A HEALTH FINANCING REVIEW OF MONGOLIA

WITH A FOCUS ON SOCIAL HEALTH INSURANCE

Bottlenecks in institutional design and organizational practice of health financing and options to accelerate progress towards universal coverage

by

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Abbreviations

ADB	Asian Development Bank
CEO	Chief executive officer
DoH	Department of Health
DRG	Disease-related groups
FFS	Fee-for-services
FGP	Family group practice
GDP	Gross domestic product
GGHE	General government health expenditure
GTZ	German Agency for Development Cooperation
HIF	Health Insurance Fund
HIO	Health insurance organization
HIV/AIDS	Human immunodeficiency virus/Acquired immune deficiency syndrome
IMF	International Monetary Fund
MDG	Millennium Development Goal
MNT	Mongolian tugrik (currency)
MoF	Ministry of Finance
MoH	Ministry of Health
MoSWL	Ministry of Social Welfare and Labour
NCPCS	National Committee for Physical Culture and Sports
NGO	Nongovernmental organization
NHA	National Health Accounts
NSC	National Statistical Committee
OASIS	Organizational Assessment for Improving and Strengthening Health Financing
OOP	Out-of-pocket (payment)
PHC	Primary health care
PHI	Public Health Institute
PPP	Purchasing power parity
RDTC	Regional Diagnostic and Treatment Centre
SHI	Social Health Insurance
SIGO	Social Insurance General Office
TB	Tuberculosis
THE	Total health expenditure
UNDP	United Nations Development Programme
WB	World Bank
WHO	World Health Organization
WHR	World Health Report

Executive summary

Universal coverage – defined as access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost – is an important policy goal for many countries. The main challenge is to improve the system of health financing in order to move towards and achieve universal coverage supported by effective financing arrangements. The Government of Mongolia is clearly committed to universal coverage and has approved a health financing strategy for 2010–2014 that is guided by the Health Financing Strategy for Asia and the Pacific (2010–2015).

The Ministry of Health recognizes the need to reform the health financing system. Thus, the purpose of this report is to assess the health financing system and its performance, and to analyse the existing institutional design and organizational practice in health financing in order to reveal their effect on the level of health financing performance. The report also aims to identify current bottlenecks in health financing and develop appropriate options for addressing these. The analytical framework used for this study focuses on the role of institutional design/organizational practice (Mathauer & Carrin, 2011).

The health sector in Mongolia has two main sources of financing – social health insurance and the state budget. In 2010, social health insurance financed 23.6% of total health expenditure with 82.6% coverage of the total population. Health insurance benefit covers mainly curative care at secondary- and tertiary-level hospitals along with limited outpatient services. As of 2009, tax-based health financing accounted for 60.9% of total health expenditure (WHO, 2011). This covers primary health care services in family group practices and *soum* (district) hospitals, specific services at secondary care level in provincial and city district public hospitals and health centres, and also specific services at tertiary care level in specialized public hospitals in Ulaanbaatar. In recent years, direct out-of-pocket payments – consisting of formal and informal fees and payments – have been increasing as a share of total health expenditure. At provider level, it seems difficult to distinguish the services funded by the government budget and those funded by social health insurance, thus limiting access to state-funded services by the uninsured.

It has been observed that financial plans approved for providers are often below their cost, and therefore public providers are allowed to charge patients fees set by the Ministry of Health in addition to health insurance copayments. A WHO study on the distribution of health payments revealed that, although direct out-of-pocket payment accounts for less than 15% of total health expenditure, people pay more for drugs and, in some cases, health payments are already catastrophic and push persons on low incomes into poverty. In 2009, 3.83% of all households experienced catastrophic health expenditure.

Institutional and organizational analysis

Policy and legal environment

Health sector issues are well reflected in long- and medium-term policies such as the comprehensive national development policy (based on the Millennium Development Goals), the

health sector master plan, the government plan of action for 2008–2012 and the health care financing strategy. The purpose of the recently approved health care financing strategy is to improve the health of the people, to provide financial protection for individuals, and to support economic growth and poverty reduction by setting up a financial system that promotes access to and efficiency of health services based on people's health care needs. One of the main emphases of this strategy is to establish an independent social health insurance organization and strengthen its purchasing capacity. Following this strategic direction, the government developed new amendments to the Citizens' Health Insurance Law and submitted these to the parliament in May 2010.

Health care financing in Mongolia is regulated by four main laws: the Health Law, the Citizens' Health Insurance Law, the Budget Law and the Public Sector Management and Finance Law. The Health Law, which was revised in May 2011, defines sources of health care funding and benefit packages that are to be provided free of charge to all the population and financed by the state budget. However, the law also includes some provisions related to health insurance financing that ensure Ministry of Health participation in health insurance policy-making.

The Mongolian Citizens' Health Insurance Law was approved in 1993 and came into force in 1994. Although health insurance financing accounts for nearly 25% of total health sector financing, efforts to improve health care financing have often started with health insurance. As a result, almost all recent governments have initiated new amendments to the Citizens' Health Insurance Law. Since 1994, the health insurance law has been changed five times, which means it has changed on average almost every three years. Legal amendments have often lacked clear objectives or strong justification, have frequently not been based on sufficient data, evidence or technical justification, and the process of discussion and approval of change has not been informed by impact assessment of the proposed changes. Some legal provisions provided in different laws contradict each other or remain unimplemented because of insufficient impact assessment or feasibility studies. The Public Sector Management and Finance Law, which was introduced after the Citizens' Health Insurance Law, enforced centralized management of the health budget and health insurance under the Ministry of Finance. It reduced substantially the role of health insurance in financing and delivering quality care to the insured.

Governance and stewardship

The Ministry of Health of Mongolia is responsible for the formulation, planning, regulation, supervision, implementation, monitoring and evaluation of national health policy. These complex duties require strong leadership, commitment, and detailed and carefully thought-out plans of action. It seems challenging for the Ministry of Health, because of its limited capacity and leadership capability, to play a leading role among different stakeholders involved in health-related matters, especially health care financing. The four laws that regulate health care financing are poorly coordinated. For instance, several councils and ministries with separate implementing agencies are involved in managing health insurance. Besides the national government, local governments at city, *aimag* (province) and district levels are also involved in budget matters as well as health insurance financing and decision-making. Likewise, the current health financing arrangement in Mongolia is fragmented and complicated, and lacks strong guidance and stewardship. In practice, the government dominates decision-making on the operational and management aspects of health insurance, with minimal involvement of the councils that consist of

representatives of government and other entities such as trade union and employers' organizations. This leads to dissatisfaction among those who do not have a proper voice in the organization and management of health insurance. Public dissatisfaction with out-of-pocket payments and poor health care quality bring criticism of the health insurance because people are paying for it every month.

This study found that weak governance and stewardship in the Mongolian health care financing system creates several challenges which need to be addressed as soon as possible. These include: fragmented actions without strategic goals and policy consensus, mistrust and misperceptions among different stakeholders, limited opportunities to build management and leadership capacity, and the lack of development of a health insurance system that can promote effective service delivery, quality and efficiency of resource use, including purchasing.

Resource mobilization

Over the last 10 years, general government health expenditure as a percentage of GDP decreased in Mongolia from 4.6% in 2000 to 3.0% in 2010 despite its growth in nominal terms. Major sources of public financing in Mongolia consist of the state budget, social health insurance, and other sources of revenue generated from both core and non-core activities. Oversees development assistance is not included in the budget.

Although the government budget is a major source of health system financing, the budget planning, implementation, monitoring and evaluation process is relatively weak at all levels. Historical line-item budgeting is widely used for budget financing without due consideration of cost inputs and the performance of health care providers. At the same time, the capacity in the Ministry of Health is too weak to generate strong economic and health outcomes that are evidence-based and can be used to justify an increased health budget with the Ministry of Finance or demonstrate the inappropriateness of historical line-item budgeting and planning. A similar weakness is observed in social health insurance financing. There is little involvement of the social health insurance authority in resource mobilization and financial planning of health care providers since major decisions on budget appropriation and disbursement, as well as on health insurance fund planning and allocation to health care providers, are controlled by the ministries of health and finance.

A review of health financing data among health care providers suggests that the share of state budget and health insurance varies among similar providers because of differing resource collection potential and allocation practices in different provinces and districts. For instance, Ulaanbaatar city allocates more funding from the health insurance fund to the district hospitals because hospitals are able to receive more funding from the health insurance than district health centres. Therefore, some hospitals receive almost 90% of their funding from health insurance alone. At the hospitals with most of funding from the health insurance the uninsured might not be treated fully, even for services financed by the state budget.

Out-of-pocket expenditure in Mongolia is reported to be about 15% of total health expenditure, but it may have been considerably underestimated in the household survey. User fees are regulated by order of the Minister of Health. The order provides a list of services to be charged at public hospitals. In addition, there are also lists of services – such as outpatient consultation and diagnostic tests conducted outside of regular working hours, inpatient private beds with additional

services, food, laundry and transportation services – that are to be charged additionally at public hospitals to increase hospital revenues. These efforts to mobilize additional revenues through user fees have a direct impact on the increase in out-of-pocket payments as a proportion of total health expenditure unless they are well regulated and monitored. In addition to the formal out-of-pocket payments, patients make informal payments (mainly due to poor quality of care and the poor attitude of medical personnel). Therefore, the resource mobilization option through user fees needs to be discussed and assessed carefully because of its potential adverse impact on access, equity and impoverishment.

Social health insurance

Strong political support and commitment have ensured many successes in introducing social health insurance in Mongolia. However, Mongolia does not have a long-term strategy for health insurance development. Fragmented and duplicated roles and responsibilities exist in different ministries and councils, making it difficult to address health insurance development in systemic ways when views are lobbied through various channels. As of now, the Ministry of Social Welfare and Labour is responsible for contribution collection and management of the health insurance fund. The Ministry of Health is charged with approving the health insurance benefit package, payment methods and tariffs, and the selection of providers. The Ministry of Finance administers both the government budget and the social health insurance fund. Under this arrangement, health care providers complain that the amount of payment from health insurance is insufficient to cover the actual cost of delivering health services. They see health insurance as a funding mechanism and therefore they are interested in receiving more funds rather than delivering quality health care benefits to the insured. It can be concluded that organizational and management aspects of health insurance, as well as technical decisions, have been administered by ministries of finance and health rather than by insurance authorities. As a result, health insurance focuses on allocation of health funds rather than contribution collection, risk protection, pooling and purchasing to ensure better delivery of health insurance benefits in the form of quality health services. However, today most stakeholders agree in principle to making health insurance an independent agency, although their views vary on what independence should imply.

Purchasing and contracting

Purchasing is a new term in health care financing practice in Mongolia. The initial payment method during the introduction of health insurance was a bed–day tariff which aimed to increase utilization of health services. A capitation payment for family group practice was used to increase health insurance coverage among the population. Later, prospective payments that separated fixed and variable costs were aimed at containing costs, improving service quality and enhancing the efficiency of utilization of the health insurance fund in attaining defined service targets agreed in the form of contracts between the fund and service providers. Recent moves towards case payment aim to improve the quality of health services. However, health care providers need more sustained support and guidance on the application of case payments (disease-related groups), because they tend to see disease-related groups as a method of increasing funding from the health insurane funding rather than a mechanism for improving the efficiency and quality of health care services. Health care providers also have very limited authority to manage and use their budgets efficiently. Because budget expenditures are controlled by each cost item – such as salary, medicine, food, electricity, and heating – there is little room to manage cases and funds. In other words, the

efficient and effective use of disease-related groups is undermined when a supportive environment is lacking.

The health and health insurance laws of Mongolia differentiate between health and medical care services provided to the population from the government health budget and those provided from the health insurance fund. The health insurance benefit package chiefly covers inpatient care. The health insurance services are provided by secondary- and tertiary-level hospitals, traditional medicine facilities, sanatoria and rehabilitation centres. In addition, 50–100% of the price of essential drugs prescribed by the *bag* (local), *soum* and family group practices are covered. Determining the type and detailed list of services to be included in the health insurance benefit package is the responsibility of the Ministry of Health.

User fees are currently charged by all public hospitals according to the health minister's order A277 (2006). The order provides a list of services to be charged at public hospitals. However, children under 16 years of age, pensioners (women above 55 years and men above 60) and disabled people are exempted from fees for outpatient diagnoses and tests, except for nuclear diagnosis, CT scan, diagnosis for cosmetic treatments, and check-ups and tests required to obtain a driving licence, employment and school admission. Health insurance also requires copayments that range from 10% of total benefit spending at secondary level to 15% at tertiary-level hospitals. Population groups whose premiums are subsidized by the government are exempted from copayments. There is a list of additional services that are to be charged for at public hospitals in order to increase hospital revenues. The cost of these services is regulated by joint order of the ministers of health and finance. Out-of-pocket expenditure comprises multiple types of payments, including direct payments and copayments to public and private providers, private purchase of outpatient medicine, and household health expenditures on overseas medical treatment.

The Public Sector Management and Finance Law required all budget entities to have a service delivery contract with relevant ministries, which was difficult to implement in practice. The Social Insurance General Office could not perform the role of purchaser due to its own lack of legal capacity and capability and inconsistent budget planning practices in public hospitals. Therefore, contracts signed between health insurance organizations and service providers turned out to be arbitrary and did not specify details for improving the performance and quality of health services. However, many efforts at introducing purchasing and contracting elements into health care financing in Mongolia are intended to improve the quality of health services. In addition, there is an increasing consensus that the purchasing capacity of health insurance needs to be improved by increasing its role and responsibilities as an insurer.

Health financing performance assessment

Health financing performance in Mongolia has been assessed by using several specific indicators proposed in the OASIS methodology, including level of funding, population coverage, financial risk protection, equity in health financing, fund pooling and administrative efficiency. Funding and population coverage levels are below Mongolia's potential. Financial risk protection and the degree of pooling are limited and health financing continues to be inequitable, whereas administrative efficiency has been improving.

Mongolia's health care financing system has realized some significant institutional achievements over the past 10 years. These include free primary health care (other than some essential drugs) for all the population through the tax-based financing system, and social health insurance that reached more than 80% population coverage in a short period of time. The government has been fully committed to supporting the low-income and vulnerable population by subsidizing their health insurance contributions. Furthermore, a system of disease-related groups has been implemented. Nevertheless, despite these achievements, some concerns relating to institutional design and organizational practice remain and impede Mongolia from achieving higher levels of health financing performance. Currently, quality and efficiency are major issues together with fragmented and uncoordinated financing schemes, weak leadership, and weak administration and implementation of health financing laws and regulations.

Conclusion and proposed options

The Mongolian government is committed to universal coverage through social health insurance. There is no unique prescription for attaining universal coverage in this way but, once social health insurance is selected as an option for health care financing, the basic merits, criteria, principles and targets need to be respected, and institutional and managerial capacity needs to be developed and strengthened. The major findings of the study include the following:

Many laws and regulations affect health care financing, but some legal provisions conflict with each other and some are unimplemented, especially in regard to the Public Sector Management and Finance Law. Frequent changes in the legal environment have been observed. Amendments to laws have often lacked clear objectives and strong justification, while the process of discussing and approving the laws has lacked reference to appropriate assessments and evidence.
Mongolia's health financing arrangements are fragmented and no mechanisms have yet been developed for effective policy dialogue and consensus-building.

Health care is becoming more expensive in Mongolia, but the value for money is not high. There are growing concerns about quality, efficiency, access, equity, coverage and consumer satisfaction. Health care coverage and resource mobilization are below potential since Mongolia does not have a clear strategy for expansion of health insurance coverage and resource mobilization.

Inequities in health care financing exist, including the level of contribution subsidy which may vary in terms of the amount and target group subsidized by the government. Access to the health insurance benefit package needs further assessment because of mixed financing from health insurance and the state budget. The current government practice of controlling the health budget does not contain costs; rather, it increases financial risk and the burden on households, and reduces access because hospitals may apply additional charges to fill their financing gap. This increases the risk of direct out-of-pocket payments and financial barriers in accessing needed health care, especially for the poor.

In conclusion, the Mongolian health sector needs "more money for health" and the future economic growth and projections suggest that there is good potential for increased fiscal space for health in the years to come. It is also essential to ensure "more equity in health" by strengthening social health insurance. Further, "more health for money" is critical in Mongolia and it is feasible to improve the efficiency and quality of health services with effective cost-containment and

efficiency improvement measures. In this regard the study proposes actions to ensure that the health sector is funded adequately, equitably and efficiently, with improved stewardship and governance.

