MONGOLIA UB HOSPITAL RESTRUCTURING PROJECT
Ministry of Health and The World Bank

FINAL REPORT

Ulaanbaatar Master Planning for Hospital Restructuring and Privatization: Strategies for Performance and Quality Improvement in Mongolia

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ABBREVIATIONS AND ACCRONYMS

ALOS	Average Length of Stay
BBP	Basic Benefit Package
DFID	Department of International Development - British Aid
DMS	Directorate of Medical Services
FGP	Family Group Practice
FSU	Former Soviet Union
GDP	Gross Domestic Product
HIF	Health Insurance Fund
HSDP	Health Sector Development Plan
IEC	Information, Education, and Communications
JICA	Japanese International Cooperation Agency
L&A	Licensing and Accreditation
MNT	Mongolian Tugrig
MOFE	Ministry of Finance and Economics
MOH	Ministry of Health
MOHSW	Ministry of Health and Social Welfare
NGO	Non-Governmental Organization
SSIGO	State Social Insurance General Office
SPC	State Property Committee
UB	Ulaanbaatar City
USAID	United States Aid for International Organization Development
WB	The World Bank
WHO	World Health Organization

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EXECUTIVE SUMMARY

The need to restructure hospital services in Mongolia is well documented and has been studied and reported on for a number of years[1]. With a large number of hospitals, mostly in the City of Ulaanbaatar[2] (UB), 17,877 public sector hospital beds and 6,448 doctors for a population of 2.5 million people, there are simply too many hospitals, excess hospital beds, and over staffing of hospital personnel. In addition to surplus capacity and staff, other shortcomings include inappropriate hospital admissions and clinical practices, poor distribution of limited technology, fragmentation of funding sources and administrative services, limited use of information, and inflexible planning and budgeting. Hospitals also serve as social care facilities for the old and infirm, particularly in winter. Adverse payment incentives encourage inefficient use of in-patient services and hospital stays are unnecessarily long, averaging 11-12 days. Public Hospital spending is approximately 75-80% of the total public healthcare expenses, and this has changed little over the last few years. It is clear that little restructuring of the hospital sector has occurred, and the main result is that the large duplication in facilities and services means that funds are not available to improve the quality of services, equipment, or medical practice. As the GOM places more emphasis for cost effective primary care services, it is only through restructuring of the secondary and tertiary care services that funds can be made available for more and better primary care.

This problem is common to all Former Soviet Union (FSU) countries, and only a few countries have had any success in moving to correct the problem. Consolidating, merging, closing, and/or privatizing facilities and reassigning, retraining, or letting personnel go, is politically difficult and often impossible. The Ministry of Health (MOH) cannot do it alone, as it does not have control of the financial and management structures that require change, and presently there are no incentives for anyone to restructure or rationalize. Privatization of facilities is premature and not a viable option at this time. However, the present environment in Mongolia, with the existing budget constraints, Civil Service reform, a new Public Sector Management and Finance Law, a Poverty Reduction Strategy, a National Public Health Policy, a Social Sector Privatization Guidelines, and other pressures have created the need to once again review the possibilities of implementing significant change in this difficult area. What is needed is a new multi-sector approach to the problem, one that develops a common "Vision and Strategy", has the requisite incentives and penalties at each level of the system, and one that can also show positive "results" to the patient and to the community that the Government of Mongolia (GOM) can improve the quality of health services in the long term.

This report outlines the necessary process, options, and recommendations, based on lessons learned in other FSU countries. The report is not an exhaustive review of the findings (as this has been done many time before), but rather clearly outlines the difficult

[1] See Annex Key Documents List: 1997, 1999, 2000, 2002, 2003 by various authors and organizations.
[2] The Mongolian National Center for Health Development states: in 2001 there were 16 specialty hospitals and centers, 46 general and special hospitals, 21 aimag hospitals, and 343 soum hospitals. In addition there are 480 private health facilities of which 124 had beds, and 178 Family Group Practice centers.

changes that must be made if this is to become a serious initiative, and is to prove successful in the longer term. The focus of this report is mainly UB, but the principles, concepts, issues, and recommendations would be the same for all of Mongolia. As the MOH State Secretary has said, "the time for restructuring is now," and "let's get on with it." This will not be an easy process and the full support of all the various sectors involved will be required. More important, is the need for donor cooperation, collaboration, and assistance, if the required resources are going to be brought to bear on the problem. The MOH must lead the process but it will need the support of all sectors, but most important it will need the support of the GOM, and the Parliament will need to clearly state that it is in support of the efforts and will assist in finding solutions to the problem.

In talking with many health managers in Mongolia, the issue that "the people love their hospitals and feel they have a right to stay in hospitals" comes up in every discussion. This is true in many countries and is not unique to Mongolia. However, when one talks with patients in hospitals, the patients express more concern with the quality of the physicians, nurses, laboratories, and pharmaceuticals rather than just wanting to stay overnight in hospitals. This usually means that the concern for quality improvements far outweigh the concern for a specific facility or for wanting to stay overnight as opposed to being treated as an outpatient. It is the issue of improvement in quality that Mongolia needs to come to grips with, and not the number of inpatient beds or facilities.

The recommendations and next steps listed below are a possible alternative to the present GOM strategy of making arbitrary cuts across the board due to budget constraints (e.g., all hospitals must reduce beds by 10% and moving the expenses to the outpatient area). Experience in other FSU countries has shown that it is preferable to utilize a more "rational" approach to restructuring, rather than an arbitrary approach. We know from experience, that closing beds saves very little money (unless the heat and electricity are turned off completely, and the staff is let go, which seldom happens), and in Mongolia beds reduced in the public sector "pop up" again in the private sector. With respect to restructuring and rationalization activities, it is usually "cost" that comes to mind, but the issue of "quality improvement" is far more important, and in Mongolia this is the bigger issue which needs to be focused upon. Only through a rational restructuring approach can the right amount of resources be moved into those areas of quality improvements in services, equipment, and facilities. While a rational approach is more politically difficult, it is better to muster the courage to do it now, rather than allowing the whole system to collapse on itself, which is the present direction.

This report outlines the various findings and recommendations, as well as the issues and challenges, that are well known, have been well documented, and have been stated by many consultants and authorities over the last decade. The report present three possible options, and one of the three is a "no change" option and more of the same. The second option presented is a mix of doing something if you cannot do it all, but is a sub-optimal solution and will create even more problems, but may be worth exploring. The solution proposed is not new, but the lessons learned from other FSU countries could be an

effective starting point in the process for finding a final, workable solution. The key changes are few in number, but will take time to implement, and are as follows:

A. **The need for a "Shared" Vision and Strategy with a cooperative process of working together toward solutions by all sectors;**

B. **A major change in the funding systems to establish a "Single Pool" of funds and an integrated "Single Purchasing" System;**

C. **An integrated system of Governance and Management of all health facilities in UB, in order to bring about efficiencies across the whole system and establish incentive at all levels for restructuring;**

D. **A flexible process toward developing a Master Plan for UB that includes a five year Capital Plan for renovations and new equipment.**

The next steps in the process are clearly outlined in this report, and are as follows:

1. **To establish a multi-sector "Steering Committee and Working Groups" of the key sectors to oversee the process, direct the efforts, and ensure ongoing results;**

2. **To secure the commitment of international donors to build on the previous work done, and to assist the MOH with the necessary resources and technical assistance to build local capacities to develop and implement the needed changes in funding systems and management.**

3. **To develop a "buy-in" by all stakeholder to a shared "Vision and Strategy," and to experiment in pilots with new funding and management methods, instead of using a broad brush (cut all hospital beds by 10%) approach which presently exists;**

4. **To initiate additional Privatization activities in the form of more outsourcing of selected services and management contracts to facilitate improved efficiencies at the facility level.**

Mongolia has a history of taking the necessary changes when the time is right and the needs of the community outweigh the individual interests of various sectors. The time to begin to restructure the health sector is now.

