pay. The most recent health sector program has sought to address this and, in 2021, exempted vulnerable groups from co-payments and introduced other measures to better protect them.

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Primary Health Care

ADB support for health system reforms in PHC occurs in stages (Figure 3). From 1997 to 2001, the focus was on the creation of family group practices, financed under a capitation model with risk adjustments for poor and vulnerable groups. The introduction of family group practices started with a pilot program in Ulaanbaatar and was then rolled out over 5 years. However, the system ran into difficulties, with continued emphasis on curative rather than on preventive medicine. The practices did not gain public popularity because of failure to socialize the concept and break down long-standing attitudes that favored care in hospitals rather than from PHC providers.

From 2003 to 2012, the emphasis for PHC reform shifted to improving services and access for rural populations. The major achievement of this period was strengthening PHC centers at the soum and bagh levels in five aimags selected by the Ministry of Health. In these areas, the government upgraded hospital facilities and equipment, and all soum hospital medical staff and bagh feldshers received clinical training that was evaluated and found to be highly effective.

From 2007 to 2014, both rural and urban health services were tackled, and resulted in the restructuring and reorganization of PHC. There was increased emphasis on preventive public health services. Family and soum hospitals were reorganized into family and soum health centers, with the formal shift to emphasize public health services over curative services. A limited number of inpatient beds were kept at soum health centers mostly for observation purposes. 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.

Figure 3: Primary Health Care Timeline

Gaining momentum. Health services are provided to address the varying needs of elderly citizens in Mongolia.
Hospital Services

In the health care sector, service rationalization included 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 health care sector regulations (Figure 4).

**Figure 4: Hospital Services Rationalization**


Songinokhairkhan District Hospital in Ulaanbaatar opened in 2021 and serves as a model of an efficient multifunctional general hospital to be replicated in other districts, thereby laying the foundation for rationalization of public hospital services in the capital. The hospital will promote effective practices such as day case care and surgery, rotation of doctors between outpatient and inpatient departments, and better linkages with long-term health care for continuity of care (Figure 5). It is piloting modern processes in concept design, functional planning, and hospital construction that will be used for other public hospitals. However, hospital governance reform has been a challenging process, as national plans and priorities have evolved, and those responsible for implementing the reforms lacked sufficient capacity to do so, especially in the face of opposition from some institutions and hospital managers.

**Figure 5: Songinokhairkhan—A Model of an Efficient Multifunctional General Hospital**

Medicines Regulation

The initial reforms to privatize and liberalize the pharmaceuticals sector led to longer-term issues that still persist in the sector and which undermine the safety and quality of medicines. The government is making significant progress in addressing these issues, by establishing a national medicines regulatory authority and upgrading the national medicines safety laboratory to international standards. It is also instituting sound national pharmaceutical practices based on international standards, developing national strategies on pricing medicines and pharmacovigilance, and introducing a system for the centralized procurement of medicines for public hospitals.

However, all of these issues have struggled to secure enough political support for the reforms to be sustainable. Mongolia still needs to transform the newly established national medicines regulatory authority into a more powerful, independent, evidence-based, and better funded institution that brings together the disparate functions of different sectors. This would ensure better quality and increased assurance of safety, covering areas such as pharmaceutical manufacturing, marketing, distribution, and inspection.
Successes, Lessons, and the Road Ahead

Mongolia has a small population, with one main urban conurbation, and an otherwise widely dispersed rural, remote, and partially nomadic population. However, many of the complex problems the government is grappling with are the same as those in other countries of Asia and the Pacific. The country is experiencing growing and accelerating urbanization. It is trying to find the road map to sustainable health care financing that brings it closer to the World Health Organization’s recommended 5% of gross domestic product to adequately fund PHC-based health systems and that combine public and private revenue sources. It is also seeking the right balance in health care regulation that ensures the public sector offers quality services that the population needs and harnesses the dynamism of the private sector without creating profit-led distortions in health care access. In trying to bring the population, health care professionals, and public and private sectors along with it on this journey, Mongolia’s experiences offer lessons to other countries.

It is possible to combine the best of old and new. With the seismic impact on Mongolia of the fall of the Soviet Union in the early 1990s, the Semashko model was no longer fit for purpose. Even before, it was clear that this top-down, input-led system could not move beyond curative and basic-level care. However, the model’s strong sense of fiscal discipline, its emphasis on getting health care to remote rural areas, and strong immunization program that helped combat communicable diseases, remain as valid as ever. Mongolia continues to adhere to these principles in the post-Semashko era (Figure 6) and combine them with policies and systems that are more compatible with the market economy. These include social health insurance, public–private partnerships, and payment models that incentivize provider performance and patient choice.