Proposed actions:

I. Ensure more money for health:

- Increase the government's share in financing health care by increasing the share of government health expenditure in total government expenditure.
- Improve health care financing data and information on national health spending and revenue projections (update of national health accounts).
- Increase collection of health insurance premiums to maximize prepayment (increased population coverage, reduced evasion).
- Consider the introduction of innovative financing mechanisms to increase domestic resource mobilization (e.g. unhealthy food tax, levy on currency transactions, mobile phone solidarity contribution, tourism tax).

II. Ensure more equity in health:

- Create an independent health insurance organization responsible and accountable for the administration and performance of national health insurance aimed at universal coverage.
- Revise health insurance benefits.
- Improve health insurance purchasing capacity with a phased plan for a single purchaser in the future.
- Monitor direct out-of-pocket payment by reviewing and analysing the risks that potentially affect its increase.
- Regularly assess financial risk protection and poverty impact of health payments.
- Assess and apply explicit equity criteria for determining health insurance benefits.
- Update and increase targeted subsidies for payment of health insurance contributions.
- Review eligibility for targeted subsidies. From an equity perspective, it is questionable whether children and other dependents from better-off families should benefit from targeted government subsidies.
- Explore family membership coverage with possibly adjusted contribution rates.
- Take measures to reduce financial hurdles that discourage uninsured self-employed people from joining the scheme.
- Organize a national campaign to share and disseminate information, with national enrolment days where lower or no-penalty fees are applied.
- Advocate and increase population coverage by raising awareness of the health insurance benefit package, health services and health insurance support values.
- Reduce evasion in resource mobilization for social health insurance through better inspection of employers and application of penalties for defaulters.
- Monitor (and possibly review) whether new penalty levels are appropriate.

III. Ensure more health for money:

- Gradually implement a policy to merge state-funded services and those funded by social health insurance into one benefit package.
- Contain health care costs by regulating prices of medicines, new admissions to health facilities, training of health manpower and use of high-cost medical equipment in hospitals.

- Update, advocate and monitor reference prices for essential medicines.
- Monitor and enforce pharmacists' compliance with ceilings of reimbursement drugs.
- Issue a licence to health facilities on the basis of the actual needs of medical doctors.
- Support rational use of medicines, diagnostic tests and laboratory examinations by improving health service standards and treatment guidelines.
- Improve drug prescription practices with a focus on generic medicine by expanding the number of drugs on the drug reimbursement list and by providing clinical pathways.
- Expand pharmaceutical insurance benefits.
- Apply cost-effectiveness criteria in defining health insurance benefits.
- Strengthen health service referrals and incentives in order to provide quality health care at the right levels.
- Monitor and enforce health insurance copayment in support of appropriate referrals.
- Strengthen strategic purchasing by gradually moving away from historical line-item budgeting towards programme- or output-based budgeting.
- Create a supportive environment for case payments to benefit from incentives for efficiency improvement.
- Provide more financial autonomy to hospitals (e.g. to use any surplus based on efficient management, to use funds according to needs rather than budget line items).

IV. Ensuring effective stewardship and governance:

- Update policy commitment, reach a policy consensus and develop a concrete strategy by which to attain universal coverage through social health insurance (coverage of the uninsured).
- Develop a suitable regulatory framework that can benefit from a the independence status of the social health insurance system.
- Enhance the role, responsibility and accountability of the health insurance council in administering and managing health insurance operations and determining health insurance revenue collection, benefit provision, funding with appropriate payment methods and tariffs.
- Reduce the number of actors involved in health insurance decision-making.
- Strengthen management, administrative, analytical and monitoring capacities of health insurance to deal with financial transactions, collection, analysis and reporting of data, information, and quality assurance programmes with feedback.
- Develop and apply basic performance criteria and indicators to assess and report on the health insurance operation and benefit provision on a regular basis.
- Adjust health insurance policy and stewardship in line with national health policies and guidelines determined by the Ministry of Health, especially in terms of quality of care and its public health mandates.
- Review and adjust health financing and budget-related laws and regulations to ensure the legal and operational autonomy of health insurance in order to implement the core principles of social health insurance.
- Increase the financial autonomy of public hospitals to recruit staff with needed skill-mixes that support better and efficient performance.

1. Introduction

Many countries are working to establish a health financing system that allows them to move towards universal coverage – defined as access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost – thereby achieving equity in access and financial risk protection as well as in health financing (WHO, 2005). This is particularly challenging for low- and middle-income countries in light of their heavy reliance on out-of-pocket (OOP) payments for health care (WHO, 2010). The challenge is to improve the health financing system in order to achieve universal coverage as an overall policy goal. Mongolia is experiencing some of the challenges in doing this. There are concerns that access to health services is limited by poverty, and OOP payments may lead to poverty not only for the poor but also for the households of the poor (WHO, 2011). This is not to ignore the tremendous achievements of Mongolia's health financing system which has a relatively high population coverage of about 80%, good coverage of health services, continuous commitment to state subsidized premium payments, and a new payment system that is further elaborated below. Yet, despite these successes and achievements, there are a number of bottlenecks in institutional design and organizational practice. These impede Mongolia from achieving the levels of health financing performance (including access, equity and efficiency) that the country could potentially attain, given its resources and priorities, and are therefore of great concern with regard to achieving universal coverage.

The Ministry of Health (MoH) is clearly committed to universal coverage and approved a health financing strategy in June 2010. Following the launch of the *World health report 2010*, Mongolia has recognized that reforming the health financing system constitutes an important step towards universal coverage. Thus, the purpose of this report is to assess the health financing system and its performance and to analyse the existing institutional design and organizational practice in health financing in order to identify and develop appropriate health financing reforms and changes. It is important to understand properly the key causes of the current health financing bottlenecks.

Section 2 presents the analytical framework and methodology used. Section 3 describes the results of the health financing performance. Section 4 presents the findings from the analysis of selected core bottlenecks in institutional design and organizational practice and their impact on performance. On this basis, policy options to enhance progress towards universal coverage, as well as conclusions, are proposed.

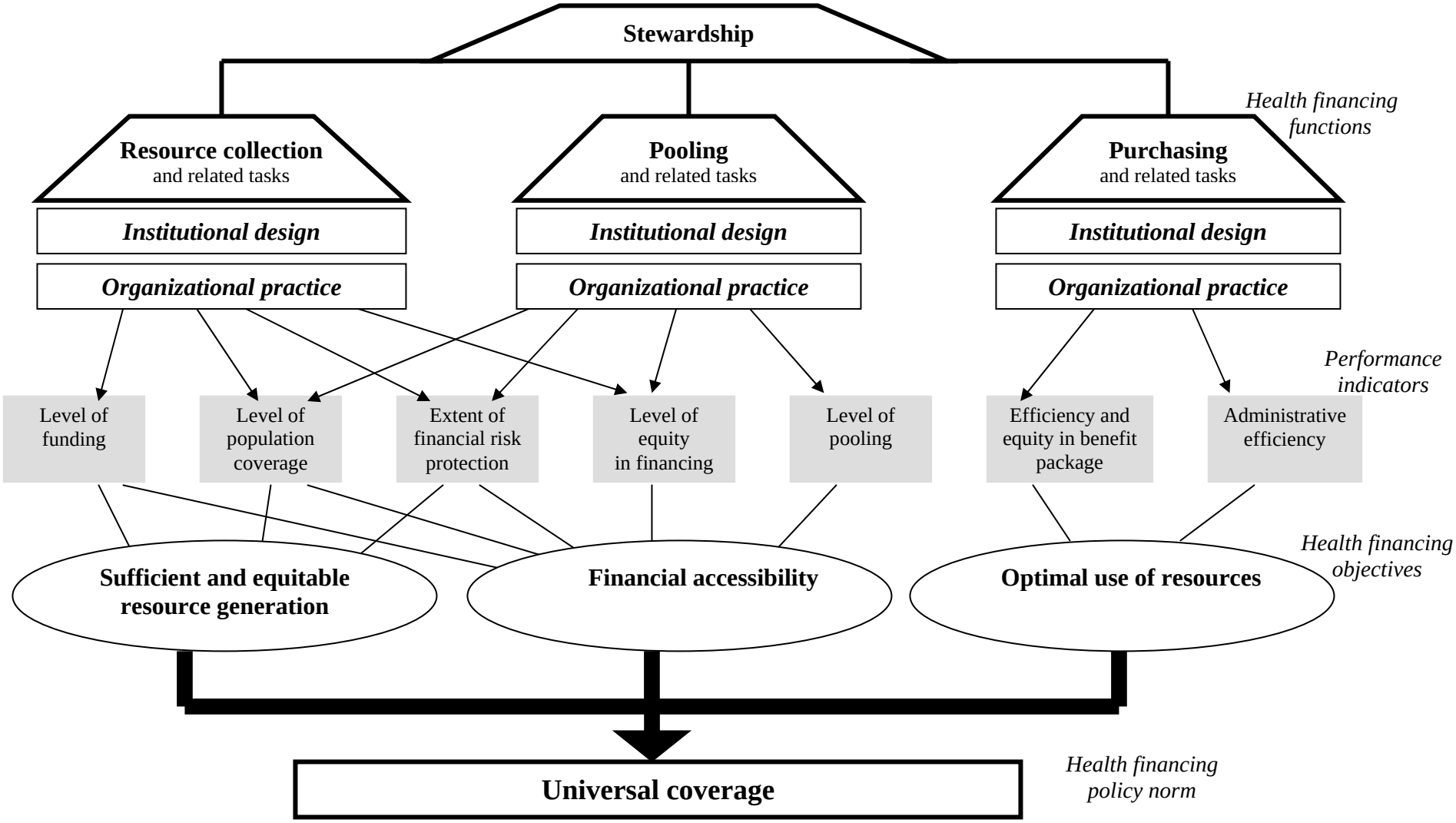
Although health insurance does not play a predominant role in current health care financing, social health insurance (SHI) is always at the centre of debates on financing and delivery of health services provided at all levels through both the public and private sectors. To some extent, this is understandable because there is growing willingness, as well as expectations, to experience the value of being insured and to exercise the health insurance benefits that make quality health services available when they are needed. The chief focus of this study is on health insurance for four reasons. First, health insurance is regarded as an important additional source of financing which was introduced during the period of economic transition. Second, health insurance is regulated by law and is implemented with the involvement of many stakeholders. (However, it is precisely this involvement of multiple stakeholders that presents challenges and weaknesses in both institutional design and organizational practice. In addition, different views on health

insurance exist among policy-makers and law-makers and some views could potentially undermine the principles of social solidarity.) Third, there is a risk of an increase in OOP payments in health care financing in Mongolia, and therefore further strengthening of SHI is considered as a way of enhancing greater equity and financial protection for those in need. Fourth, many people complain about the current operation and benefits provision of the health insurance scheme. The government is keen to address these issues by introducing new amendments to the Health Insurance Law. It is hoped that the following analysis and findings may help readers to understand the major issues faced by the Mongolian health insurance system and will help to promote improvements to the policy and implementation of health insurance development in Mongolia.

2. Conceptual approach and methodology

The analytical framework underlying this study was taken from Mathauer & Carrin (2011) and focuses on two core elements: i) the role of institutional design and organizational practice, and ii) the operationalization of health financing objectives into health financing performance indicators, as outlined in Figure 1. Table 1 presents these indicators with their detailed operationalization and guidance on how these indicators could evolve in progressing towards universal coverage in a low–middle-income country such as Mongolia. These indicative targets are based on the core values of equity and social justice, as well as on the rationale of using resources as efficiently as possible. The operationalization described below also takes account of the often limited availability of data in low- and middle-income countries.

Figure 1. Overview of the analytical framework



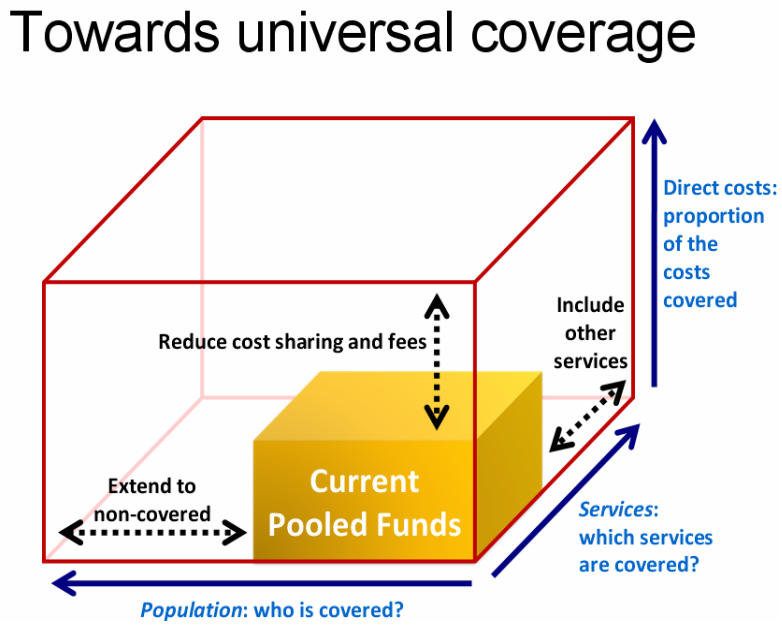
Source: Based on Mathauer & Carrin (2011), Carrin et al. (2008).

The achievement of these health financing objectives and performance indicators is contingent upon the underlying institutional design of the health financing system as well as on prevailing organizational practice. Institutions are understood as "rules [and] enforcement characteristics of rules that structure repeated human interaction" through incentives and constraints (North, 1989). Even when political will exists, these health financing rules – in the form of legal and regulatory provisions – may be inadequately designed or even socially suboptimal if they have been created and designed to serve the interests only of those with bargaining power. Organizational practice of health financing concerns the way that rules are implemented, complied with and enforced. The health financing actors are guided by both rules and incentives in combination with other motivations such as profit, utility maximization and solidarity (Mathauer & Carrin, 2011).

For the assessment of health financing performance, quantitative data were obtained from government and SHI sources, a household survey, and national health accounts, with secondary analysis being carried out. Latest available data are presented for each performance indicator. For the institutional–organizational analysis, the respective legal and regulatory provisions relating to health financing were analysed, and qualitative data were collected through a total of 15 interviews and (group) discussions using key questionnaires with selected MoH and SHI departments, employer and employee representatives, public and private health providers, and other development partners.

The above health financing performance indicators go hand-in-hand with the three universal coverage dimensions (Figure 2). The first and second dimensions (percentage of population covered, proportion of costs covered) are closely related to the health financing performance indicators. The range of services covered (third dimension) cannot be easily captured in quantitative terms and requires a qualitative assessment (Chapter 4).