EXHIBIT B- Restructuring Master Plan Outputs and Timelines has been moved up to this Executive Summary from a later section. Considering the length of the report, it was felt that a larger Executive Summary, which might be translated would be more effective for use by the MOH/DMS.

EXHIBIT B
RESTRUCTURING MASTER PLAN OUTPUTS AND TIMELINES

	Master Plan Activity	Estimate of Time to Complete	Outputs	Year #1	Year #2	Year #3
A.1	Establish Cross-Sector Steering Committee with membership of all key sectors (MOH, DMS, SSIGO/HIF, MOFE, SPC, GOM, and others as needed)	1-3 months and Not later than July 31, 2003	Establishment of Committee, terms of reference, goals, objectives, and work plan	**X**		
A.2	Establish Work Groups for: 1.Facilities and Equipment 2. Quality Improvement 3. Funding and Costing 4. Management and Human Resources	1-3 months and Not later than August 31, 2003	Establish Work Groups and outline goals, objectives, terms of reference, outputs, a work plan, and related activities	**X**		
B	**VISION AND STRATEGY**					
B.1.	Develop a shared Vision and Strategy Statement	3-6 months and Not later than October 31, 2003	A Vision and Strategy Statement that outlines the goals, objectives and outputs, including time frames for beginning implementation of a Master Plan for UB	**X**		
B.1.1	Workshops and Seminars with all sectors in order to develop a shared vision and strategy for restructuring, rationalization, and privatization of various sectors of the health care system	3-4 months and not later than August 31, 2003	List of Strengths, Weaknesses, Opportunities, and Threats leading to Vision and Strategy Statement	**X**		

B.1.2	Publishing a Vision and Strategy Statement with communications to all sectors and facilities as part of a Communications Strategy	6-9 months and not later than December 31, 2003	Publish Statement and begin communicating to all sectors	**X**		
B.1.3	Developing a detailed step by step process with time lines for completion of various activities, including a detailed communications strategy	1-3 months and not later than March 31, 2004	A written plan with time frames and activity outputs, including a detailed communicatio ns strategy	**X**	**X**	
B.1.4	Implementing the Vision and Strategy for Restructuring, Rationalization, and Privatization	12-24 months and not later than December 31, 2004	Implementation		**X**	**X**
	WORK GROUP #1					
C.	**FACILITIES AND EQUIPMENT**					
C.1.	Evaluation of all Facilities and Equipment: -which facilities to close/sell -which facilities to improve -what new equipment to purchase Refer to the documents developed under HSDP1 (3 pilot Aimags) for assessment criteria, methods, and costing techniques	3-6 months and not later that October 31, 2003	1.List of the Facilities and Equipment in poor condition and not able to meet new Accreditation standards. 2. List of Facilities and Equipment in good condition	**X**		
C.1.1	List of facilities that are in very poor condition and should be sold as real estate or torn down; List of new Equipment and renovations needed to improve remaining facilities	3-6 months and not later that October 31, 2003	3. List of Facilities that might be privatized or sold.			
C.1.2	Development of a 5 Year Capital Plan for Equipment and Facilities to Improve	3-6 months and Not later than December 31, 2003	A Capital Equipment List	**X**		
C.1.3	Approval of Funding Sources for Capital Plan	6-12 months and Not later than June 30, 2004	Approval of Funding Sources	**X**	**X**	

			Sources			
C.1.4	Tenders and Contracts	3-6 months and not later than December 31, 2004	Development of Tenders and Contracts	**X**	**X**	**X**
C.1.5	Begin closing facilities, consolidating services, and selling outdated building	24-36 months and not later than December 31, 2005	Implementation in UB and entire country		**X**	**X**
	Master Plan Activity	**Estimate of Time to Complete**	**Outputs**	**Year #1**	**Year #2**	**Year #3**
D	WORK GROUP #2					
D.1	**FUNDING AND COSTING**					
D.1.1	Initiate Work Group and develop work plans and activities	1-2 months and not later than June 30, 2003	Establishment of Work Group	**X**		
D.1.2	Develop proposed changes to funding system with Single Pool of funds and Single Purchaser System	3-6 months and not later than September 31, 2003	Develop recommendat-ions	**X**		
D.1.3	Develop techniques to do Costing of Services and Products	3-6 months and not later than September 31, 2003	Develop recommend-Ations	**X**		
D.1.4	Develop techniques to improve flexibility in budgeting and spending at the facility level	3-6 months and not later than September 31, 2003	Develop recommend-Ations	**X**		
D.1.5	Conduct workshops, training, and capacity building as needed	6-12 months and not later than April 31, 2004	Conduct workshops	**X**	**X**	
D.1.6	Pilot these changes in a small experiment to work out policies and procedures	3-6 months and not later than December 31, 2004	Pilot changes in one or more locations	**X**	**X**	
D.1.7	Roll out proposed changes after testing in pilot	6-12 months and not later than December 31, 2005	Roll out changes to entire country		**X**	**X**
E	**WORK GROUP #3**					
E.1	**QUALITY IMPROVEMENT**					
E.1.1	Initiate Work Group and develop work plans and activities	1-2 months and not later than June 30, 2003	Establishmen t of Work Group	**X**		
E.1.2	Develop proposed changes to protocols for referrals, admissions, length of stay, and discharge criteria	3-6 months and not later than December 31, 2003	Develop recommendat ions	**X**		
E.1.3	Conduct workshops, training, and capacity building in clinical pathways, protocols	6-12 months and not later than December 31, 2003	Conduct workshops	**X**	**X**	**X**

	improvements, and clinical training as needed					
	Master Plan Activity	**Estimate of Time to Complete**	**Outputs**	**Year #1**	**Year #2**	**Year #3**
E.1.4	Pilot these changes in a small experiment to work out policies and procedures	3-6 months and not later than June 31, 2004	Pilot changes in one or more locations		**X**	
E.1.5	Roll out proposed changes after testing in pilot	6-12 months and not later than December 31, 2004	Roll out changes to UB and then all of Mongolia		**X**	**X**
F	**WORK GROUP #4**					
F.1	**MANAGEMENT AND HUMAN RESOURCES**					
F.1.1	Initiate Work Group and develop objectives, work plans and activities	1-2 months and not later than June 31, 2003	Establishment of Work Group and list of objectives and a work plan	**X**		
F.1.2	Outline possible options and methods of improving the governance and management of the health system	3-4 months and not later than August 31, 2003	List of options and methods to improve the governance and management of health facilities	**X**		
F.1.3	Conduct workshops, training, and capacity building as needed	6-12 months and not later than December 31, 2003	Conduct workshops	**X**		
F.1.4	Outline possible changes to improve the performance contracts with facilities to add more financial incentives and penalties	3-4 months and not later than August 31, 2003	Outline the improvements to Performance Contracts	**X**		
F.1.5	Pilot these changes in a small experiment to work out policies and procedures	3-6 months and not later than June 31, 2004	Pilot changes in one or more locations		**X**	
F.1.6	Replace Facility Directors not able to perform in the new environment	12-18 months and not later than June 31, 2004	Replace of Facility Directors as needed		**X**	
F.1.7	Roll out proposed changes	6-12 months and not later than December 31, 2004	Roll out changes		**X**	**X**
F.1.8	Begin to Merge, consolidate, and close facilities, and improve capital equipment and renovations in remaining facilities	6-12 months and not later than December 31, 2004	Document savings and benefits accrued		**X**	**X**