Figure 6: Semashko Versus Post-Semashko Models

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<th>Old Versus NeW</th>
<th>Semashko</th>
<th>POST-Semashko</th>
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<tr>
<td></td>
<td>• Strong sense of fiscal discipline</td>
<td>• Social health insurance</td>
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<td></td>
<td>• Well-organized immunization programs</td>
<td>• Public–private partnerships</td>
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<td></td>
<td>• Emphasis on getting health care to remote rural areas</td>
<td>• Payment models incentivizing provider performance and patient choice</td>
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Restructuring is hard to hurry however urgent the need. It took time to introduce and socialize new concepts. This process required extensive consultations to overcome resistance due to vested interests in the status quo, and to build the capacity of key stakeholders. Reform often calls for the restructuring of an existing system, and may have several phases, as was the case with establishing the Health Insurance General Office. Reform also requires government expenditure, political will, and a favorable economic climate. Changes in key personnel interrupt this process, and there is a need to reintroduce new concepts. Health professionals do not always make good health systems managers, and there is a lack of experts specialized in health care financing with practical experience to conduct the reform. Mongolia needs to move toward strategic purchasing, linked to the efficiency of provider performance and the health needs of the population they serve, while prioritizing financial protection of the people. This, too, will take time.

Social health insurance relies on a large formal economy. With the advent of the market economy in Mongolia, social health insurance was a logical solution to the need for a sustainable health care financing model. However, social health insurance typically relies on contributions from the formal sector, which, in the Mongolian context, means that a minority of the population contributes the most revenue, and therefore heavily subsidizes the health care costs of the majority outside the formal economy. The bulk of the funding shortfall is then provided by government contributions to the social health insurance scheme. Together with direct government funding to the health system, this created two parallel streams of government expenditure. Mongolia addressed the inefficiencies and contradictions that this induced by merging the two into a single payer.

Good quality primary health care needs sustained financial and policy commitment. In the 1990s, Mongolia emphasized increased access to services. Although the family group practice pilot was successful, and this model was rolled out to eventually cover 60% of the population, it did not address quality issues. The uptake of services offered by family group practices was poor. The practices did not break away from the Semashko model emphasis on curative rather than on preventive care, and failed to fulfill their potential to act as gatekeepers of expensive hospital care. In the 2010s, family group practices were restructured with more emphasis on quality and preventive services. Alongside soum health centers, which continue to serve as an entry point for access to health care in rural areas, family health centers have developed into a sustainable model for PHC delivery. They contribute the most to the provision of PHC in general, in urban areas in particular. However, the sector is still grappling with service and quality issues due to the partial implementation of the necessary governance and funding reforms.

Privatization is a double-edged sword for access to medical products. Mongolia’s current pharmaceuticals sector is built on a foundation of earlier reforms to privatize and liberalize it. Yet those very reforms have resulted in the longer-term issues that persist in the sector, and which undermine the safety and quality of medicines. Poorly regulated growth of the private sector resulted in a dramatic increase in the number of retail pharmacies and manufacturers and wholesalers of medicines, disproportionate to the size of the population.
The pharmaceutical supply system in the country is now fully decentralized—leading to small procurements by individual public hospitals—which undermines the country’s ability to control pharmaceutical costs through economies of scale. There are also no mark-up controls in wholesale and retail operations, reference pricing, or tax exemptions for essential medicines (Figure 7). As a result, consumer prices for medicines are among the highest in Asia, up to 5.5 times higher than international reference prices. There is also a prevalence of substandard, unregistered, or falsified medicines (although this is decreasing), and many medicines in the supply chain are of low quality. The first step toward addressing these and other issues was the 2021 establishment of a national medicines regulatory authority.

**Figure 7: Medicine Safety, Quality, and Pricing**

- No mark-up controls, reference pricing, or tax exemptions for essential medicines
- Substandard, unregistered, or falsified medicines
- Fully decentralized pharmaceutical supply system undermines ability to control costs through economies of scale


**Changing entrenched behaviors is hard.** Despite the efforts of the Government of Mongolia to shift health services usage from the hospital to the PHC sector, people’s entrenched health-seeking behaviors proved hard to shift. When the reforms to the PHC sector did not deliver timely, quality care, people did what they had always done and visited hospitals directly. With the legacy of the Semashko model, whereby there were no incentives for short hospital stays, both patients and health care providers had a shared belief that long stays were the norm. Shifting such deep-rooted ideas about health care requires that public education is sustained. However, it also points to the reality that, unless new systems offer tangible improvements, people will do what they need to do to access the services they need.

Unless new systems offer tangible improvements, people will do what they need to do to access the services they need.
Safer medicines. A national medicines regulatory authority was established in 2021 to address the high price of consumer medicines as well as the prevalence of substandard, unregistered, or falsified medicines.
Further Reading