Figure 2. The three dimensions of universal coverage



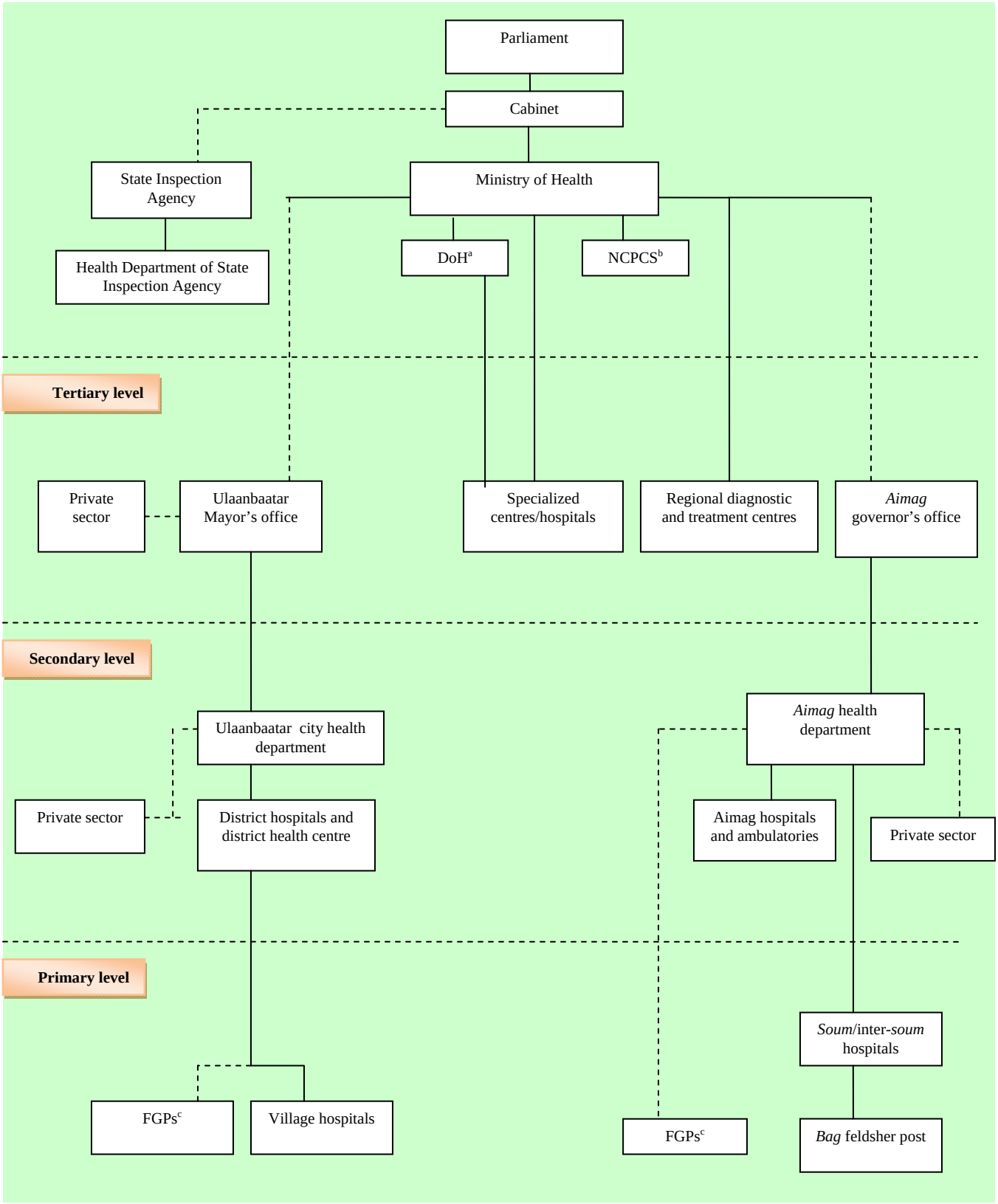
Source: World health report, 2010 (WHO, 2010)

3. The current health financing system

3.1 Health service delivery

The World Bank classifies Mongolia as a lower–middle-income developing country. Administratively, Mongolia has 21 provinces, with each province consisting of between15 and 27 *soums* and each *soum* divided further into 4–8 *bags*. Outside the capital, health services are organized following this administrative structure starting from the "feldsher" (i.e. community health worker) assigned at *bag* level, rural *soum* hospitals at *soum* level with 4–15 beds, secondary hospitals with 150–200-bed capacity at provincial level, and topped by tertiary care hospitals. In addition, family group practices, which were introduced in 1998, provide primary health care to their catchment populations in all provincial centres and in the capital city Ulaanbaatar. Family group practices run as private operations funded by public money. About half of the 2.7 million population of Mongolia live in the capital city, where health services are offered starting from family group practice (FGP) to city district health centres, secondary and tertiary hospitals, and specialized health institutions. The primary health care level (*feldsher*, FGP, *soum* hospital) is accessed by all the population and the provision of care is assumed as a state responsibility. Secondary-level health services are provided by *aimag* and district general hospitals. Tertiary-level health services are provided by regional diagnostic and treatment centres, state clinical hospitals, and other specialized national centres such as the Maternal and Child Health Centre, the National Centre for Cancer Research, and the National Centre for Communicable Disease Research located in Ulaanbaatar city. Figure 3 provides an overview of the health service delivery structure.

Figure 3. Health administration and service delivery structure



Source: Health Sector Strategic Master Plan, Volume 1, 2005

NCPCS: [a] DoH: Department of Health; [b] NCPCS: National Committee for Physical Culture and Sports; [c] FGP: Family Group Practice

The conditions of the health financing system are also influenced by the country's low population density (due to the small size of the population and the vast territory), the high dependence of the national economy on mining, nomadic livestock sectors and importation of fuel and other goods, the harsh climate with long cold seasons, associated living costs and the increasing level of poverty. Tables 2 and 3 present some core development indicators and health expenditure data.

Table 1. Demographic, economic and health indicators of Mongolia

Indicators	Mongolia	Source
Population size	2 754 685	WHO, 2011
Economically active population	540,300	NSC, 2010
Formal sector size	NEED DATA	
Gross domestic product (GDP) per capita (current US$)	1577	WHO, 2011
Poverty headcount ratio at PPP US$ 2 per day (% of population)	NEED DATA	SOURCE
Gini index	0.36	Household survey, 2009
Adult literacy rate (% of people > 15)	NEED DATA	SOURCE
Maternal mortality (modeled estimate, per 100 000 live births)	65	WHO, 2011 (GHS)*
Under-5 mortality (per 1000 live births)	29	WHO, 2011 (GHS)*
Life expectancy (male/female)	65/74	WHO, 2011 (GHS)*

* GHS: Global health statistics, 2011

Table 2. Health expenditure data for Mongolia

Indicators	Mongolia	Source
Total health expenditure (THE) as % of GDP	4.7%	WHO, 2011 (NHA)*
THE per capita (current/2009 PPP US$)	75/167	WHO, 2011 (GHS)
General government health expenditure (GGHE) as % of THE	85%	WHO, 2011
OOP expenditure as % of THE	12%	WHO, 2011

* NHA: National Health Accounts.

As in many central Asian and eastern European countries, the health sector in Mongolia has undergone fundamental changes during the economic transition which started in the early 1990s. The focus of health policy has shifted from curative care to public health

with an emphasis on primary care and the introduction of SHI. However, some reforms in the transition to a market economy created a number of challenges to the efficient use of resources. For example, a policy to encourage private sector development was poorly linked with public sector capacity and performance. Without effective public and private partnership and coordination, the number of private health providers has doubled since 2004, with 536 private providers newly established during this period. Furthermore, in addition to the state medical university, three private medical universities have opened in the capital city. As a result, the number of new doctors increased from 1025 in 2000 to 2782 in 2010. The distribution of medical professionals between urban and rural settings has worsened because of the freedom of choice as to where to work and live. In 2010, the MoH reported that there were eight physicians per 10 000 population in rural areas versus 40.3 physicians per 10 000 population in the capital city. Accordingly, a shortage of physicians and other health workers such as nurses, midwives and feldshers at the primary health care level undermines universal access to quality health services, especially for persons in greatest need.

3.2. Health financing

During the transitional economy reform, the health sector in Mongolia began to use different sources of financing, namely tax-based state budget and SHI which was introduced in 1994. As of 2009, it was estimated that tax-based health financing accounted for 60.9%, SHI accounted for 24.3%, and private sources (including OOP payments) constituted 14.8% of total health expenditure (WHO, 2011). The total revenue covers primary health care services in FGPs, *soum* hospitals, and also specific services at secondary care level in provincial and city district public hospitals, health centres, and specialized public hospitals at tertiary care level in Ulaanbaatar.

SHI benefit covers mainly curative care at secondary- and tertiary-level hospitals along with limited outpatient services and outpatient drugs. Health insurance uses collective contracts with public hospitals, whereas private hospitals are selectively contracted. The major part of OOP spending is on medicines.

4. Institutional and organizational analysis

Before the collapse of the Soviet Union, Mongolia had impressive institutional achievements in the health financing system. An extensive health service network funded from general taxation provided free health care to all the population. Later, SHI was introduced and reached more than 80% population coverage. The state is committed to supporting the low-income and vulnerable population by subsidizing their health insurance contributions. The development of health insurance in Mongolia has had positive impacts on financial planning and the management of resources in public hospitals. It applied sophisticated payment methods by separating fixed and variable costs, bed–day tariffs, risk-adjusted capitation, and now is moving towards case payments.

The achievement in the health financing performance indicators, when set against the indicative targets outlined in Annex 1, is still suboptimal. Funding and population coverage levels are below Mongolia's potential. Financial risk protection and the degree of pooling are limited; health financing continues to be inequitable, whereas administrative efficiency has been improving. In this section, selected core bottlenecks in institutional design and organizational practice in health financing are analysed in detail and the incentives of the stakeholders involved are examined.

4.1 Policy context

The following long- and medium-term policies and plans are being implemented in Mongolia:

- MDG-based comprehensive national development policy;
- Health Sector Master Plan;
- Government Plan of Action for 2008–2012.

The government of Mongolia considers health care financing to be an important component of health care reform and is committed to improving health care financing on the basis of international best practice and experience. In line with the Health Financing Strategy for Asia and the Pacific for 2010–2015 and the *World health report 2010*, the MoH developed a National Health Care Financing Strategy for 2010–2014. This strategy was approved by the Government of Mongolia by joint order of the ministers of Health, Finance, and Social Welfare and Labour. The purpose of the strategy is to improve the health of the people, to provide financial protection for individuals, and to support economic growth and poverty reduction by setting up a financial system that promotes accessibility to and efficiency of health services based on people’s health care needs. The strategy has three specific objectives which are directed to the improvement of equity, quality of health care services and efficiency in resource use through strengthening health care financing with a focus on SHI. However, as of 2011, there is no detailed policy on how to reach universal coverage (i.e. how to enroll the uninsured).

Furthermore, one of the main emphases of this strategy is to establish an independent SHI organization and strengthen its purchasing capacity**.** The government has developed new

amendments to the Citizens' Health Insurance Law (see below) and submitted them to parliament in May 2010, though as yet they have not been discussed and no decisions have been taken. Since this will be a fundamental change in SHI development, broad discussions are ongoing in Mongolian society. These discussions are challenging in view of very different opinions of health insurance that exist among policy-makers and law-makers, some of which could undermine the principle of social solidarity.

4.2. Legal framework

Health care financing in Mongolia is regulated by several major laws that affect health financing directly, namely:

- the Health Law;
- the Citizens' Health Insurance Law;
- the Budget Law;
- the Public Sector Management and Finance Law.

The Health Law defines sources of health care funding and benefit packages to be provided free of charge to all the population. However, the law also includes some provisions related to health insurance financing. New amendments introduced in May 2011 stated that the health insurance benefit package, payment methods, tariffs and selection of health care providers should be approved jointly by the health and finance ministers and the head of the health insurance organization (HIO), which aims to ensure that the MoH participates in health insurance policy-making. Table 3 outlines the new amendments and their anticipated implications.

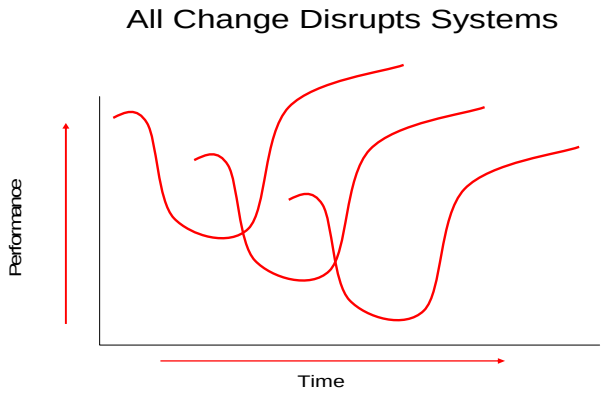
Table 3. New amendments in the Health Law of Mongolia relating to health financing

Issue:		
Prior to 2011	**2011 amendment**	**Implications of amendment**
Health minister approves a list of services to be paid by OOP and rules to deliver these services at state hospitals.	Health minister approves a list of care and services to be paid by OOP and rules to deliver these services at state hospitals. The comparative direct payment amount will be approved jointly by the health and finance ministers.	The law does not clarify objectives related to financial risk protection of people. It remains unclear how coherence with the health insurance benefit package can be ensured, since the package is decided by MoH, MoF and HIO (according to the approved revisions of the Health Law, see below; but not in line with the proposed revision of the Citizens' Health Insurance Law, art. 10.2) This reduces hospitals'
State hospitals earn an income by providing additional services and care, including services paid by OOP. The hospitals spend this income on improvement of working conditions and social security for health personnel, maintenance and service of medical equipment and tools, and supplies of equipment and medicine.	This article is the same, what is added is that the health and finance ministers jointly approve a regulation on spending this income source.	

		financial decision-making space, and makes it an even less conducive environment for DRG.
Government members in charge of health matters approve a list of services to be funded by the state budget and the health insurance fund (HIF), and payment methods and tariffs. Government members in charge of health matters approve a rule to select health care providers to be financed by HIF.	Health and finance ministers jointly approve a list of services to be funded by the state budget, and tariffs and rules for delivery of services.	Involvement of finance minister in defining the list of services is not clear.
Services funded by the state budget: – Medical emergency and ambulatory; – Tuberculosis, cancer and mental illness; – Epidemiological and sanitation measures for communicable diseases, including disinfection and routine immunization; – Consultation, diagnostics and treatments related to pregnancy and childbirth until end of the postnatal period; – Treatment of individuals who have been injured or become ill while saving lives of others or when preventing large-scale damage or disasters; – Some drugs for diseases that require lengthy treatment and palliative care; – Primary health care.	Services funded by the state budget: – Medical emergency and ambulatory – Tuberculosis, cancer and mental illness (by DRG); – Epidemiological and sanitation measures for communicable diseases, including disinfection and routine immunization; – Consultation, diagnostics and treatments related to pregnancy and childbirth until end of the postnatal period; – Treatment of individuals who have been injured or become ill while saving lives of others or when preventing large-scale damage or disasters; – Some drugs for diseases that require lengthy treatment and palliative care; – Medical services for children provided by public hospitals; – Public health services, medical emergency and ambulance services, services provided by the family, *soum* and village health centres, services during disasters and infectious disease epidemics.	In addition to the services previously provided: – Providing medical services to children will affect the option to include children in family coverage); – Primary health care is redefined as services to be provided by the *soum*, village and family health centers. Changing from *soum* hospitals to a concept of health centres may have implications for downsizing health activities, and hence resources allocated for those health facilities.
	Health and Finance ministers and head of SHI governing body jointly approve a list of care and services to be paid by the HIF, payment methods, tariffs, and rules for selecting health care providers.	It will limit the independence of the HIO.
	Health care provider charges and payments for medical services provided for uninsured patients.	The uninsured poor have to pay for services received.

The Mongolian Citizens' Health Insurance Law was approved in 1993 and came into force in 1994. The implementation of this law in Mongolia has had both successes and challenges. One of the challenges relates to the legal environment which has changed quite often. It has been argued that the lack of a long-term vision for an SHI system enabled policy-makers to change the law frequently. Despite health insurance's limited role in financing compared to that of central and local budgets, efforts to improve health care financing have often started with health insurance. As a result, since 1994 the Citizens' Health Insurance Law has been amended five times (in 1997, 1998, 2002, 2006 and 2007), which means that it has changed almost every three years. Some studies argue that frequent changes, without proper assessment, often disrupt the system and reduce performance over time, as shown in Figure 4.

Figure 4. Performance decrease through changes in the system



Source: cf. Bayarsaikhan et al. (2005)

Amendments to the law have often lacked clear objectives or strong justification, have frequently been based on insufficient data, evidence or technical justification, and the process of discussion and approval of change has not been informed by impact assessment of the proposed changes. For example, the health insurance law amendments introduced in 2006 excluded primary health care from the benefit package. Accordingly, the government budget became fully responsible for financing FGPs, *soum* hospitals and specified services at secondary-level and tertiary-level hospitals. However, this change seems to have been introduced without sufficient assessment of its impact on coverage, financing and delivery of health insurance benefits. Although this change ensured universal access to primary health care, the incentive to maintain health insurance membership status has been weakened, especially among the rural nomads, and has created difficulties for referral to secondary- and tertiary-level hospitals.

Efforts to draft rules and regulations aimed at implementing new amendments to the law often come after, rather than before, the discussions on the amendments. No specific

targets and indicators have been identified to monitor and evaluate overall health insurance performance systematically.

Some legal provisions of different laws contradict each other or remain unimplemented so far because of insufficient impact assessment, no study of feasibility, or lack of implementation of regulations and procedures. For example the Public Sector Management and Finance Law which was approved in 2002 contradicts the Citizens' Health Insurance Law in several ways. According to the health insurance law, the HIF which is formed from the collection of contributions is supposed to be managed by the responsible health insurance body. Moreover, the current Budget Law makes the social insurance fund separate from the state budget which is administered by the government. Social insurance, including the HIF, is administered according to social insurance law. However, the Public Sector Management and Finance Law introduced centralized management of the state budget and the HIF under the control of the Ministry of Finance (MoF). The later law also introduced output-based budgeting with the aim of increasing financial autonomy for all budget organizations. Accordingly, the Minister of Health arranges output-based contracting with directors of tertiary-level health care facilities and *aimag* and city governors, thus substantially reducing the role of the HIF in financing and management . The Public Sector Management and Finance Law also conflicts with the Budget Law which supports line-budget planning.