I. BACKGROUND AND INTRODUCTION

A. Background

Mongolia has made great strides in health care reform over the last decade. Significant restructuring to more and better primary care has been implemented, large numbers of personnel have left the health sector, beds have been closed, administrative decentralization installed, and a Health Insurance Fund has been implemented. However, there is still much to be done in Mongolia, and especially in Ulaanbaatar City (UB), as previously highlighted, and included excess facilities, beds, and staff, as well as inappropriate admissions, long lengths of stay, and large expenditures in heat and electricity. Addressing these issues has become a higher priority as current fiscal difficulties have necessitated significant cuts in UB hospital budgets, making it difficult to continue sustaining the large and inefficient hospital network.

The MOH requested World Bank assistance to develop a plan for carrying out the hospital restructuring. The consultants with significant experience in other Former Soviet Union (FSU) countries with hospital restructuring and privatization were contracted to assist the MOH in developing a planning process that over a number of months could lead eventually to a Master Plan for UB, and hopefully present a model for all of Mongolia. A number of Master Plans for both Mongolia and for UB had been previously developed through the Health Sector Development Project (HSDP) with loan assistance from the Asian Development Bank (ADB).. Significant resources had gone into this process during 1997-2002 and a number of documents and recommendations were developed. The problem is that these Master Plans proposed by various consultants were never implemented.

One major difficulty is that hospital restructuring, rationalization, and privatization is a difficult, complex, and often "thankless" task for all parties involved. In the present environment there are no incentives for hospital restructuring, rationalization, privatization, merger, consolidations, or closure for anyone. The Ministry of Health (MOH) cannot do it by itself, as it has little control over most of the financial and management areas to be restructured (Health Insurance Fund, UB City Budget, or UB City Health Department). Restructuring means loss of jobs, and this is very difficult in the present economic environment. Hospital facilities are deeply "loved" by their communities, and the national right to "health care services" is a cultural reality. Attempting to close a facility will bring down the wrath of the community on the head of any politician attempting to carry this out. Few FSU countries have had much success in this area, but it is clear that a "do nothing" approach to rationalization of hospitals does not reallocate scarce resources to the areas they are most needed. Privatization of health facilities is a limited option, but can work in certain situations. The experience with privatization of health facilities in FSU countries is not good, and few hospitals have been successfully sold or operated by outside management. What is needed is a new and different approach, one that has proven effective in a few FSU countries.

B. Definitions

Beginning with the World Health Organization (WHO and UNICEF) Alma Ata Conference in 1978, the various country health systems around the world have been attempting to reallocate scarce resources away from expensive secondary and tertiary services to more cost effective primary care services. With the breakup of the Soviet Union in 1990, all of the former Soviet Union (FSU) countries have been in the process of health reform. Over the last twenty years a number of terms have arisen which are often used interchangeably but are very different concepts. For the purpose of clarity, the following rather simplistic definitions are utilized in the context of the Mongolian environment:

Restructuring: This is the process of reallocation and redistribution of a variety of health resources (personnel, equipment, facilities, pharmaceuticals, supplies, and financing) from one level (primary, secondary, tertiary) to another level as well as the process of improving existing resources, both quantity and quality, within the same sector. This term is used most frequently with regard to reallocating resources to improve primary care (forming Family Group Practices, training for Primary Care Practitioners, equipment, pharmaceuticals), but is also a key component of the process of reallocating resources (primarily finances) from hospital care to primary care.

Rationalization: This is usually defined as the process of "down-sizing" or "right-sizing" the secondary and tertiary sectors, usually defined as both hospitals and the narrow specialty services in polyclinics. Most commonly this has meant reduction of beds, reducing the average length of stay (ALOS), merging facilities into general hospitals or multi-profile hospitals, closing facilities, and related activities in order to reduce heat and electric costs as well as personnel.

Privatization: This is normally defined as the process of assigning a range of activities and services now provided in public facilities (owned by the State or local municipality) for public patients (and sometime private patients), to be provided by private ownership or private management. This includes "outsourcing" of services – private management contracts to operate the service (dietary, housekeeping, security, laboratory, et. al.) – as well as management of all services (the total facility), usually for a management fee or bonus arrangement. This also includes outright sale of the facility, and may or may not include the real estate or land value.

C. Environmental Assessment

As a background document and as a point of understanding of the environment for health reform in Mongolia, the 1999 Health Sector Review paper presents a table of the Strengths, Weaknesses, Opportunities, and Threats of the health sector. All of these issues are still apparent in the present environment of 2003:

Table 22. Strengths, weaknesses, opportunities, and threats of the Mongolian Health System, Mongolia Health Sector Review (1999)[3]

STRENGTHS	WEAKNESSES
• Decentralization • Compulsory health insurance with wide coverage • Commitment to development of rural health services, including volunteer health workers • Relatively good access to services • Good data bases • Adequate number of health personnel • Dedicated health staff • Many well functioning health programmes • Over 90% immunization coverage • Implementation of family physician concept	• MOHSW has only a few tools to implement national health policy because of strong decentralization and separation of financial resources allocation reporting to MOFE • Retrospective hospital payment system created incentives for over servicing • Shortage of essential supplies and equipment • Weak maintenance of equipment and facilities, lack of spare parts • Intersectoral collaboration in initial stage • Community participation is still low • Skills of family doctors and community workers need improvement • Quality Assurance mechanisms are lacking • Financial reporting inadequate and separated from reporting of performance • Weak management skills • Orientation to illness, not to health • Oversupply of doctors and hospital beds
OPPORTUNITIES	**THREATS**
• Present transition is opportunity for achieving successful health reform • Experiences with health reform in other countries represents an opportunity to learn from others • Opportunity for more effective use of human resources by improved training	• Lowered morale of key personnel due to transition changes and low salaries • Expectations too high to privatization, which needs to be kept within limits if health sector efficiency and equity are to be maintained • Unemployment of health workers after rationalization measures

D. Lessons Learned in Other FSU Countries[4]

As highlighted above, only a few FSU countries have had any real success with hospital restructuring and rationalization, although all countries have tried. Kyrgyzstan in Central

[3] MONGOLIA Health Sector Review, 1999; now being revised and updated by the MOH

[4] Kutzin, et. al., Health Sector Reform in the Kyrgyz Republic: Lessons Learned and Implications for the CIS-7 Countries, World Bank, October 2000; and Atun, Rifat, et. al., Kyrgyzstan Hospital Rationalization Project, DFID, February 2001.