It is difficult for the HIO to take action to improve the performance of health care providers and the quality of health services. Health care providers also face challenges in developing financial plans for budget and health insurance financing controlled by the MoF. The system reduces the distinction between budget funds and health insurance funds and does not allow funds to be managed at hospital level because of restrictions of line-item budgeting. There is no incentive for service providers to improve efficiency since the MoF still uses historical budgeting methods for public hospitals, thus encouraging hospitals to spend more. Such incoherent legal provisions create an unfavourable legal environment and provide many disincentives to improving the performance of health insurance as purchaser and hospitals as service providers. Accordingly, the Mongolian health insurance system is gradually losing its basic operational features as an insurance agency and is becoming more of a funding agent that supplements central and local budget allocations to the health sector without due consideration of actual health insurance benefits, costs and service quality.

As a follow-up to the Health Financing Strategy, the MoH drafted a new legal amendment on SHI which has been approved by the government and submitted to the parliament. The core reform in this new amendment is to make health insurance an independent, efficient and accountable agency with increased purchasing power. Table 7 lists the key proposed amendments with expected implications, together with suggestions for addressing the concerns noted above.

Table 4. The government's newly proposed health insurance law amendments submitted to the parliament in May 2010

Proposed 2011 amendment	Implications of amendment	Suggestions for addressing concerns
Structure of the health insurance scheme		
Institutional status: Implementing agency (art. 15.1), under administration of the government member in charge of health matters; subnational HIO departments: will be under higher HIO *and* governor of relevant administrative/territorial unit. (art. 15.2)	The legal text specifies the HIO as an implementing agency of the MoH and therefore the HIO will not be an independent legal body. It also creates two accountability lines: national council and government member in charge of health matters.	Independence status of SHI agency/organization should be clearly spelt out: e.g. semi-public agency, NGO or whatever status Mongolian law offers.
Institutional attachment: MoH (art. 15.2).	If the insurance agency is really independent and if there is an appropriate division of labour between the stakeholders/contributors involved in decision-making, the actual institutional attachment will be of less importance. However, government agency law of Mongolia puts the agency under the administration of a ministry and therefore makes it ultimately accountable to the respective minister and not to contributors.	
Oversight board: National Council (art. 14.1).		
Appointment of National Health Insurance Council chairman: By prime minister, upon recommendations of the tripartite parties (art. 14.3).	Limits independence of health insurance governing body by making it accountable to the government.	In a really independent model, the oversight board (the National Council) would elect the chairman from among members.
Appointment of other members of the National Council: Prime Minister (art. 14.3).	This clause undermines the power of the National Council (art. 14.1) as the highest governing body of the SHI. The clause	The three parties (government, employers, and policy-holders) should appoint their representatives.

	makes the members of the National Council appointable by one of the three representatives of the Council itself	More detailed implementation regulation would ensure that formal-sector employees, informal-sector employees and subsidized members are all adequately represented among policy-holder representatives.
Duties and powers of the National Council: Monitoring of expenses and performance of income/expenditure; deliberating finance of insurance organization; recommending rate of insurance premiums.	Limited	
Appointment of HIO head (chief executive officer, or CEO): By government, as recommended and selected by the government member in charge of health matters, from among the persons nominated in accordance with para. 45.1 of Law on Public Sector Management and Finance.	Appears like a political appointment, which creates opportunities for (political and other) influence by the MoH.	Ideally, the National Council should appoint the CEO.
Appointment of director of HIF departments at subnational levels: By governor, negotiating with head of central HIO.	HIO thus has no clear authority over its key managerial staff as these are equally dependent on the governor.	Subnational HIO managers should be accountable only to the central HIO, and should therefore also be appointed by it.
Health insurance core functions		
Duties relating to core health insurance functions: Developing proposals relating to the benefit package. No other functions mentioned (e.g. tariff setting, decisions on provider payment mechanism).	These core health insurance functions are regulated by the recently amended Health Law, but not in the spirit of an independent health insurance body.	It is advisable to shift the regulations on health insurance core functions into the SHI law and provide sufficient decision-making space to health insurance.
Determination of premium rates: By government, based on recommendations by the National Council (art. 8.1).		OK.
Benefit package definition: By minister in charge of health matters, taking into account recommendations by the HIO.	In the Health Law: MoH, MoF and Chair of National Council - hence not coherent with the proposed provisions here.	It should be decided as proposed in the SHI law.
Selection of providers: By HIO (art. 10.3).	Important element of strategic purchasing	Good.

Setting of provider selection procedures: By MoH, with recommendations from HIO (art. 10.3).	Limits HIO role as *strategic* purchaser over providers.	It is advisable to specify regulations on health insurance core functions in the SHI law and provide sufficient decision-making space to health insurance.
Total HIO spending: Determined by MoH, with recommendations from HIO (art. 10.6).	Limits independence of HIO in deciding how to spend its revenues.	It is advisable to give financial resource management power to the HIO if one wants to ensure its independence.
Benefit package		
Benefit package composition: (art. 10.1).	Vague. Difficult to assess with the available information. All inpatient services? What is being excluded??	It is advisable that the SHI law should set criteria for defining the benefit package, such as cost-effectiveness etc., in order to avoid ad hoc political decisions.
Benefit package maximum: Prescribed by MoH, with recommendations from HIO.		How to ensure that maximum is not too low, but also not too high? Once set, it should not be dependent on the financial situation of the HIO. The benefit limit should not result in people who need more health services having to face catastrophic health expenses.
Coverage of expenses for health services received abroad:	This will create inequities in access to these services: the better-off and better informed will tend to benefit, as experience from other countries shows.	Health services delivered abroad should be excluded from the benefit package.
Sources and expenditure		
Sources of health insurance funds: No mention of state revenues for subsidized groups (only art. 20.1.3 on human development fund).	An important revenue source is omitted and may endanger the funding of the HIO.	The law should include also a provision for state budget subsidy for target groups. (What happens if the HDF is short of funds?)
HIO expenditure for administrative costs: Not mentioned in art. 21.1.		Law should also include expenditure for administrative costs of the HIO.
Other issues		

Health insurance inspection: Regulated by MoH (art. 18.2).	Does not give the HIF the scope to organize its inspection services according to its needs.	Should be regulated by the HIO itself
Supplementary insurance: Allowed to be offered by HIO, but details remain vague (art. 11.4).	While the law refers to supplementary insurance (arts.11.4, 12.4), it actually means complementary insurance, since this additional voluntary insurance would cover the cost-sharing for services covered under the mandatory insurance. This is not advisable. It creates incentives for moral hazard as top-up insurees would not incur any user fees at all.	A clearer concept of the role and terms of supplementary insurance is needed. It is better to provide supplementary insurance, i.e. cover services (or parts of the costs) that are currently not included in the mandatory insurance benefit package.
Health insurance employee/inspector to be financed for postgraduate study after 3 years (art. 18.3)	This will result in very high fluctuation; moreover, the HIO will lose staff as many of them may not come back.	Such benefits should not be granted after 3 years only, and the grant should be provided only if the returns to the HIO. The law should not specify operational details of the HIO. This should be left to the HIO management.
Patient appeal mechanisms: (art. 24.3) Insurance organization should receive and decide on complaints on quality of health care services from policy-holders and should take actions to protect policy-holders' rights.	New amendment	Good
Quality control: The HIO should involve a professional inspection agency.	This needs more details. It is not clear how this will go together with (art. 24.1) the HIO's own unit on quality control.	In the long term it is good to have an external agency involved in quality control.

Penalties: (art. 26.5) In case of failure to implement health insurance legislation, the higher organization's resolutions and decisions, and health insurance inspector's demands, the guilty official shall be fined 30 000–60 000 MNT, and the organization shall be imposed a fine of 150 000–250 000 MNT.	Vague. Penalties are not differentiated by insured, insurer and providers and thus do not provide sufficient disincentives for noncompliance.	Fines for employers and health service providers should be higher.

4.3 Governance and stewardship

The MoH is responsible for national health policy formulation, planning, regulation, supervision, implementation, monitoring and evaluation. These complex duties require strong leadership and commitment, and detailed and carefully thought-out plans of action. It seems challenging for the MoH, because of its limited capacity and leadership capability, to play a leading role among different stakeholders involved in health-related matters, especially in the context of a contradictory legal environment, as outlined above. The MoH deals with the benefit package, provision and payment methods, and tariffs. The MoF administers both the government budget and the HIF. The MoF plans and determines the health budget and the HIF at national and subnational levels. The MoF and local authorities approve budgets of central, provincial and district hospitals, taking into consideration health insurance revenue plans.

The Health Insurance Inspection and Financing Department of the State Social Insurance General Office (SIGO), under the Ministry of Social Welfare and Labour (MoSWL) is responsible for contribution collection and management of the HIF. There are 22 branches of SIGO, and each branch is responsible for the management of its local funds. The Health Insurance Inspection and Financing Department has relatively few staff, and deals more with budgeting, allocating funds and inspecting than acting as a usual health insurance agency. The size and skill-mix of the staff has not changed over 10 years, indicating a lack of the stewardship role of the MoSWL. According to the Social Insurance Law, the main managing body of social insurance is the National Council on Social Insurance. This council reports to the parliament. The council consists of three members from the ministries of Finance, Justice, and Social Welfare and Labour, three members from the Federation of Trade Unions and three employer representatives from the Employers' Association. The Health Insurance Subcouncil under the National Social Insurance Council has 22 branches divided over the *aimags* and one in the capital city, and has also sub-branches in districts, with the same representatives from government, employers and employees. Duties and responsibilities of these councils are determined by the Citizens' Health Insurance Law (Table 17). The role and capacity of the Health Insurance Subcouncil is limited. The MoH plays the dominant role in decision-making partly because the subcouncil has been chaired by the State Secretary of the MoH. Table 5 shows the roles and responsibilities of multiple agencies involved in health insurance policy implementation and administration

Table 5. Role and responsibility of different agencies involved in health insurance policy implemenation and administration

Agency	Roles and responsibilities
National Council on Social Insurance	• Approve a regulation on family coverage. • Approve a regulation on quality and performance incentives for health care providers. • Approve a regulation on a full health check-up as an incentive for beneficiaries who do not use HIF in three consecutive years.
Health Insurance Subcouncil	• Determine a list of essential drugs to be reimbursed by the HIF, reimbursement rate, and ceiling. • Draft a proposal to improve and revise health insurance matters and propose to related organizations. • Organize a technical working group to develop recommendations. • Develop a proposal on contribution rates. • Determine an annual ceiling for health services to be funded.
National government	• Determine the contribution rates for population categories, except for owners of business entities and the self-employed. • Approve a regulation on selection of a health care provider.
MoH, MoF, MoSWL (jointly)	• Determine the variable cost tariffs for health care services to be financed from the HIF.
MoSWL/SIGO	• Draft a proposal related to the health services to be financed from the HIF. • Determine a contribution rate for owners of business entities and the self-employed.
MoH	• Approve a list of services to be financed by the HIF. • Approve payment method.

Source: The Citizens' Health Insurance Law

The government domination of decision-making with minimal involvement of other members in the Health Insurance Subcouncil creates dissatisfaction among those who do not have a proper voice. In addition, public dissatisfaction with OOP payments and the poor quality of health care brings criticism of the health insurance because clients pay for it every month. Currently, this compels the ministries to give attention to health insurance, and as a result the revision of the Citizens' Health Insurance Law has been debated for the past two years.

The newly developed health insurance law amendment proposes to establish an independent health insurance agency. In this regard, there are ongoing debates regarding which ministry the new health insurance body should operate under. Annex 2 outlines the current institutional-organizational set-up of health insurance in more detail and suggests institutional-organizational requirements for a more independent health insurance scheme.

4.4 Resource mobilization

According to preliminary estimates of the National Statistical Committee (NSC) of Mongolia, GDP growth reached 6.1% in 2010. International market prices coupled with an increase in the main export commodities of Mongolia (such as copper, gold and the use of mining resources) are expected to contribute to the country's economic growth in the near future. This will increase the fiscal space for health. The International Monetary Fund (IMF) estimates that by 2015 the economic situation of the country will improve and GDP will triple due to the start of large mining projects. These positive economic factors are expected to lead to an increase in the state budget as well as in budget allocations to health. Economic growth will also affect people's well-being, and increased household income will enable them to consume and contribute to health.

In the past 10 years, there has been a significant increase in all major sources of health care finance, as shown in Table 9. Both GDP and the general government budget in 2010 were 6.7 and 7.1 times more than in the base year of 2000. During the same time, government health expenditure and SHI increased by 5.3 and 6.2 times respectively. OOP payments increased three times.

However, past experience also suggests that there is no guarantee that health financing revenue will increase at rates similar to GDP growth. In the last 10 years, government health expenditure as a percentage of GDP has decreased in Mongolia from 4.6% in 2000 to 3.3% in 2009 despite its growth in nominal terms. Government health expenditure trends and sources of financing with major categories of expenditure in the last 10 years are shown in Table 6.

Table 6. Trend of government expenditure on health by major source and categories

Expenditure/year	2000	2005	2006	2007	2008	2009	2010
Government health expenditure as % of GDP	4.6	3.3	3.3	3.4	3.5	3.3	3.0
Government health expenditure, Mio. (MNT)	46 861	83 726	103 138	155 400	211 497	206 429	250 265
Government health expenditure per capita (MNT)	19 603	32 862	40 029	43 092	79 530	76 183	90 732
Financing sources							
State budget (%)	74	69	73	77	79	75	73
SHI (%)	20	26	23	20	18	22	24
Other sources of revenue, including OOP (%)	6	5	4	3	3	3	3
Expenses by level of care							
Tertiary health care	23.3	21.4	21	26.6	21.2	21.7	21.2

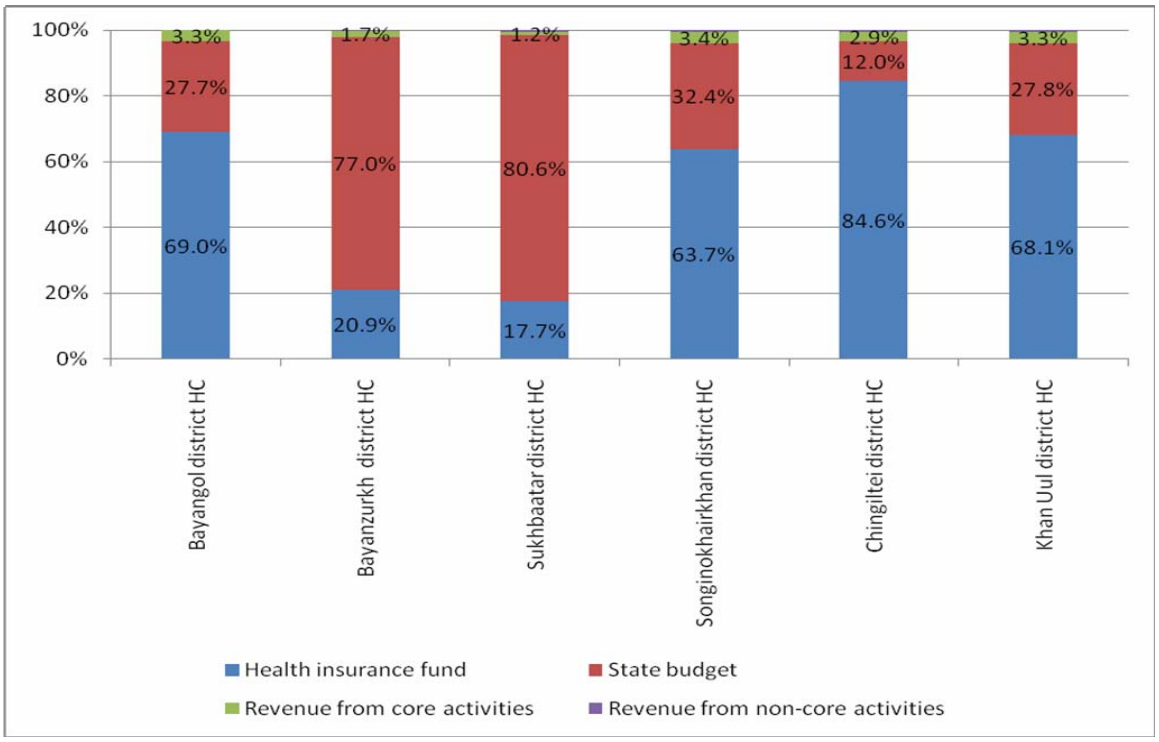
(%)							
Secondary health care (%)	28.7	32.4	32.3	42.3	31.3	31.7	31.6
Primary health care (%)	17.6	22.4	22.7	28.9	24	23.6	21.8
Other (%)	30.4	23.8	24	2.2	23.5	23	25.4
Total (%)	100	100	100	100	100	100	100

Source: 2010 Health Indicators, Department of Health, Mongolia

Table 6 shows that the major sources of public financing in Mongolia consist of the state budget, SHI and other sources of revenue generated from core and non-core activities. However, it does not include official development assistance, such as foreign loans, and OOP spending.

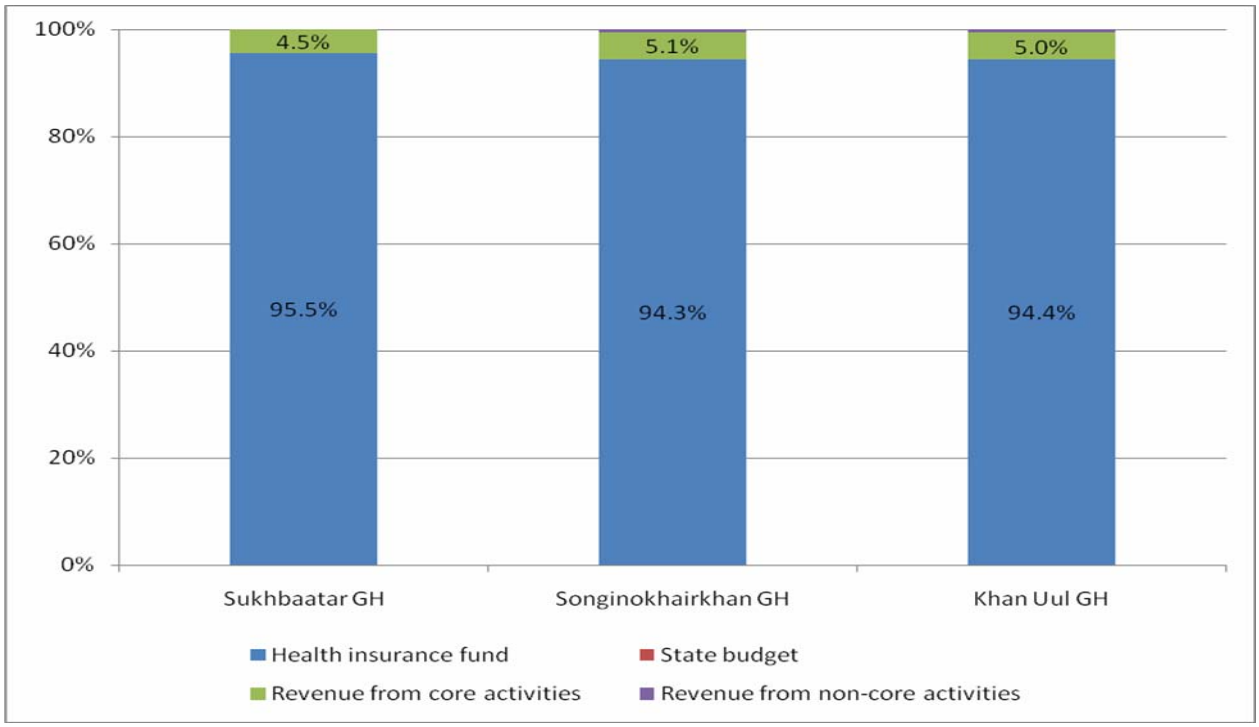
A review of the financial situation of health care providers suggests that the share of state budget and health insurance varies tremendously between similar providers because hospitals are able to receive more funding from the HIF than health centres due to the high utilization of DRG rates. In some cases, hospitals receive almost 90% of their funding from health insurance alone. Figures 5, 6, 7 and 8 show different resource combination patterns for district health centres, district hospitals, *aimag* hospitals and tertiary-care facilities.

Figure 5. Source of funding by district health centres, 2010



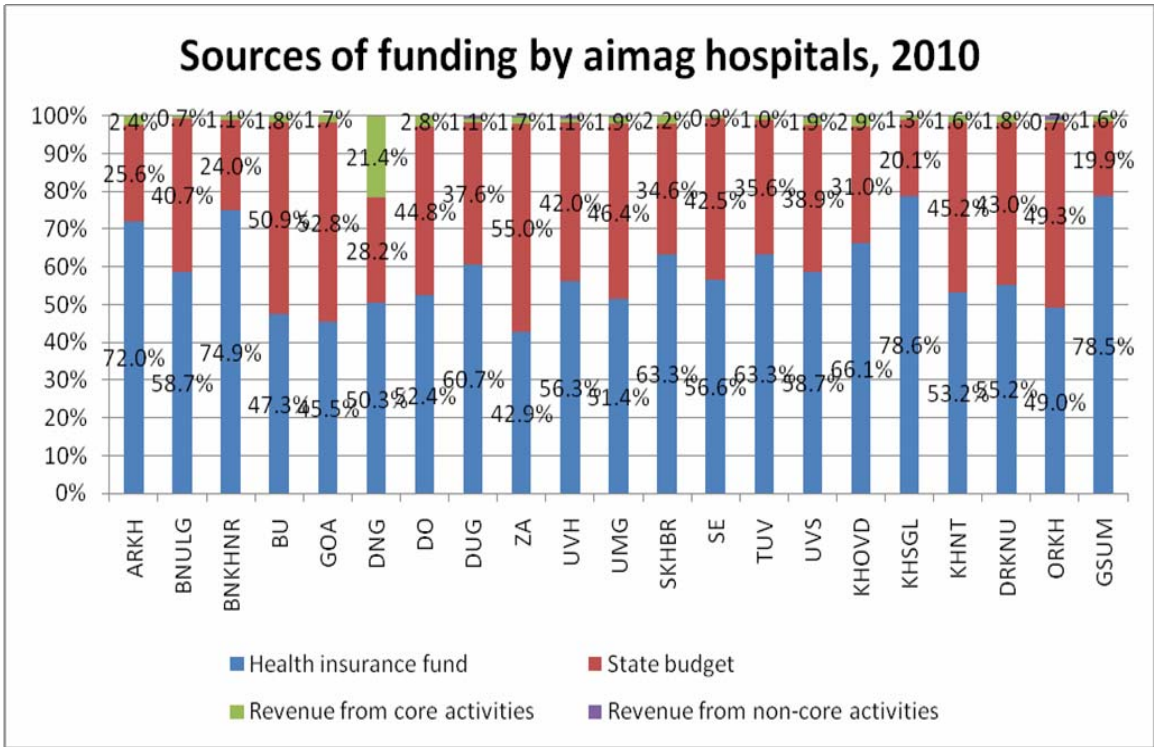
As shown in Figure 5, the share of state budget in public financing ranges from 12% to 80.6% among district health centres which offer the same service and which are governed by the same financing arrangements.

Figure 6. Source of government funding at selected district hospitals, 2010



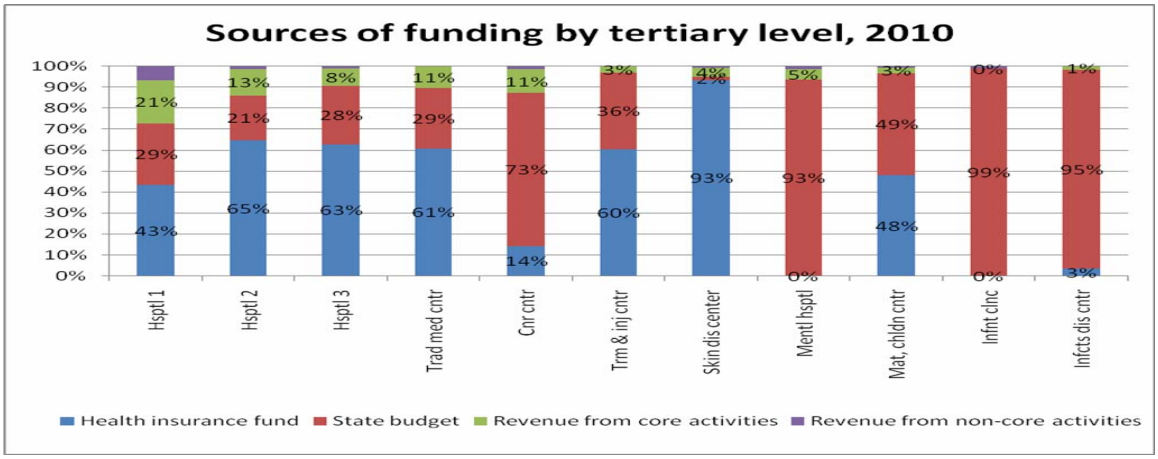
As shown in Figure 6, health insurance funding dominates at district hospitals. At these district hospitals with nearly full funding from the HIF, uninsured persons may not be treated or may not be adequately treated even with services that in principle are financed by the state budget . Ulaanbaatar city allocates more funding from the HIF to the district hospital health centres. For instance, during the influenza season district hospitals kept sick children for 2–3 days but coded for high-cost DRGs such as chronic lung diseases for which a higher average lengths of stay is built into the SHI-DRG tariffs.

Figure 7. Sources of government funding at *aimag* hospitals, 2010



The shares of state budget and HIF in public financing vary notably across *aimag* general hospitals, as shown in Figure 7. In some *aimags*, the state budget is responsible for 19–20%, but in other *aimags* it ranges from 49% to 50%. Likewise, there are large variations for health insurance funding, ranging from 42.9% to 78.6%. A similar pattern is found among tertiary health care facilities located in Ulaanbaatar (see Figure 8).

Figure 8. Sources of government funding by selected tertiary health care providers, 2010



These data suggest that SHI-DRG tariffs largely determine the financing pattern of public health providers rather than the actual health care benefits to be funded by the state budget or SHI.

Although the government budget is a major source of health system financing, the budget planning, implementation, monitoring and evaluation process is relatively weak at all levels.

SHI is the second largest revenue source in health care financing. Currently, there are 2,122,900 thousand insured people who contribute 72.4 billion MNT to health insurance funds, out of which 56.9 billion MNT were spent on health insurance benefit provision to 1736.6 insured beneficiaries in 2010. There is thus a large surplus, and in fact a very large reserve level accumulated over the past years. About 67.9% of revenue is collected from employee and employers' contributions, 13.3% from the state subsidy and 7.3% from the contributions of herders, students and unemployed insured people. However, there is little involvement of the SHI authority in resource mobilization and financial planning of health care providers since major decisions on budget appropriation and disbursement, as well as health insurance fund planning and allocation to health care providers, are controlled by the MoF.

The parliament approved a new Law on the Human Development Fund in 2009 which established a human development fund from the revenue collected from the mining sector. It was decided to allocate some proportion of this fund to the health sector by supporting health insurance coverage and contribution payments. Accordingly, the parliament approved the allocation of 10.9 and 20.2 billion MNT in 2010 and 2011 to pay health insurance contributions for the people eligible for a government contribution subsidy.

OOP expenditure has become a potential source of revenue in Mongolia. Currently, user fees are being charged in all public hospitals according to the health minister's Order A277 (2006). The order provides a list of services to be charged at public hospitals, which is shown in Table 10. However, children under 16 years of age, pensioners (women above 55 and men above 60) and disabled people are exempted from fees applied for outpatient diagnosis and tests except for nuclear diagnosis, CT scan, diagnosis for cosmetic treatments, and check-up and tests required to obtain a driver's licence, employment and admission to schools.

Table 7. Health services to which user fees are applicable in public hospitals

Outpatient diagnostics and tests	Outpatient treatments	Others
• Nuclear diagnostics • CT scan • Electrocardiograph • Electroencephalograph • Endoscopy • Ultrasound (abdominal organs excluded) • Radiology (except fluorography) • Doppler ultrasound • Bacteriological tests • Immunological tests • Cytological and gastrological tests • Diagnosis for cosmetic treatments • Health check-up and tests required for obtaining driving licence, employment and admission to schools.	• Nuclear treatment • Adult dental treatment, prosthesis and ortodental services • Laser correction of eyesight • Voluntary vaccination • Artificial insemination and fertility • Abortion.	• Prosthetic devices for surgery such as braces, artificial limbs, bones, vessels, pacemaker • Tubes and substances for angiograph, mimeograph, astrograph etc • Filter for dialysis of chronic kidney failure • Other prosthesis • Diagnosis and treatment of injury and poisoning related to alcohol and substance abuse.

The amount of user fees set by hospitals is based on cost analysis and approval by the MoH. Since 2010, outpatient diagnostic tests began to be supported by health insurance up to an amount of 30 000 MNT per case per month. The diagnostic tests mostly include electrocardiography, ultrasound and blood tests.

Health insurance also requires copayments that range from 10% of total benefit spending at the secondary level to 15% at tertiary-level public hospitals. However, the following population groups are exempted from these copayments:

- children under 16 years of age (or under 18 if in high school);
- persons on a pension and without other sources of income;
- mothers or fathers looking after their babies under two years of age (or under three years in the case of twins);
- military personnel on active duty;
- persons specified in article 18 of the Social Welfare Law (handicapped people with more than 50% disability, the elderly with no one to look after them, women who are head of households with four or more children, etc).

The joint order (A370/387) of the health and finance ministers in 2006 approved a list of additional services to be charged at public hospitals in order to increase hospital revenues, as follows:

- outpatient services and diagnostic tests, outside of regular working hours;
- inpatient private bed with additional service (use of up to 10% of total beds allowed);
- food service specially ordered;
- laundry;
- transportation service;
- home visits at patient's request outside office hours;
- accommodation (hotel service) for patients' relatives;
- contracting with economic and business entities and organizations for outpatient diagnostic tests and services;
- other services, such as providing a daily newspaper, computer, fitness room, swimming pool and children's playground.

These efforts to mobilize additional revenues through user fees have a direct impact on the increase in the OOP share of total health expenditure unless they are well regulated and monitored. According to the Living Standard Measurement Survey of 2002–2003 and the Socio-Economic Survey of 2007–2008 (National Statistics Committee), OOP expenditure increased by 2.4-fold from 1919 MNT in 2002 to 4676 MNT in 2007 (MOH/ADB/GVG, 2010). A survey conducted by the MoH (Tsolmongerel et al., 2011) revealed that 51.1% of patients admitted to secondary-level hospitals paid fees (Table 8).

Table 8. Health payments at the *aimag* and district hospitals

No	Type of services paid for by OOP	Share of patients who paid fees (%)	Average fees (MNT)
1	Inpatient copayment	39.3	17 530.2
2	Payment for surgical materials	3.2	42 668.0
3	Payment for private room	5.0	17 066.9
4	Payment for laboratory tests	3.0	21 797.5
5	Payment for other diagnostic tests	3.9	27 277.7
6	Payment for drugs and supplies	1.9	24 811.4
7	Payment for treatment devices	0.9	4650.0
8	Payment for nonmedical services	0.7	4968.7
	For all types of services:	**51.1**	**25 011.5**

Source: Survey report on OOP payments at *aimag* and district health facilities, Tsolmongerel et al., 2011.

In addition to formal OOP spending, patients make informal payments mainly due to poor quality of care and poor attitude of medical personnel. The survey findings showed that 9.1% of outpatients and 15.5% inpatients paid informal fees when they received medical care (Tsolmongerel et al., 2011).

OOP spending in Mongolia consists of multiple types of payment, including direct payments and copayments to public and private providers, private purchase of outpatient medicine, and household health expenditures on overseas medical treatment. Therefore, the resource mobilization option through OOP payments needs to be assessed carefully because of its potential adverse impact on access to health services and in terms of equity and impoverishment of the population. International experience suggests that OOP payment is not the advisable option for resource mobilization for health. Countries need to look for other options and use predominantly prepayment mechanisms that include various taxes and insurance contributions.

4.5 Social health insurance

As of today, the HIF supports medical services in secondary- and tertiary-level hospitals, for outpatient consultations, diagnostic tests and outpatient medicines that are included in the national list of essential drugs. The insured are eligible for medicine benefits if prescribed by *soum* or family doctors.

The main objective of SHI is to ensure access to a benefit package of quality health services by all members according to their needs. It is also seen as an instrument for promoting social solidarity and the willingness to share financial risks among members, thereby contributing to the goal of equity. Health insurance is an option for funding health care.

4.5.1 Organization and management of social health insurance

Strong political support and commitment has ensured many successes in introducing SHI in Mongolia. The law ascertains SHI as a part of social insurance managed by the MoSWL, with specified government roles and a tripartite health insurance council for organizing and managing health insurance, and with the SIGO in principle in charge of the management and operation of the SHI scheme.