Asia has had considerable success (with assistance of WB, USAID, DFID) in actually rationalizing hospital beds, facilities, equipment, and personnel, both in the rural areas and is now working on the major urban area of Biskek, the capital city. The Central Asia Model for Health Reform is very similar to that in Mongolia and the lessons learned in Kyrgyzstan should have direct applicability to the Master Planning process under development. Outlined below is a list of the key issues, and a further discussion can be found in the individual country papers. The major lessons are as follows:

1. The process must be both top/down and bottom/up at the same time, with incentives and penalties developed for each level of the system;

2. The MOH can not do rationalization by itself; there is no "magic bullet" nor easy solution, the process is highly political, and solutions must be found using a multi-sector approach to problem solving;

3. There is a strong relationship between finances and rationalization, and a single-payer system with pooling of funds from all sources (Health Insurance, local budget, and central budget) is one of the major keys to success;

4. Governance and Management of both City and Republican (MOH) facilities should be under one management structure in order to implement required efficiencies across the whole health system;

5. Building strong "stakeholder" support, patience, and commitment is needed if long term success is desired;

6. Successful "piloting" of new ideas and new systems, with the requisite adjusting of policies and procedures, is important before "rolling out" the change to the entire country; this is especially important in "privatization" activities;

7. There is a need to demonstrate "early on" tangible savings in finance and cost;

8. Strong donor cooperation, collaboration, and support is critical to the success of the efforts; successes in rural areas often comes easier and often before taking on the major urban capital city area, which is the most political environment;

9. Building local capacity in finance, costing, economics, quality improvement, and management development is critical to long term success;

10. A strong humanitarian approach including new human resource policies and funding to assist with personnel reassignment, retraining, and redundancy payment is important to acceptance and success of the restructuring efforts.

This is the environment for continued health reform in Mongolia. The task will be difficult and the road to success in a long one, but Mongolia has a history of dealing effectively with change when needed.

II. FINDINGS AND RECOMMENDATIONS - ISSUES AND CHALLENGES

The sections that follow are a discussion of the basic findings and recommendations to take UB and Mongolia along a path to seriously restructuring, rationalizing and privatizing of some sectors of the health care system. There is not an exhaustive analysis of the data, as this has been documented by many authorities and is highlighted in a number of documents in the Appendix section. The focus of this report is recommendations and discussion of the lessons learned from other FSU countries as they apply to the issues, processes, decisions, and methods, to improve the existing health system in Mongolia. A flexible step-by step process for the next three-year period is outlined with the respective activities and outputs at each stage.

A. Excess Beds, Facilities, and Personnel in UB

1. FINDINGS

Ulaanbaatar, the major capital city, has an estimated 760,000 to 1.1 million people, which is about 48% of the entire country. It is estimated that 40-60% of UB's population (440,000 to 660,000) is living in the "Ger" areas, in either temporary or permanent housing, and approximately 15-20 % of these people (85,000) lack official permission to be there. The UB population grew by 25.8% between 1995 and 2001.

The public health facilities and services in UB include 16 clinical and tertiary hospitals and centers that come under the control of the MOH, and some 46 hospitals of various types (Maternity, Pediatrics, District, Khoroo, Railway, Security, Prisons, and other Specialty facilities), and approximately 119 Family Group Practices (FGP's), that come under the Mayor/Governor's office and are operated by the UB Department of Health. Public Hospital spending is approximately 75-80% of the total public health care expenditure, and this has changed little over the last few years. There is also a large and growing private sector or hospitals, clinics, laboratories, and pharmacies. There have been some consolidations of facilities over the last few years (TB Hospital into the Infectious Disease Hospital, and Pediatrics Hospitals into District Hospitals), but this has been a limited effort. The statistics and a list of all these facilities have been well documented and are presented in the HSDP Assessment Paper and the Health and Poverty Paper for the PRSP.

It is not possible to compare the total number of hospital facilities in UB with a city of similar size in another country. The FSU countries all have a large number of specialty facilities. However, the total number of sixty-two (62) hospitals of various types, with 16 MOH tertiary facilities and with another 46 other hospitals (under the UB Mayor and UB City DOH), this is still a very large number. In a major city in a western country with a similar population of around 1 million, there would be at the very most, a total of 15-20 hospitals, which is one third or one quarter of the present number in UB. By any

comparisons (see discussion below) the number of hospitals, hospital admissions, beds, and admissions per capita, are unfavorable. All of this means that with regard to restructuring, rationalization, and possible privatization of some facilities, there is a huge potential for savings in facilities, beds, personnel, heat, electricity, and all other expenses. While at this stage it is impossible to estimate the potential savings, it would be conservative to estimate the savings at 10-20 Billion Tugrig, over 3-5 years. This is not meant to be a detailed estimate and is based on reducing the duplication between city and MOH facilities by consolidating services, equipment, and personnel, as well as closing and selling various facilities throughout the entire city. This will be defined more fully as a plan becomes available of which facilities might be closed.

In light of a tight budget and economic environment over the past five years (1998-2002), one would expect significant reductions in all related hospital capacity, efficiency, and input/output indicators. This has not occurred and in fact most indicators have increased and not decreased:

- Total hospital beds increased by 3.5% in whole country (+630 beds)[5];
- Real per capita health care expenditure increased by 72%;
- Total number of physicians increased by 17%, and nurses by 6%;
- Total hospital beds in UB have decreased by only 8 % (-587 beds) and almost all of this is at only six (out of 62) hospitals: Hospital #3, (-80 beds), Dermatology (-50 beds), Infectious Diseases (40 beds), Railway (-58 beds), Narcology (-25 beds), and Prison Unit (-75 beds); the others have either decreased only a few or no beds;
- Private hospital beds in UB have increased by 500%, + 892 beds;
- Private hospital beds in the Aimags have increased by 200%, +452 beds;
- Admissions to public hospitals in UB have increased by 12 %;
- Admissions to private hospitals in UB have increased by 500%;
- The total country average length of stay (ALOS) has decreased only by 12% (from 12.3 to 10.7 days), and by only 2.2 days in the clinical tertiary facilities, by only the average in the Aimags, and essentially stayed the same in Soum hospitals.

It is clear is that the health sector and especially the hospital sector have grown significantly over the last few years.

In relation to key hospital efficiency indicators used by other FSU countries and by European Union (EU) countries (a possible goal for Mongolia) the comparisons in all hospital indicators is not favorable, except for physicians per 1000 population, where Mongolia has less physicians per capital than its respective FSU neighbors. While there is a serious mal-distribution of physician services throughout the country (see Appendix), the quantity and increase in the number of medical personnel does not appear to be a major concern. There are other serious issues as highlighted below:

[5] HSDP and Directorate of Medical Services Database 1998-2002.