However, there is no long-term strategy for the development of health insurance. Different views and positions of related line ministries remain puzzling. It is difficult to address health insurance development issues systemically when some views are lobbied through various channels. All stakeholders agree that health insurance should be an independent agency. However, their views on independence differ. For some stakeholders and decision-makers, it will be important to decide who will appoint the CEO or director of this new health insurance agency and to whom the director will report. Mongolian government agency law requires that all related financial and human resources decisions should be made by the respective minister under whom an agency will operate. In principle, however, if SHI is really independent, this is not so important as long as the new agency/organization bears full responsibility for the operation of health insurance – including population coverage and revenue collection – and is accountable for benefit spending and the provision of quality services to the insured. The MoH supports the proposal to give a sufficient degree of independence to health insurance operation and

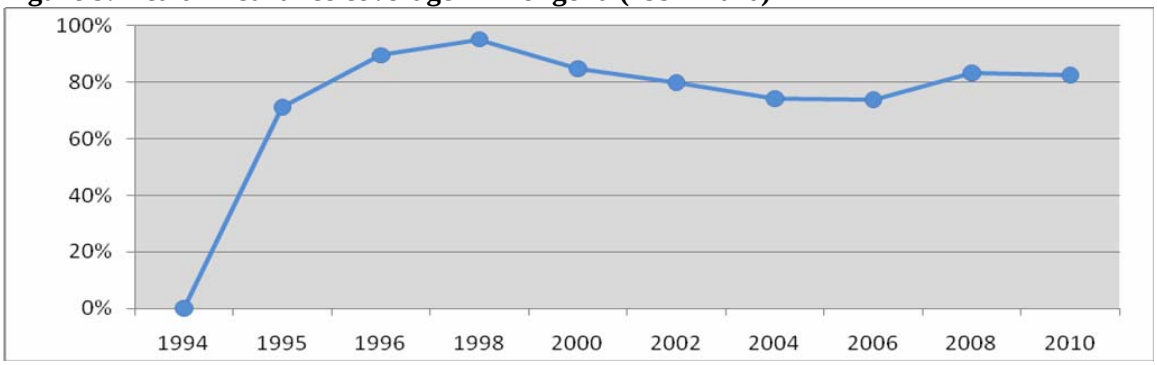
fund management. Despite such willingness, the newly approved Health Act has enabled the MoH to approve the benefit package, select providers and set payment tariffs for SHI services in discussion with the MoF and the Chair of the Health Insurance National Council.

Issues related to the HIO and management aspects have been administered by the MoF rather than by the insurance authorities. As a result, health insurance operation focuses on the allocation of health funds rather than on contribution collection, risk protection, pooling and purchasing aimed at ensuring better delivery of health insurance benefits in the form of quality health services. On the other hand, the MoH decides all other technical matters for SHI.

4.5.2. Coverage

The Mongolian Citizens' Health Insurance Law has a notion of universal coverage since it stipulates coverage of all population categories by collecting health insurance contributions on both a compulsory and a voluntary basis. The law defines health insurance membership by individual population categories such as children under 18 years of age, students, salaried employees, informal-sector employees such as self-employed herdsmen, and low-income vulnerable groups including older persons living without any income except their old-age pension allowance. In 2003, health insurance became mandatory for all population groups.

Figure 9. Health insurance coverage in Mongolia (1994–2010)



Source: State Social Security General Office, 2011.

As shown in the Figure 9, health insurance coverage was almost universal during the period 1996–1998 after its introduction in 1994. However, it has reduced since 1999 and currently it is estimated that 82.6% of the population is covered by health insurance. This is mostly due to low health insurance coverage among herders (24.3% in 2009) and students (33.8% in 2009).

4.5.3. Contribution collection

The government was given the authority to examine and approve health insurance contribution rates proposed by the Health Insurance Subcouncil. The law specifies the type of health insurance contribution and its payment arrangements for each population category. The contribution rate for salaried workers and civil servants was set as a percentage of monthly salary, and both employers and employees are to share equally the contribution payment. Initially, the rate was 6% of salary but this was reduced to 4% in 2006 as part of a policy decision to reduce the burden of contributions to the social security system. As an employer, the government pays a half of contributions for civil servants. A flat-rate contribution is applied to vulnerable, low-income and self-employed persons. In addition, the government is responsible for payment of contributions on behalf of vulnerable and low-income population groups such as children under 16 year of age, pensioners, and the poor with only an old-age pension or social assistance allowances, as well as women caring for children under two years of age. Initially, the health insurance contribution rate subsidized by the government was set at 400 MNT (less than US$ 0.3) per person and was raised to 500 MNT in 2002 and 670 MNT (about US$ 0.5) in 2006. The contribution rate for self-employed persons is set at 1% of monthly income.

Table 9. Health insurance revenue and expenditure

	1996	1999	2002	2005	2008	2009
Total revenue	**5780.8**	**9525.8**	**22 252.5**	**32 574.2**	**62 559.2**	**68 524.4**
State subsidy	3360.1	4857.2	4856.6	4856.6	8094.3	8094.3
Premium contributions	2420.7	4668.6	17 395.9	27 717.6	54 464.9	60 430.1
Total expenditure	**523.8**	**10 805.4**	**14 635.6**	**22 360.1**	**47 736.5**	**53 272.4**
Public hospitals		10 012.3	12 603.8	17 185.2	41 021.5	45 198.8
Spas and sanatoria	261.4	171.5	290.7	462.7	1190.8	1507.6
Drug discounts	219.1	149.3	424.6	571.1	884.4	1486.2
Private hospitals	43.3	472.3	1316.5	2154.0	4639.8	5079.8
FGP				1987.1		
Others	8924.2	560.4	684.4	1221.2		

Source: Ministry of Social Welfare and Labour, 2010.

Table 9 provides an overview of health insurance revenue and expenditure for the period 1996–2009. Because of high coverage, health insurance contributions of the formal sector account for a substantial part of health insurance revenue. However, whereas in 1996 revenue from state premium subsidization amounted to 58%, it constituted only 12% in 2009, against full coverage of the members with a subsidized premium. While cross-subsidization is an important element of an SHI scheme, these figures may indicate that

the current rate of subsidized premiums is rather low and, in particular, way below the average benefit package costs.

Potential revenue collection from the self-employed is not fully realized because of low insurance coverage compared to other population categories. Recently, the health insurance administration has tightened the penalty for uninsured self-employed people with a condition to pay a full four years' contribution in order to become an insured member. In principle, this is important for improving governance and compliance with the law and regulations. On the other hand, it is questionable whether the amount is affordable for the majority of uninsured persons who seem to have limited opportunities for income-generation (ADB, 2009)

4.5.4. Utilization of health insurance benefits

Attaining universal coverage under SHI implies not only population coverage but also equal and effective access and utilization. In other words, it is important to ensure that the insured people have access to and use of needed health services without exposing themselves to financial hardship. Utilization of health services among insured persons in Mongolia is shown in Table 10 which contains data from 2005.

Table 10. Utilization rate among different insured categories, 2005

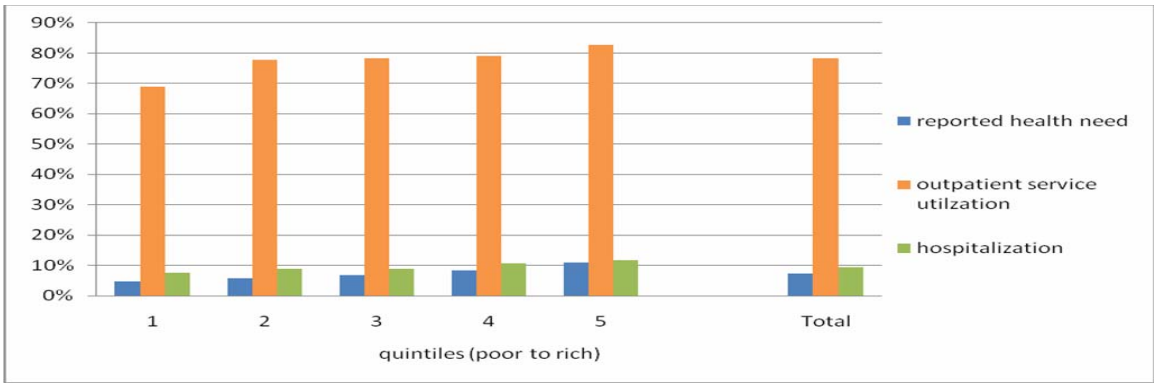
Population category	Utilization rate	Number of insured	Number of insured who used insurance benefits
Children			
Provincial and rural centres	0.36	634 851	226 094
Capital city	0.15	310 244	47 228
Formal-sector employees			
Provincial and rural centres	0.52	174 658	91 001
Capital city	0.18	203 287	35 624
Informal-sector employees			
Provincial and *soum* centres	0.27	150 938	40 132
Capital city	0.64	71 056	45 768
Pensioners utilization rate			
Provincial and rural centres	1.70	162 402	275 820
Capital city	1.00	85 100	85 118
Self-employed, including nomads			
Provincial and rural centres	0.29	221 565	63 622
Capital city	0.01	17 772	164
Students			
Provincial and rural centres	0.22	24 313	5313
Capital city	0.14	35 500	4930
Low-income and vulnerable			
Provincial and rural centres	0.41	75 840	31 374
Capital city	0.45	22 422	10 019

Source: Ministry of Social Welfare and Labour, 2006.

Table 10 suggests that elderly, low-income and vulnerable people use health insurance benefits more than any other insured category. Low utilization is observed among the self-employed and students. Insured people also tend to use more provincial and rural health facilities, except for the informal-sector employees who earn income in the capital city rather than in provincial and rural centres. This can partly be explained by the size of families and the number of nomad households which are the main features of rural and provincial settings compared to urban cities. On the other hand, it may also be associated with morbidity and mortality patterns in the rural and urban populations.

Health care needs and utilization of health services (outpatient and inpatient) by income quintiles are shown in Figure 10. The health service utilization is fairly similar across all quintiles, except for minor differences between the well-off and the poor. It suggests that Mongolians can access and use health services relatively equitably due to the dominant tax and SHI financing. However, the rate of reported health needs of the lowest income quintile is less than half that of the richest income quintile, which is somewhat counterintuitive since lower-income quintiles are usually expected to have a higher disease burden. Yet, cultural reasons and self-perception critically influence self-reported health needs.

Figure 10. Health care utilization by income quintile



Source: Oyungerel et al., 2011

However, there is risk as long as health care providers require official and unofficial payments. Therefore, health insurance administrators need to analyse the use of different types of health insurance benefits, their costs and their impacts on household income.

4.6 Benefit package

The health and health insurance laws of Mongolia differentiate the health and medical care services that are to be provided to the population according to whether they are funded from the government health budget or the HIF. Initially, the government budget was intended to cover the provision of preventive, public health services, maternal and child care and treatment of chronic and infectious diseases such as diabetes and HIV/AIDS. The health insurance benefit package included outpatient and inpatient care

delivered at primary, secondary and tertiary levels. The benefits also included outpatient drugs prescribed by *soum* hospitals and family physicians in order to support the essential drug policy.

The health insurance benefit package mainly covers inpatient care. The health insurance services are provided by secondary and tertiary care hospitals, traditional medicine facilities, sanatoria and rehabilitation centres. According to the Citizens' Health Insurance Law, services and care for diseases of the internal organs, nervous system, eye, ear, skin, bone and muscle tissue, as well as non-emergency injuries and surgery are included in the benefit package. In addition, 50–100% discount on essential drugs prescribed by the *bag*, *soum* and FGPs are covered. Determining the type and detailed list of services to be included in the health insurance benefit package is a responsibility of the Minister for Health. The benefit package was extended to outpatient diagnostics and tests, palliative care and long-term rehabilitation services by the 180th Order of the Minister for Health in 2010. Subsequently, the tariffs of outpatient diagnostic tests and outpatient services were revised and separate tariffs were established. Table 11 presents the most recent situation with regard to the composition of the benefit package.

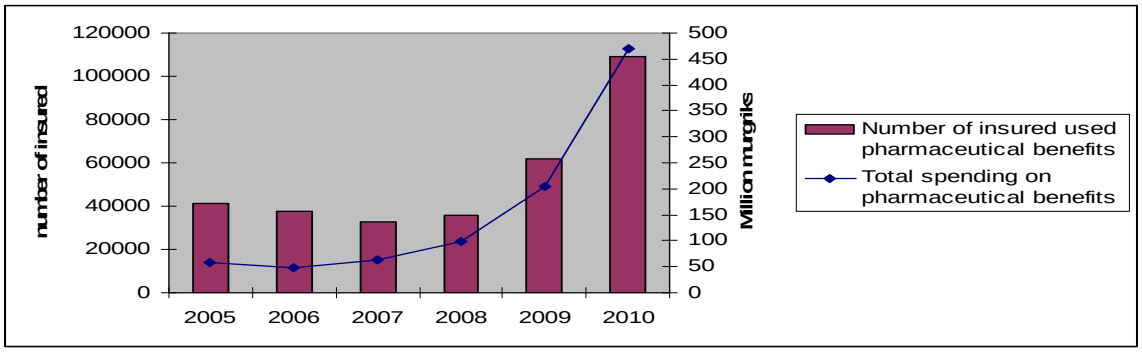
Table 11. Health service benefits funded by the state budget and by health insurance

Health services and treatment of diseases financed by state budget	Services and treatment of diseases funded through health insurance
Consultation, diagnostics and treatments related to pregnancy and childbirth until the end of the postnatal period.	Inpatient and outpatient services at secondary and tertiary care levels.
Medical services for children provided by public hospitals.	Day care at secondary care level.
Epidemiological and sanitation measures for communicable diseases, including disinfection and routine immunization.	Diagnostic tests.
Public health services, medical emergency and ambulance services, health services provided by the family, *soum* and village health centres, and medical services during disasters and infectious disease outbreaks.	Traditional inpatient treatment. Long-term care for patients admitted to sanatoria and rehabilitation centres.
Treatment of individuals who have been injured or become ill while saving the lives of others or preventing large-scale damages.	Inpatient palliative care.
Treatment of tuberculosis, cancer, HIV/AIDS and mental illness (by DRG).	Rehabilitation services for patients admitted to sanatoria.
Some drugs for diseases that require lengthy treatment and palliative care.	Essential drugs prescribed by the *bag*, *soum* and family doctors.

It is argued that the financial plans approved for providers are often below their cost of services and, therefore, public providers are allowed to charge patients fees set by the MoH. However, a study (Oyungerel et al., 2011) suggested that variable cost of services was 204 694 MNT and the SHI-DRG tariff was set at 200 000 MNT. Copayment is allowed at public hospitals for all except children under 16 years of age, pensioners and disabled persons. However, it is common for people to pay more to providers informally. This has resulted in a gradual increase in the direct OOP share of total health expenditure.

Specifically, health insurance benefit spending on pharmaceuticals needs more attention. A study on the distribution of health payments and the assessment of catastrophic health expenditure in Mongolia revealed that almost 80% of OOP spending relates to pharmaceuticals. Currently, the private sector dominates the pharmaceutical market and medicine prices are poorly controlled and monitored. As a result, pharmaceutical prices and expenses have increased notably in the last two years and it is likely there will be a higher demand for pharmaceutical benefits among the insured. Figure 11 shows the utilization of pharmaceutical benefits in the capital city for the period 2005–2010.

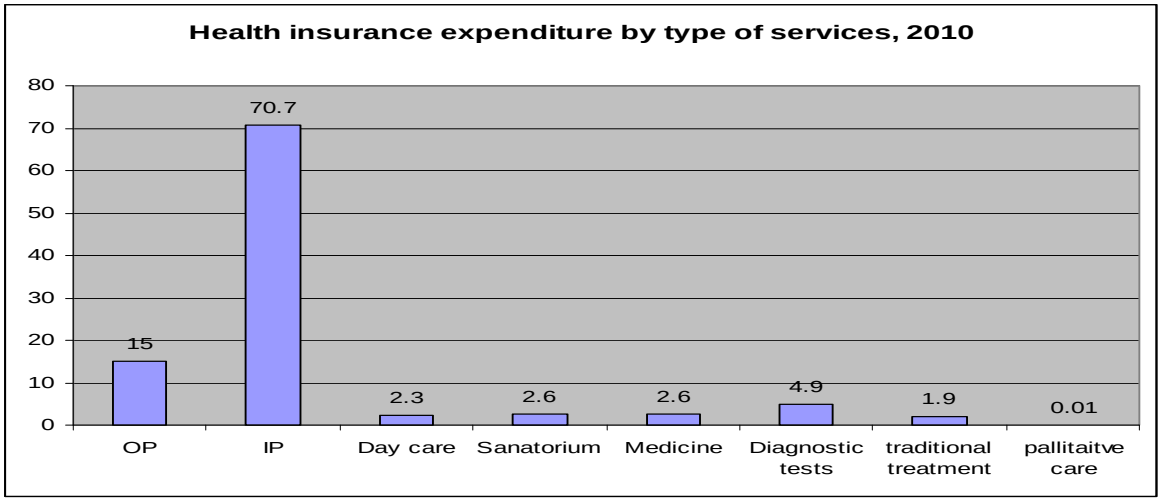
Figure 11. Utilization of outpatient pharmaceutical benefits in Ulaanbaatar, 2005–2010



Source: Data from Ulaanbaatar city health insurance administration office, 2011.