COMPARISIONS[6]
MONGOLIA HOSPITALS AND OTHER COUNTRIES

SELECTED HOSPITAL INDICATORS

Country	Hospital Beds Per 1000 pop-ulation	Hospital Admissions Per 100 population	Average Length of Stay	Physicians per 1000 population	Out-patient Visits Per capita	Public Health Expend-iture % GDP
Mongolia	**7.7**	**20.1**	**12.3**	**2.4**	**4**	**4.7**
Ukraine	7.6	18.3	13.4	3.0	10	2.9
Azerbaijan	7.5	4.7	14.9	3.8	1	1.0
Georgia	4.6	4.7	8.3	4.4	1	0.8
Armenia	5.5	5.6	10.4	3.0	2	4.0
Turkey	2.2	7.3	5.4	1.2	2	3.3
United Kingdom	4.1	15.0	7.0	1.8	6	5.8
Norway	3.3	14.7	6.5	4.2	4	7.0
EU Average	**4.6**	**18.75**	**8.32**	**3.7**	**6**	**6.7**
NIS[7] Average	6.8	18.6	13.3	3.8	5	2.9

While this type of comparison can be questioned (due to data reliability, the year being reported, the source of the information, and other factors); it is clear that with regard to the three key hospital efficiency indicators (beds per population, admissions per population, and average length of stay) Mongolia has a long way to go to improve its key hospital indicators.

The increase in private beds and admissions has shown that the demand for private services (usually perceived as higher quality) has made up for any reduction in public beds. It is apparent that many people are going out of the country for serious illnesses and high technology services. Experience in other FSU countries has shown that closing beds saves very little money, unless heat, energy, and personnel are reduced accordingly. This seldom happens, and a

[6] European Observatory, WB/WHO, HSDP, 1998 or data available;
[7] NIS is the Newly Independent States of FSU: Northern Tier includes Poland, Hungary, Czech Republic, Slovakia, Slovenia, Lithuania, Latvia, and Estonia; Southern Tier includes Croatia, Romania, Bulgaria, Albania, Bosnia-Herzegovina, Macedonia, Serbia, Montenegro and Kosovo; European NIS includes Russia, Ukraine, Moldova, Belarus, Georgia, Armenia, Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan.

closed bed is difficult to keep closed and often pops up in the private sector. Only by closing, merging, and consolidating facilities, can expenses really be reduced or permanently eliminated.

The large duplication of hospital facilities and services (with large electric and heating bills), the large excess of beds, overstaffing of personnel, especially in UB, all means that scarce resources could be better used to meet other health care needs. The potential saving in both fixed and recurrent cost in merging, consolidating, and closing old outdated facilities is huge.

The basic GOM strategy has been a "broad brush" approach of cutting 10% of the beds and moving the expenses to outpatient services. It is the clear from the results (as highlighted above) that this broad-brush policy with respect to restructuring and rationalizing the secondary and tertiary sector has simply **not** worked effectively.

What is required is a flexible Master Planning Process, including new capital for renovation of facilities and new equipment, over the next 3-5 years with cross-sector cooperation and assistance in solving the existing problems. If the health and hospital system is to be restructured (shifting resources to where they are most needed instead of by historically allocations), then the incentive to bring about this type of behavior must exist, both within the MOH and at the facility level.

2. RECOMMENDATION

Develop a flexible, step-by-step Master Planning process over a three year period, that involves cross-sector cooperation, and will eventually lead to mergers, consolidations, and closures and possible sale of some outdated facilities, and will also allow a capital infusion for existing facilities including renovations and new equipment that will improve the quality and provision of health care services over the long term. A Matrix of Activities, outputs, target dates, and possible timelines for this process is presented in Exhibit B, page 28-32.

The consultants were requested to assist the MOH develop a process to get to an eventual Master Plan for UB Hospital Sector Restructuring. The development of any Master Plan for a capital city with a population of 1 million with some 181+ health facilities is no easy task. It is certainly not something that can be done in a few weeks or a few months. More important, it needs to be the Master Plan that includes all of the various stakeholders involved in the change process, and not just the MOH, and it needs to be the GOM's plan and not the consultant's plan. In the present regulatory environment, the MOH does not have the control over the key management and financial mechanisms that must be changed if the Master Plan is to be successful. What is needed at this stage is

not a highly detailed plan, but rather a roadmap, a flexible process toward an eventual master plan that will take a number of years to develop and implement.

B. Shared Vision and Strategy

1.FINDINGS

The major constraints of restructuring, rationalization, and privatization of the health sector are primarily political and not technical. Merging, consolidating, and closing facilities with the resulting savings in both fixed and recurrent costs means that personnel must be reassigned, retrained, or let go. Politically this is difficult and often impossible in the present economic environment. However, to improve overall health services this is what must be done. This means that in order to bring about the needed changes, all the various sectors affected (MOFE, SSIGO/HIF, MOH, SPC, and the local UB government) must be involved in the process of finding workable solutions and developing an effective strategy. As highlighted in the previous section, it is clear that the present GOM strategy has not been effective.

In the present environment there is little cross sector cooperation on health issues. The MOH has control of the 16 clinical and specialty centers, but the UB City Administration and UB Department of Health control the remaining facilities in the city, with the exception of some of the special hospitals. The SSIGO/HIF controls most of the funding – see Appendix - and the local or central budget controls the remaining funds, except the out of pocket payments. Each group has it own priorities and there is no clear understanding of the need to restructure, rationalize, or privatize the health sector. The new Directorate of Medical Services (DMS) is off to a good start, but there is significant confusion between its new roles and functions, and those of the existing MOH. The staff of the MOH has been reduced and there is limited capacity within the MOH to carry out any real restructuring effort.

When the consultants discussed restructuring with the various sector representatives, it was unclear if this mean just efficiency (reducing personnel and length of stay? or it means permanently reducing costs (closing and selling outdated facilities), or something else altogether. The role of the new Licensing and Accreditation function is not clearly understood and does not work closely with the HIF; consequently, different sectors sees their own role in very different terms. Is it meant to improve health quality, reduce costs, or eliminate ineffective and dangerous physicians? There is also confusion about the possible conflicting goals of the poverty reduction strategy and the restructuring efforts. Apparently, there is no clear vision of what restructuring means, why it is necessary, or if it is worth the political costs and effort to carry it out.

2. RECOMMENDATION

In order to develop an effective Master Plan, the first priority should be the development of a common and shared "Vision and Strategy" among the various sectors that must be involved in the process, including the GOM, MOH, DMS, MOFE, SSIGO/HIF, SPC, and others as needed.

It is clear that the leadership must come from the MOH for any serious restructuring effort. Only the MOH/DMS can provide the direction and coordination that is required to implement a Master Planning process. However, with the limited capacities in the MOH, it should be the new DMS that should be in the "driver's seat" and the DMS has the capacity and technical abilities to develop and implement such a process.

The process of developing a clear vision and strategy should begin with the implementation of a multi-sector Restructuring Steering Committee with the required Working Groups to do the development of the necessary recommendations to bring Master Plan into reality.

A proposed organizational structure for this process is presented in Exhibit A on page 31.

The dissemination and communication of this strategy will need significant effort and the utilization of many professional medical groups within the country. The Public Health Professions Association is one example of the groups that could assist with the dissemination of this vision and strategy.

C. Change to Funding Systems

1. FINDINGS

Once again, many of the financial disincentives and funding issues have been well documented in other reports – see Appendix – and need not be repeated here. However, a brief review of some of the ineffective policies needs to be highlighted in order to understand the recommendation.