As shown in Figure 11, the number of insured people who use outpatient pharmaceutical benefits increased from 41 129 in 2005 to 109 292 in 2010. The total spending on pharmaceutical benefit also increased from 58 061 937 MNT to 468 532479 MNT. In per capita terms, pharmaceutical benefit spending is increased from 1412 (US$ 1.2) to 4287 MNT (US$ 3.5). It more than doubled in 2010 compared to 2009. Therefore it is advisable to analyse these increases in utilization of pharmaceutical benefits for at least two reasons: firstly to contain the cost by rationing utilization of pharmaceutical benefits, thus increasing efficiency in resource use, and secondly to provide greater financial risk protection against high pharmaceutical expenditure, especially for low-income and vulnerable persons. However, overall, spending on pharmaceuticals through health insurance is still rather low. Figure 12 shows the expenditure proportions for the year 2010 (see also Table 13).

Figure 12. Health insurance expenditure by type of services, 2010



Source: Health indicators, Department of Health, 2010.

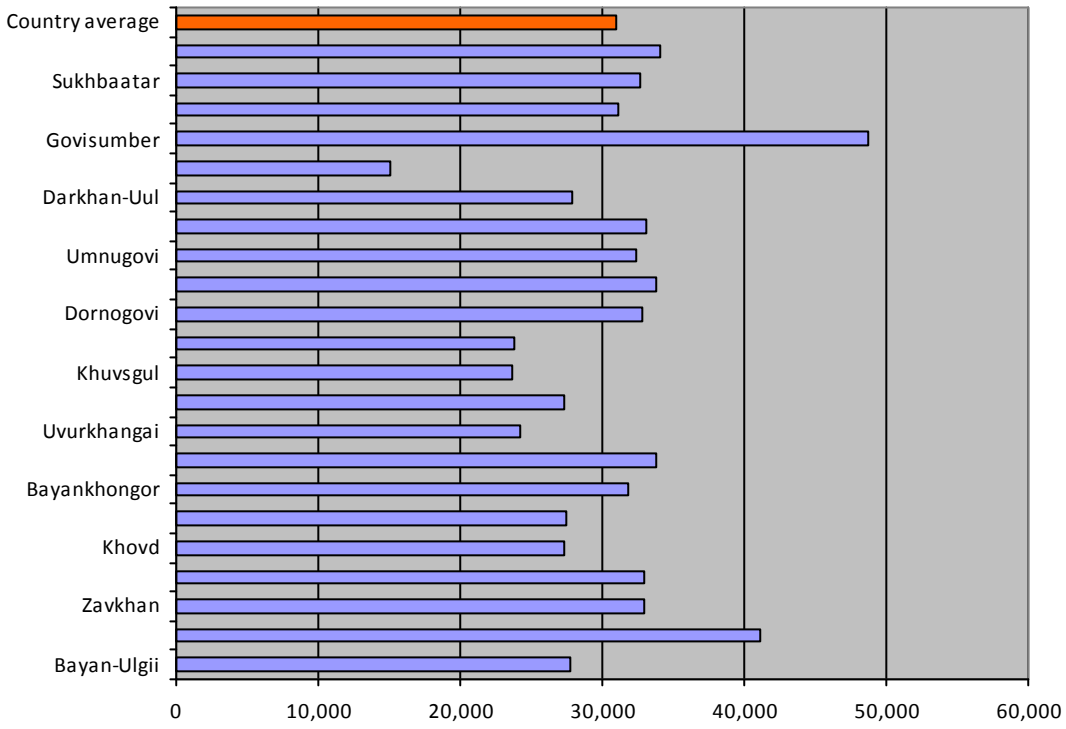
Health care providers often see health insurance as a funding mechanism and therefore, they are interested in receiving more funds rather than delivering quality health care benefits to the insured. Health insurance administrators also see health insurance as a funding mechanism, but no efforts are exerted to advocate for health insurance benefits among the population or to make them more clear, attractive and responsive to people's needs. Similar views exist among budget and finance experts but no initiatives have yet been taken to contain health care costs. This is possibly one of the reasons why the government was able to keep its subsidized flat-rate contribution for low-income and vulnerable populations at a very low level for many years despite substantial increases in health care costs.

Without addressing these issues, it will be extremely difficult to advance SHI development and provide a decent health insurance benefit package with sufficient and sustainable contributions. It is also desirable that health insurance benefits are attractive enough and include comprehensive ambulatory and inpatient care with a strong primary health care base and an efficient referral system that is updated regularly.

4.7 Purchasing and contracting

Government allocation to *aimag* governors and directors of tertiary-level hospitals and specialized centres is based on historical line-item budgeting rather than on actual need. As a result, per capita spending across *aimags* is considerably unequal, as shown in Figure 13.

Figure 13. Per capita government health expenditure across *aimags*, 2006



Source: Chimeddagva D, Health Care Financing System in Mongolia, 2008.

Purchasing is a new concept in health care financing practice in Mongolia. Under centralized management of the economy, the government alone provided and funded all health services for the entire population. Mongolia began to experiment with provider payment methods when health insurance was introduced in 1994. Initial payments such as bed-day tariffs aimed to increase utilization of health services in public health facilities. Capitation payments for FGPs were used to increase health insurance coverage among the population. Later prospective payments that separated fixed and variable costs were aimed at containing costs and at improving service quality and efficiency of health insurance fund utilization in attaining defined service targets agreed between the health insurance and service providers in the form of contracts.

Payment tariffs for private providers have not changed since 2003. The base tariff was kept at about 35 600 MNT for seven years. The basis for paying private providers was a percentage established through an accreditation process. Meanwhile, payment tariffs for public providers have changed five times since 2003. Private hospitals have full liberty to set their service fees and there is a lack of regulation for setting ceilings or limiting OOP payments at private hospitals. This means that patients at private sector facilities have been bearing the difference between approved tariffs and provider costs, and this has surely affected the level of OOP spending in Mongolia. Since 2010, however, the MoH has increased the payment tariffs for private hospitals. However, the payment level has been kept on average at half of the amount reimbursed to public hospitals.

Recent moves towards case payment (DRG) aim to improve the quality of health services. However, health care providers need more support and guidance on the application of case payments. They see DRG as a method for increasing funds from health insurance rather than as a mechanism for improving the efficiency and quality of health care services. Health care providers also have very limited authority to manage and use their budgets efficiently. Partially due to poor financial planning, budget expenditures are controlled by each cost item (such as salary, medicine, food, electricity and heating) and therefore there is a very little room to manage cases and funds. In other words, the lack of a supportive environment will undermine the use of DRG in efficient and effective ways.

Historical line-item budgeting is widely used for budgetary financing without due consideration of cost inputs and the performance of health care providers. At the same time, the capacity in the MoH is too weak to generate strong economic and health outcomes that are evidence-based and can be used to justify an increased health budget with the MoF or demonstrate the inappropriateness of historical line-item budgeting and planning.

Table 12 gives an overview of health service benefits and respective provider payment methods in Mongolia.

Table 12. Overview of services/ benefit package and respective provider payment mechanism and cost-sharing scheme

Level	Name	No. of pro-viders	Services	State fund		Health Insurance Fund	
				Provider payment mechanism	Cost-sharing	Provider payment mechanism	Cost-sharing
PRIMARY	*Bag* feldsher		Home visits Antenatal and postnatal care Health promotion and education Early detection of diseases Refer cases to *soum* hospitals Prescribe essential drugs.	Salary (included in *soum* hospital budget)	No	-	20–50% of the outpatient drug cost prescribed by a *bag* feldsher
	Soum hospitals	274	Outpatient services, including prescription of drugs Inpatient services, including delivery Diagnostic tests Home visits Emergency care Public health services.	Capitation payment: 21 980 MNT x coefficient which differs by *aimag*. Different coefficients for *soum* and inter-*soum* hospitals within the *aimag* *	No	-	20–50% of the outpatient drug cost prescribed by a *soum* doctor
	FGPs	218	Outpatient services, including prescription of drugs Diagnostic tests Home visits Emergency care (limited) Public health services.	Capitation payment adjusted by age, sex and location (varies from 5040 to 16 128 MNT **	No	-	20–50% of the outpatient drug cost prescribed by a family physician
SECONDARY	Inter-*soum* hospitals	37	Outpatient services, including prescription of drugs Specialized inpatient services, including delivery Diagnostic tests Home visits Emergency care Public health services.	Budget (fixed costs)	No	DRG for a secondary hospital	No
	Aimag and district	*Aimag* 17; District	Outpatient services, including prescription of drugs Inpatient services	Budget (fixed costs)		DRG Fee for service for outpatient	10% copayment (vulnerable

	hospitals	12; Rural general 6	Outpatient and inpatient diagnostic tests Emergency care Public health services.			consultation (9000 MNT) and diagnostic tests (up to 30 000 MNT per case)	population categories are exempted) Outpatient fee for services set by the hospital according to the Minister's Order 277, 2006.
TERTIARY	Tertiary hospitals and National specialized centres	RDTC 4; Tertiary hospitals 3; National specialized centres 13	Outpatient services, including prescription of drugs Inpatient services Outpatient and inpatient diagnostic tests Emergency care.	Budget (fixed costs)		DRG	15% copayment (10% for RDTC) (vulnerable population categories are exempted) Outpatient fee for services set by the hospital ***
	Pharmacies	666	18 pharmacies have licences to sell essential drugs reimbursed by the HIF in Ulaanbaatar districts. Each *soum* and *aimag* centre also has pharmacies with a licence.	Privately owned	100% outpatient drugs (except for essential drugs reimbursed by the HIF)	50–80% of drug price reimbursed by the HIF to the pharmacies for 135 essential drugs (362 drugs by commercial names)	20–50%

	Private hospitals	166	Nationwide, 134 hospitals are selected to receive funding from health insurance (Health Minister's Order A99, 2011). Outpatient consultation, diagnostics, treatment and prescription Inpatient services.	Fee for service for outpatient services	100%	DRG (half of the public hospital tariff)	Flat rate for inpatient care in addition to HIF payment
	Private clinics	947	Outpatient consultation, diagnostics, treatment and prescription.	Fee for service	100%	-	-
	Sanatoria	16	9 sanatoria and 9 rehabilitation centres are selected to receive funding from health insurance (Health Minister's Order A 99, 2011).	Flat rate		DRG (50 000 MNT for or rehabilitation and sanatorium services)	Flat rate

Source: Health Minister's Orders; Health indicators, 2010, Department of Health

RDTC: Regional Diagnostic and Treatment Centre

* Health and Finance Minister's Joint Order A16/19 in 2007.

** Health and Finance Minister's Joint Order, 2010.

*** According to the Minister's Order 277(2006) and Joint Order 370/387 (2006) .

In principle, both public and private providers can deliver health services to the insured and receive funds from health insurance. In practice, only some selected private providers who have contracts with the HIF receive funds from the HIF. Private hospitals are supposed to be selected through a formal selection process. However, the relevant regulation on this was not effective until June 2010. The selection criteria are expected to be two main types of indicators – general and specific. Nine general and seven specific indicators are proposed. The general indicators relate to structure, capacity and service quality of private providers and the specific indicators relate to professional staff and their skills, which are the same for all hospitals.

The Public Finance and Management Law, which was approved in 2002, required all budget entities to have a service delivery contract with relevant ministries, which was difficult to implement in practice. Even the SIGO could not perform the role of purchaser because of lack of capacity and capability, and inconsistent budget planning practices in public hospitals. Therefore, contracts signed between the HIO and service providers turned out to be very short and did not specify details for improving performance and the quality of health services. On the other hand, the effect of contracting on quality improvement seemed slight because only one hospital is available in each province and *soum* and their performance and quality of services do not depend on health insurance financing alone. Some activities such as training of medical professionals, capital investment, renovations, supply of medical equipment and medicines are managed and supported by central and local budgets.

Efforts to introduce purchasing and contracting elements in health care financing in Mongolia are intended to improve the quality of health services. At the same time, updating treatment guidelines, protocols, accreditation and licensing initiatives were supported by various international organizations. Public hospitals also established quality units to carry out continuous quality improvement. However, these efforts and initiatives need to be well linked and supported by the major health financing schemes, including budget and health insurance at all levels. It is a welcome initiative to create posts for health insurance inspectors, but their current role and performance are limited to reviewing the appropriateness of provided care and medicine according to treatment protocols, prescription guidelines and clinical pathways.

However, there is increasing consensus that the purchasing capacity of health insurance needs to be improved. Therefore, the new law amendments propose the establishment of an independent health insurance agency with a separate unit in charge of quality monitoring and improvement. It is expected that this unit will help to improve provider and health insurance relationships, leading to better monitoring of continuous quality improvement in both public and private health facilities.

Recent introduction of DRG is still at an early stage and there are some issues which need to be reviewed and monitored carefully in order to use the full potentials of DRG in the Mongolian context. These include cost estimates of individual cases, information support, monitoring coding of DRG cases, quality of treatment, impact on OOP spending and financial risk protection, especially for the low-income and vulnerable populations. DRG

incentives for provider efficiency should consider the logic of "money follows patient" rather than predetermined case volumes per hospital. Hospitals would require more financial autonomy, which would not suit the current line-item budgeting practices. Efficient management and a surplus should not endanger next year's budget. Actions to address these issues will be fundamental to sustaining health financing and health insurance reform. Policy and financial support will be also needed not only for purchasing and contracting functions but also to assist service providers to rationalize their spending and improve technical efficiency in delivering quality health services to the entire population.

This study revealed clearly that weak governance and stewardship in the Mongolian health care financing system create several challenges which need to be addressed as soon as possible. These include fragmented actions without strategic goals and policy consensus, mistrust and misperceptions among different stakeholders, limited opportunities to build management and leadership capacity, and lack of development of a health insurance system that can promote effective service delivery, quality and efficiency of resource use, including purchasing.

5. Health financing performance assessment

Health financing performance in Mongolia has been assessed by using five specific indicators proposed in the OASIS methodology application. A brief assessment under each of these indicators is provided as follows:

5.1 Level of funding

Mongolia spends a relatively high amount on health compared to its national income. As of 2009, it is estimated that 4.7% of GDP was spent on health. However, the level of spending in per capita terms is still insufficient to provide comprehensive quality health services. WHO estimates that total health expenditure (THE) per capita was US$ 75 as of 2009. This is low in comparison to the regional average of US$ 500.

5.2 Population coverage

Mongolia experienced a single tax-based financing system that ensured universal health care coverage for many decades. SHI coverage was high and reached almost 95% of the population after its introduction in 1994, but it had declined to 82.6% by 2010. Although precise information on who the uninsured are is not available, it is assumed that they are mainly unemployed and informal-sector workers, including herdsmen, who have opted out of health insurance coverage. The poor and near-poor who do not meet the criteria for a full premium subsidy remain uninsured. Health insurance coverage is further analysed in detail in section 4.3 of this report.

5.3 Financial risk protection

Financial risk protection is assessed with the prepayment ratio that shows the share of general taxation and SHI in total health spending. In Mongolia the ratio is relatively good and accounted for 85.2% of THE as of 2009. However, there is a risk of increase of private health spending (especially direct OOP payments) because of limited coverage of medicine and diagnostic tests. People often pay from their pocket for medicines. A survey by the MoH and WHO estimated that 70.6% of household spending on health relates to medicines, since SHI does not cover the full cost of medical services and medicine patients are required to share costs. In addition to this, patients are required to share 10% and 15% of DRG tariffs at *aimag* and tertiary care hospitals as a copayment. Hospitals can also charge additional user fees to cover their actual costs on top of the remunerated DRG tariffs. All these issues need to be at the centre of health financing reform in Mongolia in order to increase financial risk protection even among the insured population.

A WHO study on distribution of health payments revealed that, although direct OOP payments account for less than 15% of total health expenditure, people pay more for drugs and, in some cases, health payments are already catastrophic and push people with low incomes into poverty. Table 13 suggests the need for financial risk protection among different income quintiles.

Table 13. Household catastrophic health expenditure

Expenditure quintiles	Households experiencing catastrophic expenditure (%)
Total population	3.83
1st quintile	1.59
2nd quintile	3.11
3rd quintile	3.21
4th quintile	3.67
5th quintile	7.54

Source: MOH & WHO, 2011, Household Socio-Economic Survey (2009 data)

Table 13 shows that 3.83% of all households experienced catastrophic expenditure in 2009. However, the share of households facing catastrophic expenditure is nearly five times higher in the lowest quintile compared to the highest quintile, and is twice as much as in the other quintiles. It should be noted that households are facing catastrophic health expenditure while health insurance coverage is 80% of the population. Many low-income households are thus challenged by a considerable financial burden. Given that the lower income quintiles' reported need is less than half of that of the higher income quintiles (which is counterintuitive when one considers that lower income groups usually have a higher disease burden), which also lowers utilization rates, the much higher share of low-income households with catastrophic expenditure is a major concern.