Experience in other FSU countries has shown that the establishment of a Health Insurance Fund (HIF) is often meant to bring in additional funds into the health care sector in order to improve provision and quality of services. This has not happened, and usually the Government begins cutting back the budget at about the same amount that the new HIF infuses funds into the system. This appears to the case in Mongolia, and the new HIF funds, as well as the HIF design, have only added to the over-funding situation of the secondary and tertiary care sectors, and the under-funding of the primary care sector. This is a major policy error.

The present HIF system greatly rewards hospitals, especially tertiary hospitals and only recently have any changes come about to improve the funding of primary care. The existing HIF system (the deficiencies are well known and need not be repeated here) utilizes a historical basis of cost/input based norms and standards, to pay different rates to different levels of hospitals, resulting in preferential rates for each hospital admission to higher cost tertiary hospitals. This is "the worst of all possible worlds" with regard to hospital payment. It encourages over-utilization at tertiary facilities (they get paid more to do the easy cases), discourages cost reductions at all facilities (historical cost based payment), allows cost shifting (HIF picks up local budget costs through more HIF admissions), favors tertiary facilities (more equipment and better physicians), and reduces competition in the health sector (everyone gets paid their historical cost/budget regardless of performance). No policy could be worse for hospital restructuring and rationalization.

The lack of proper incentives at the facility level is another policy error in the existing system of budget funding and spending. The former FSU system of chapter budgeting with no flexibility between chapters, the inability to mix fixed and recurrent budget and spending, the lack of the ability to retain savings and end of year "savings carryover", is one of the most disadvantageous policies. While the new Law on Public Sector Management and Finance is designed to change these deficiencies, at present it has had little impact at the facility level. Facility Directors do **not** know about these changes, and have **not** been able to utilize them. Without incentives for savings at the facility level, no facility head will effectively reduce personnel or spending. Hospital director can reduce personnel and fixed cost but will **not** do it unless the right incentives are in place. Experience in other FSU countries has shown that developing incentives for savings (and resultant bonus payments to management and staff) can result in large permanent savings in both fixed and recurrent costs.

Experience in other FSU countries has shown, that the single most effective change required to restructure and rationalize the health care sector is the establishment of a "single pool" of funds and an "integrated single purchaser" function, combined with incentives for savings at the facility level. If Mongolia makes no other change, it will make great strides toward restructuring the health system and significantly reducing operating costs.

2. RECOMMENDATION

Development and Implementation of an integrated "Single Pool" of Funds with "Single Purchaser", that allows flexibility in the collection, budgeting and spending of funds, with the requisite incentives for facility performance and penalties for performance failure. A "single pool" means one account or one fund that all funds, except out of pocket, (HIF, central, and local funds), go into, and all facilities are paid out of this fund/account

based on negotiated performance objectives and outputs and not historical cost inputs.

While all of the technical details will need to be developed and piloted before changing policies, the consultants were able to determine that the Treasury would allow one account or one fund for all facility payment, and possibly the HIF could go into this single account. However, it is unclear if the co-mingling of funds, as well as the present use of funds designated for "recurrent" costs, could be used for "fixed" cost and vice versa. It is important to be able to spend funds where it is needed and not where it came from. The recent change to the use of central budget funds instead of local funds for funding city facilities, should allow a smoother transition to a "single pool/single purchaser" function. Again, these details and various possible problems would need to be explored and solutions devised by the Funding and Costing Work Group, and piloted in a small setting before going citywide or nationwide with the change.

The new Law of Public Finance and Management, Act 27, has many excellent provisions that will take time to implement. The development of Performance Contracts and Business Plans for each facility is an important first step in the process. Unfortunately, experience in other FSU counties has shown than only with the right financial incentives for facility savings and performance build into these contract, as well as penalties for non-performance, the outcomes will not be what might be expected. These performance contracts, reviewed by the consultants, will need to be improved in the coming year to add these financial incentives and penalties to the facility contracts.

The existing system of budgeting on a historical basis of cost/input based norms and standards will need to be changed toward objective output based indicators including more quality assurance standards, using the L&A process as well as mortality and morbidity indicators. There also needs to be a closer relationship between L&A and the HIF or the new Single Purchaser in order to develop more effective controls on referrals, inappropriate admissions, and lengths of stay. The use of Clinical Pathways and other modern clinical tools and methods will need to be developed and implemented by the Quality Improvement Work Group.

As highlighted by many authorities, the present HIF system has many deficiencies that will need to be corrected over the coming years, and all of these need not be mentioned here - see Appendix. The need for a "Case Mix" Payment System, whereby different rates are paid for different procedures, and one rate is paid all institutions for the same procedure (e.g., a "hernia repair" is paid the same amount to all hospitals regardless of type or size. This not need be a complicated process, and could be major groupings of 10-25 categories, and not 300+ different rates. This would greatly discourage tertiary facilities from doing the "easy" secondary cases, as they would not be paid to cover their high tertiary costs for doing secondary procedures.

The lack of an effective "Gate Keeping" function at the FGP and primary care level, the lack of enforcement of the "Bypass Fee" are major factors that could reduce costs to the HIF. The HIF should seriously consider a incentive for reducing LOS for all procedures. The lack of financial penalties and utilization controls for inappropriate admissions, referrals, and unusually long lengths of stay in the hospitals, all need attention in the development of effective payment reform, as part of the process of development of a Master Plan for Hospital Restructuring. There should be controls on primary and secondary care referrals if hospital admissions are to be reduced.