5.4 Equity in health financing

International evidence suggests that equity in health financing is reached when a health system is predominantly funded by taxation and SHI. However, tax collection can be regressive if the top quintile bears a lesser tax burden compared to others, especially the poorest quintile. SHI can provide more equity because of cross-subsidization in terms of health risks and household income. In Mongolia, SHI contribution is designed to be more equitable since it is set at 4% of salary without exceptions for the high-income group. However, the flat-rate contribution used for informal-sector employees may create an equity concern in the future because the flat rate is not strongly associated with household income. The flat-rate contribution for the low-income and vulnerable population which is fully subsidized by the government seems to be very low. It will be an issue in the near future to continue the current government practice to subsidize children of wealthy and poor families in the same way. Health care financing in Mongolia clearly shows that OOP is the most inequitable financing method. As shown earlier, lower-income quintiles are heavily burdened with a high share of OOP spending compared to high-income households. This is also seen in their utilization of health services. Despite their greater health needs, many poorer households are not utilizing health services due to financial barriers in seeking and accessing needed health care.

5.5 Pooling

Mongolia has developed a single tax financing pool under a centralized planned economy. With the introduction of national SHI, Mongolia began to experience two separate financing schemes. It created fragmentation not only in financing but also in provision of health care. Given the fact that almost everyone is covered by publicly funded health services and the majority (80%) is insured, this fragmentation may cause less concern in terms of coverage but it is problematic in terms of efficiency. As of today, health care provision is fragmented even within government-funded health services. Unequal distribution of health expenditure in per capita terms is noticeable across different provinces and providers at the same levels. In contrast, there is a considerable level of pooling and solidarity within SHI and this needs to be maintained and advocated in the future.

5.6 Administrative efficiency

The administrative cost of health insurance is low and it accounted for 2.73% in 2010 (SIGO, 2011). This is somewhat lower than in other middle-income countries (Mathauer & Nicolle, 2011). Enhancing administrative efficiency is not necessarily only about reducing administrative costs. Administrative expenditure may indeed be required to enhance the performance of an SHI system. Therefore, the lower administrative costs may suggest that the administrative capacity in managing SHI in Mongolia could be too limited to improve performance by addressing important issues such as contribution setting, collection, benefit provision, quality assurance, provider payment, accountability, transparency and customer satisfaction.

6. Conclusions and proposed options

Mongolia's health care financing system has in the past provided a fairly comprehensive and equitable delivery of health care. Earlier institutional achievements include free health care for all the population through a tax-based financing system, and later SHI reached more than 80% population coverage in a short period of time. The state was fully committed to supporting the low-income and vulnerable populations by subsidizing their health insurance contributions. As a result, population health and health financing performance improved over the years. Despite these achievements, however, the study found that there are some issues related to institutional design and organizational practices which impede Mongolia from achieving higher levels of health financing performance. Currently, quality and efficiency are major issues, as are fragmented and uncoordinated financing schemes, weak leadership and administration, and poor implementation of health financing laws and regulations.

The Mongolian government is committed to universal coverage through SHI. However, there is no unique prescription for attaining universal coverage under SHI. Once SHI is selected as an option for health care financing, the basic merits, criteria, principles and targets need to be respected and institutional and managerial capacity needs to be developed and strengthened.

This study focuses on health insurance for this and other reasons. First, health insurance is regarded as additional source of financing, but it still needs to do more to increase its potential role in financing by attaining universal coverage. Second, it is regulated by law and implemented with the involvement of many stakeholders, which creates fragmentation, inefficiency and limitation in providing effective financial risk protection in view of the risk of a rapid increase in OOP payments. Third, there is increasing dissatisfaction among contributing members about the operation of health insurance and the management of quality health service delivery. Fourth, there are ongoing efforts from the government to address these and other issues by introducing new amendments to the health insurance law. However, different views on health insurance exist among policy-makers and law-makers and some views undermine the principle of social solidarity. Therefore the study aims to support the MoH in discussing and addressing some of these challenges and reaching policy consensus on the key agenda for health care financing reform.

The major findings of the study are as follows:

- Many laws and regulations affect health financing, but some legal provisions conflict with each other and some are unimplemented, especially with regard to the Public Sector Finance and Management Law.
- Frequent changes in the legal environment have been observed. For example, the Citizens' Health Insurance Law has changed almost every three years since its enactment. Law amendments have often lacked clear objectives or strong justification, and the process of approval has not been informed by evidence or impact assessment of the proposed changes.

- Mongolia does not have a nationally agreed long-term strategy for SHI development
- The drafting of rules and regulations aimed at implementing new laws and amendments often come after discussion of laws and amendments rather than before. Doing so before would facilitate law adoption. Mongolia lacks systematic monitoring and evaluation practices to monitor law and policy implementation against defined objectives and expected outcomes.
- Mongolia's health financing arrangement is fragmented and no mechanisms have yet been developed for effective policy dialogues and for reaching consensus.
- Health care is becoming more expensive in Mongolia, but the value for money is not high. There are growing concerns about quality, efficiency, access, equity, coverage and consumer satisfaction.
- The major factors contributing to rapid cost increases and inefficiencies include the unregulated expansion of inputs such as the number of medical doctors, newly established private providers, expansion of public hospitals and beds, poor control of pharmaceutical prices, irrational use of high-cost technologies, unnecessary hospital admissions and long stays.
- Health care coverage and resource mobilization is below its potential as Mongolia does not have a clear strategy for expansion of health insurance coverage and resource mobilization.
- Inequities in health care financing include the level of contribution subsidy in terms of both amount and target group subsidized by the government. One example is that the contribution subsidy for children of wealthy families could be less of a priority compared to the financial support needed for low-income and vulnerable populations. This is especially the case in situations where some of the poorest and those with low incomes are still not eligible for a subsidy and therefore do not yet have any coverage or protection.
- Access to the health insurance benefit package needs more assessment because of the mixed financing of health insurance and the state budget. Current government practices for controlling the health budget do not contain cost; rather, they increase financial risk and the burden on households and reduce access when hospitals can apply additional charges to fill the financing gap. This increases the risk of direct OOP payments and financial barriers in accessing needed health care, especially for the poor.
- Current financing arrangements do not encourage improvements in efficiency. Historical and line-item budgeting do not provide incentives for hospitals to improve efficiency and value for money. The newly introduced case payments under health insurance need further improvements to ensure that "money follows patient". Current uncoordinated dual financing creates a greater administrative burden for hospitals.
- Both health insurance and hospital planning need improvements to ensure equitable and efficient use of resources.
- A large insurance reserve level is observed. However, there is a tendency to exhaust it in short terms if no appropriate policy is not developed.

In conclusion, the Mongolian health sector needs "more money for health" and the future economic growth and projections suggest that there is good potential for increased fiscal space for health in the years to come. It is also essential to ensure "more equity in health" through strengthening SHI. Additionally, "more health for money" is critical in Mongolia, and it is feasible to improve efficiency and quality of health services with effective cost-containment and efficiency improvement measures. In this regard the study proposes actions to ensure that the health sector is funded adequately, equitably and efficiently with improved stewardship and governance.

Proposed actions:

V. Ensure more money for health:

- Increase the government's share in financing health care by increasing the share of government health expenditure in total government expenditure.
- Improve health care financing data and information on national health spending and revenue projections (update of national health accounts).
- Increase collection of health insurance premiums to maximize prepayment (increased population coverage, reduced evasion).
- Consider the introduction of innovative financing mechanisms to increase domestic resource mobilization (e.g. unhealthy food tax, levy on currency transactions, mobile phone solidarity contribution, tourism tax).

VI. Ensure more equity in health:

- Create an independent health insurance organization responsible and accountable for the administration and performance of national health insurance aimed at universal coverage.
- Revise health insurance benefits.
- Improve health insurance purchasing capacity with a phased plan for a single purchaser in the future.
- Monitor direct out-of-pocket payment by reviewing and analysing the risks that potentially affect its increase.
- Regularly assess financial risk protection and poverty impact of health payments.
- Assess and apply explicit equity criteria for determining health insurance benefits.
- Update and increase targeted subsidies for payment of health insurance contributions.
- Review eligibility for targeted subsidies. From an equity perspective, it is questionable whether children and other dependents from better-off families should benefit from targeted government subsidies.
- Explore family membership coverage with possibly adjusted contribution rates.
- Take measures to reduce financial hurdles that discourage uninsured self-employed people from joining the scheme.
- Organize a national campaign to share and disseminate information, with national enrolment days where lower or no-penalty fees are applied.
- Advocate and increase population coverage by raising awareness of the health insurance benefit package, health services and health insurance support values.

- Reduce evasion in resource mobilization for social health insurance through better inspection of employers and application of penalties for defaulters.
- Monitor (and possibly review) whether new penalty levels are appropriate.

VII. Ensure more health for money:

- Gradually implement a policy to merge state-funded services and those funded by social health insurance into one benefit package.
- Contain health care costs by regulating prices of medicines, new admissions to health facilities, training of health manpower and use of high-cost medical equipment in hospitals.
- Update, advocate and monitor reference prices for essential medicines.
- Monitor and enforce pharmacists' compliance with ceilings of reimbursement drugs.
- Issue a licence to health facilities on the basis of the actual needs of medical doctors.
- Support rational use of medicines, diagnostic tests and laboratory examinations by improving health service standards and treatment guidelines.
- Improve drug prescription practices with a focus on generic medicine by expanding the number of drugs on the drug reimbursement list and by providing clinical pathways.
- Expand pharmaceutical insurance benefits.
- Apply cost-effectiveness criteria in defining health insurance benefits.
- Strengthen health service referrals and incentives in order to provide quality health care at the right levels.
- Monitor and enforce health insurance copayment in support of appropriate referrals.
- Strengthen strategic purchasing by gradually moving away from historical line-item budgeting towards programme- or output-based budgeting.
- Create a supportive environment for case payments to benefit from incentives for efficiency improvement.
- Provide more financial autonomy to hospitals (e.g. to use any surplus based on efficient management, to use funds according to needs rather than budget line items).

VIII. Ensuring effective stewardship and governance:

- Update policy commitment, reach a policy consensus and develop a concrete strategy by which to attain universal coverage through social health insurance (coverage of the uninsured).
- Develop a suitable regulatory framework that can benefit from a the independence status of the social health insurance system.
- Enhance the role, responsibility and accountability of the health insurance council in administering and managing health insurance operations and determining health insurance revenue collection, benefit provision, funding with appropriate payment methods and tariffs.
- Reduce the number of actors involved in health insurance decision-making.

- Strengthen management, administrative, analytical and monitoring capacities of health insurance to deal with financial transactions, collection, analysis and reporting of data, information, and quality assurance programmes with feedback.
- Develop and apply basic performance criteria and indicators to assess and report on the health insurance operation and benefit provision on a regular basis.
- Adjust health insurance policy and stewardship in line with national health policies and guidelines determined by the Ministry of Health, especially in terms of quality of care and its public health mandates.
- Review and adjust health financing and budget-related laws and regulations to ensure the legal and operational autonomy of health insurance in order to implement the core principles of social health insurance.
- Increase the financial autonomy of public hospitals to recruit staff with needed skill-mixes that support better and efficient performance.

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Appendices

Annex 1: Health financing performance indicators and their operationalization

Health financing performance indicator and operationalizations	Guidance for indicative targets
1. Level of funding	
- THE per capita	↑ for low and lower middle-income countries
- THE/GDP	(i.e., the existing resource mobilization potential is realized)
- GGHE/THE	*Average THE as a share of GDP in lower middle-income and low-income countries is 4.8% and 4.6% respectively.*
- GGE/GDP (fiscal space)	
- GGHE / GGE (fiscal space for health)	
2. Level of population coverage	
- Percentage of population covered by a financial risk protection mechanism. (This means that a person is not put at financial risk due to the costs of care.)	100% Equal population coverage across quintiles or population groups.
3. Degree of financial risk protection	
- Government funds prepayment ratio: GGHE/THE	≥ 70%
- Percentage of households experiencing catastrophic expenditure in each scheme	0%
4. Level of equity in health financing	
- Total and specific health financing payments (e.g. taxes, contributions, insurance premiums, co-payments, out-of-pocket expenditure for health) as a share of household income	Health financing payments as a share of non-food consumption is equal across all households.
5. Level of pooling across the health financing system	
- Health care spending per pool member set in relation to overall health risks of pool members	Equal health care spending per pool member across pools when set in relation to health

	risks of pool members.
6. Level of operational efficiency	
7. Level of equity in the delivery of a given benefit package at a given level of quality standards	
For each health financing scheme: - Absence of over-provision (e.g. providing too many services and medicines, up-coding), under-provision (e.g. providing too few services and medicines, or of substandard quality), cost-shifting, cream-skimming	No indications for and minimized incentives set by provider remuneration systems for over-/under-provision, cost-shifting and cream-skimming
8. Cost-effectiveness and equity consideration in the benefit package definition	
9. Level of administrative efficiency	
▪ Total administrative costs for all health financing schemes as a share of total health expenditure	↓ *The average from National Health Accounts data for low- and middle income countries for 2008 is < 8%, with similar averages since 1995.*

Source: Mathauer/Carrin (2011)

[a] Health care payments are at or exceeding 40% of a household's capacity to pay in any year.
[b] The assessment of this indicator requires a qualitative, institutional analysis and is thus dealt with in Section 4.

Annex 2: Current institutional-organizational set up and institutional-organizational requirements for a more independent health insurance

Issues	Current institutional and organizational set up	Desirable institutional and organizational requirements
Despite the existence of health insurance law with a focus on universal coverage, there is low awareness about SHI.	The current HIO does not have adequate capacity to act as an insurer accountable for coverage, contribution collection, and management of funds to deliver quality benefits to the insured. It mainly implements decisions made by related ministries, whose primary interest is not health insurance. There is insufficient information and communication among all concerned actors.	Once health insurance is accepted, the core principles of SHI need to be respected and maintained by health insurance administrators to provide responsive and satisfactory services to the insured. Decisions need to be made by multiparty board consisting of representatives of all interested parties.
Health insurance benefit is not clear enough for the population and contributing members do not see significant value of being insured. Health insurance not always meets their expectations.	A dominant role of the MoF in allocation of health insurance fund in combination of health budget significantly reduces the visibility of health insurance benefit for contributing members.	It is an important requirement of the HIO to advocate health insurance benefits to collect and manage health insurance contribution to provide defined health care benefits to contributing members when they them.
Composition of the board	Currently the health insurance board consists of representatives of the government, insurer, insured both employees and employers and health care providers.	It is desirable that health insurance board has equal presentation of at least three participating parties such as government, insurer, and insured.
Appointment of board members	Board members are appointed by a joint ministerial degree based on proposals of respective ministries and organizations such as trade union and employers' association.	Appointment should ensure independent and accountable board operation. This means that Board members have equal participation in decision making hence this will require the board not to be dependent on any of the parties.
How is the director appointed?	No predefined professional criteria used for selection and appointment of the head of health insurance.	It is desirable that proper post description for senior management staff is developed for their selection and appointment by the board.
To whom is the board accountable?	In principle, the board is accountable for appointed body, but the role of the board in managing health insurance is minimal.	The board can be accountable for all participating parties including contributing members.
How is senior management staff appointed and by whom?	Senior management staff is appointed by the government.	Senior management staff can be appointed by the board based on proposals of the director which meets the predefined professional criteria and post description.

Employment status of HIF staff?	Senior management appoints employees of health insurance.	Senior management can appoint employees of health insurance.
Budget ceiling?	Contribution ceiling was introduced to reduce contribution burden of all social insurance schemes.	It is undesirable to have contribution ceiling which reduces revenue and fund pooling.
Ceiling for administrative costs?	A ceiling is determined by the Social Insurance National Council.	With establishment of independent health insurance, the administrative cost ceiling can be increased up to 10% of revenue.
Are budget items to be approved by parliament?	The Parliament approves health and health insurance budget and the MoF control them by line items.	The parliament can approve health insurance revenue and expenditure plans, but the HIO should be able to administer them
Who will determine how funds are spent?	The MoF determines and allocates insurance funds and health care providers are accountable for spending.	The new HIO should determine how funds can be spent effectively and efficiently to respond to the health needs of the insured.
Who will determine how surplus/reserves are dealt with?	Legally, accumulated unspent reserves should be used for expansion of benefits or reduction of contribution rates. No actions taken yet so far with large sum of accumulated reserve.	The board can be given the authority to decide the use of surplus or reserve funds in transparent and accountable manner. An annual financial report needs to prepared and published for information dissemination, discussion and feed back.