Funds Flow Diagrams and Discussion

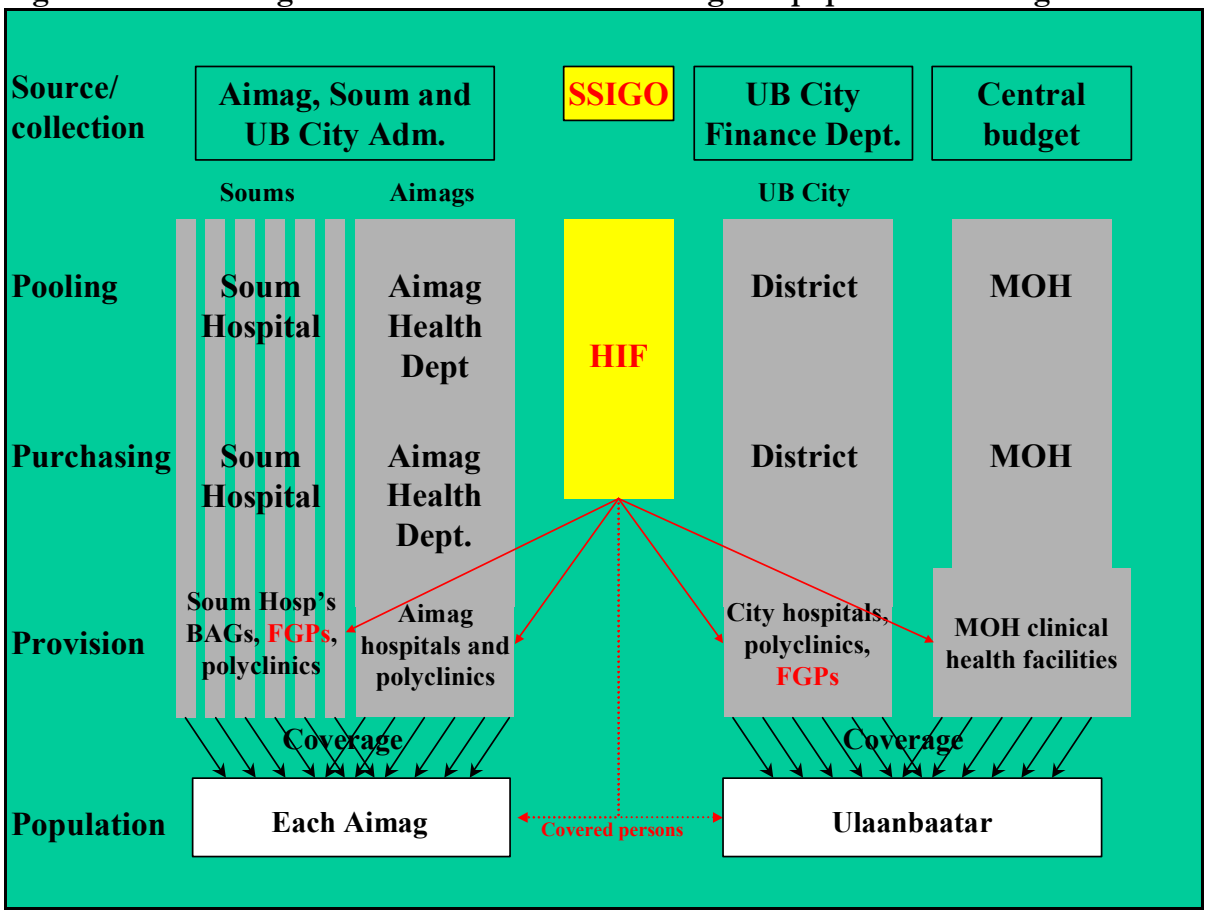
The role of the consultants was not to redesign the existing funds flow system, but the MOFE requested some diagram of what was recommended, showing before and after systems. The discussion below is somewhat simplistic, and the current system as shown may not be exactly as presently exists in Mongolia, as the consultants did not have the time to document all of the existing system. However, what is presented below is a general discussion of what is and what could be, and the "Work Group on Funding and Costing" will need to develop their own model and "pilot" before it is implemented in the Aimags or in UB City. The diagrams have been modified from work in another FSU country (Krygyzstan) and may not be correct for Mongolia, but the basic idea is the same.

The present system has four payers and four pools (HIF, local budget, central budget, co-payments <5,10,15%>and out of pocket payments) and some facilities are paid by HIF and local budget (e.g.. district hospitals), and others are paid HIF and central budget (e.g., MOH tertiary facilities), and some get just local budget (e.g., Maternity Hospital), as well as other variations. The existing pools have a historical cost basis and different restrictions on the use of the funds and some funds can only be used for fixed cost, and others for recurrent costs. This restriction in the use of funds is a significant disincentive for operating a facility efficiently, and facility heads cannot use funds where they are needed, but must use the funds for expenses, where they were allocated. It is possible that the new law on Public Sector Management and Finance, Act 27, will change all this, but that was unclear to the consultants at the time of the visit.

The change to a "Single Purchaser" is meant to have just one pool (not 2-4 or more pools – except for out of pocket payments), and one purchaser, where all funds collected go into one account or one fund or one pool, and regardless of where the funds were collected, the funds in the single pool are used to pay all any expenses (fixed or recurrent) in all facilities (MOH, UB City, District, etc.) based on a negotiated performance contract between the facility and the Single Purchaser. One basic principle is the separation of purchaser and provider of services. The past practices of the local Government or the UB City, both purchasing services and providing services should not be permitted. You want a purchaser who is a good negotiator, has no special interest to protect, and is interested in the needs of the community and the provision of quality health services and "value for money" in paying for health services.

The key issue is the "single pool and the single purchaser," as well as the transparency and accountability of payments. The big question is, who will be the Single Purchaser and who will control the Single Pool?. There is no easy answer to this question, and it will take much discussion to determine who might be the best single purchaser. It could be the HIF, the MOH, or some new organization. Possibly it could be an Authority like the Directorate of Medical Services (DMS) that supervises the Licensing and Accreditation process with facilities. Contracts and payments should be linked to the revised HIF guidelines, and the retention of hospitals with the appropriate licensed staff and who can meet accreditation guidelines. The next step would be to develop quality outcome measures and performance incentives and penalties to encourage the good clinical practice and discourage poor health delivery performance. An approximate diagram of the present system is as follows:

Figure 1. Present Organization of health care funding and population coverage

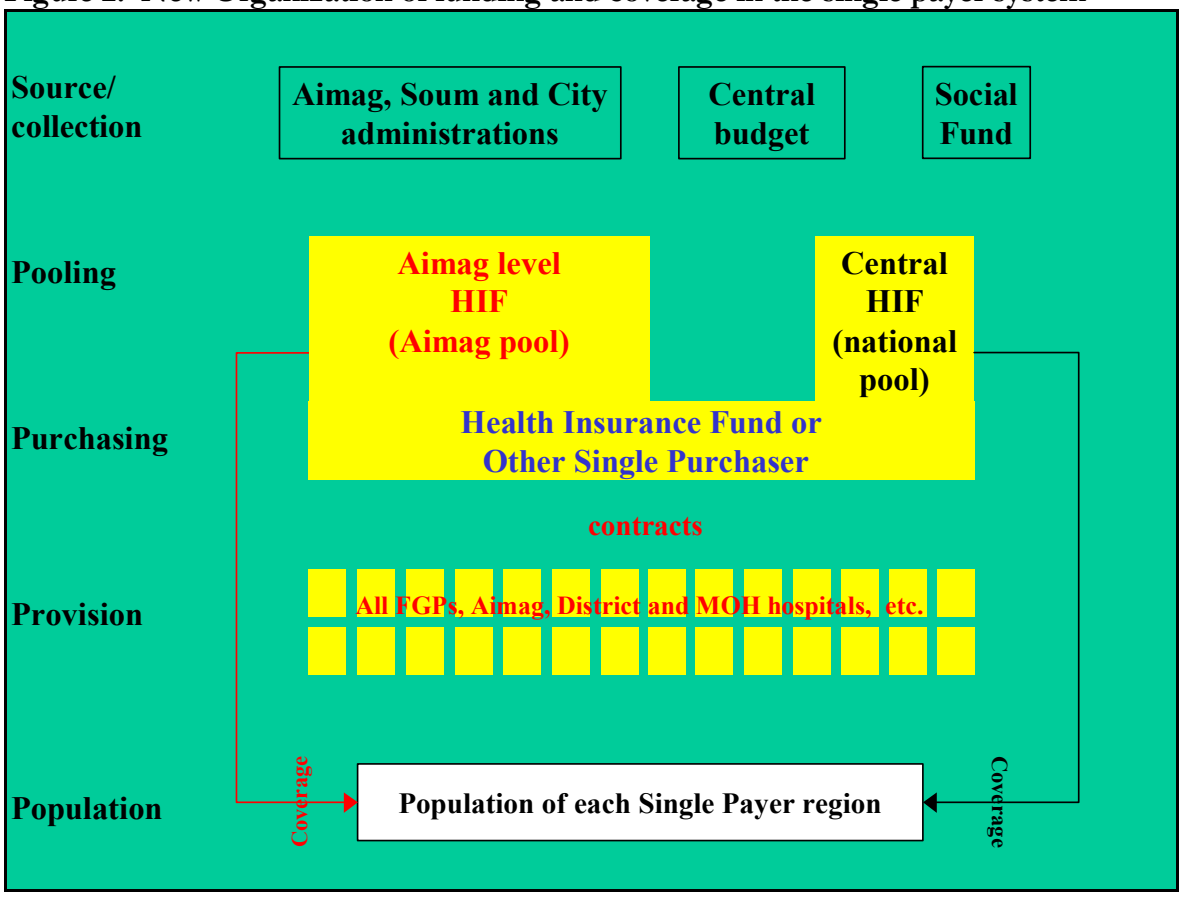


Note: Again, this is a generalized diagram, and the Mongolian system may not be exactly like the diagram shown, but the general idea is the same.

The change to a single pool should allow one centralized fund or account where all payments, except out of pocket payments, go into one account, to then be used as the needs of the facility dictate, whether fixed or recurrent, heat, salaries, or bonuses.

The new Single Pool and Integrated Single Purchaser might look something like the following diagram below. Once again, this is a generalized diagram and the one finally designed may look different than that shown below:

Figure 2. New Organization of funding and coverage in the single payer system



Please note that these are simplified diagrams and the actual Mongolia situation will need to be developed and presented in the correct format.

D. Governance and Management of the Health System

1. FINDINGS

Once again the disparities and dysfunctional consequences of the existing system of governance and management of the health care system in UB need not be elaborated here – see appendix. It is sufficient to say the major split between the MOH facilities (16 clinical and tertiary facilities) and the UB City Department of Health facilities, with six (6) separate district Governors under the direction of the UB Mayor/Governor, does not allow for any serious restructuring or rationalization activities across the entire health care system (primary, secondary, and tertiary). There is little real competition among

public facilities. Patients bypass cost effective primary care and lower cost secondary care and go directly to higher cost tertiary care facilities without penalty or consequences. While this may be good for the patient, it is not good for the population, nor is it good for the GOM, and results in serious misuse of critically short health care resources and unnecessarily increases the budget and demands on HIF funding each year.

There is little or no coordination between the MOH and the UB City Department of Health. There is no joint development of Strategic Plans or Operational Plans, nor Capital Equipment Plans, and each group naturally do what it thinks is best for itself. The new DMS, while off to a good start, still has undefined roles and responsibilities especially authorities with the MOH and all this will take time to work out effectively. The MOH, no manner how persistent, could not restructure facilities in UB, as they do not control the larger number of facilities nor do they have control of the funding mechanisms, incentives, or penalties that need to be implemented.

The various types and levels of management, the lack of cooperation and coordination between the various administrations, and the various political factors at all of these levels means that without some type of reorganization, nothing will happen to effectively restructure the health care system of UB. The forces of "status quo" and "business as usual" are simply too great, and as previously highlighted in the introduction, there are no incentives for anyone – not the MOH, the UB Department of Health, the Governors of the six districts, nor the Mayor/Governor – to attempt to restructure, rationalize, or private any of the health facilities or services. Merging, consolidating, closing, and privatizing some facilities with the resultant changes in personnel including reassignments, retraining, and redundancy issues is simply not possible in the present management structure in UB City.

What is needed is a new system or governance and management of the UB health system, one that allows restructuring, rationalization, and privatization incentives across the whole system. By "governance,"it is meant that a community oriented board would be the oversight function for the management group, and would ensure that restructuring and rationalization, is in line with community needs and resources.

2. RECOMMENDATION

Development and implementation of an integrated Governance and Management System for the entire UB health care network, including all facilities and services, with one community oriented board overseeing the process of reform, restructuring, rationalization and privatization.

The new Public Sector Finance and Management Act and the recent Civil Service Reform have provided the opportunity to do something significant in the area of restructuring and rationalization. More accountability, more flexibility in budgeting and spending, allowing savings to accrue to the institutions, the development of business plans and performance contracts for each facility can greatly assist the restructuring

effort, but they are not enough by themselves. Without new governance and management, the probability of success is very limited.

E. Privatization of Health Facilities and Services

1. FINDINGS

Background

A pilot health sector privatisation program was launched in 1997 under Government resolutions No's 160 and 219. Within the pilot exercise, one District Hospital and Soum level hospital were to be managed either by the private sector or individuals on a contract basis. The Bayanzurkh District Hospital and 47 Soum hospitals of 16 Aimags were covered by the pilot program. The aim of the program was to improve the quality and access to health services, increase efficiency and identify issues and principles that should be followed for further application of contracting out mechanisms in the health sector.

The scope of the program included the potential contracting out of some medical services, laboratories, diagnosis, cleaning, canteen services and management contracts for Soum, Aimag, District, Clinical Hospitals and Specialised Centres. Contracting out of health and associated services must comply with the Constitution of Mongolia, the Health Act 1998 (as amended), the Civil Code, the Health Insurance Act as well as other legal acts adopted in conformity with these laws. The MOH, MOFE and SPC were responsible for the establishment of the contracting out policy, guidelines and implementation.

In 1998, the Ministry of Health and Social Welfare and the Asian Development Bank implemented the Mongolia Health Sector Development Program (HSDP). Its' objectives were the:

- Promotion of the Primary Care Health Model
- Encouragement of private health sector participation in health services delivery
- Restructuring of health facilities
- Rationalisation of health personnel
- Improving health care financing and management
- Protection of the poor and vulnerable groups

On 25 January 2001, Privatisation Guidelines for 2001 – 2004 were approved by Mongolian Parliament. The Government's overall policy goal was/is to accelerate the privatisation process and increase private sector participation in the economy, thereby improving economic efficiency, generating economic growth and enhancing the welfare of the people. Based on the Guidelines, the Government would adopt annual action plans specifying the enterprises and assets to be privatised by the State Property Committee during the year and the methods to be utilized. For each privatisation, the Government would choose the most appropriate method and structure of sale to achieve its' objectives. The Government would prepare annual progress reports on the implementation of the

privatisation policy for submission to and review by Parliament. Government approved the final Social Sector Restructuring Guidelines in July 2002 and passed appropriate legislation in September of that year. The final list of social sector entities subject to "privatisation" was approved by the Prime Minister on 13 April 2003 and the nominated health institutions are listed in that document.

Privatisation Achievements to Date

A. Primary Health Care (PHC)

The ADB through the HSDP has been assisting the Government to plan and implement health sector reforms since 1998 and has introduced significant and necessary changes in the Mongolian health system. The aim was/is to replace an old Soviet model, dominated by an extensive network of hospitals that were overstaffed, emphasised facility-based curative care and was not sustainable in post-transition, with one that is more responsive to client needs, based on PHC and preventive services, of good quality, and sustainable.

One of the major accomplishments under HSDP was the introduction of the family group practices (FGPs) to provide PHC to the population. FGPs—a team of doctors and nurses work as private entities through contracts with local administrations. The Government established 238 FGPs in Ulaanbaatar and in all Aimag centres nationwide by early 2002. FGPs are paid by a capitation payment under performance-based contracts that incorporate incentives for FGPs to see the poor.

Increased utilization of FGPs and patient satisfaction at FGPs were observed. However, the population, particularly in Ulaanbaatar, continues to report directly to hospitals, bypassing FGPs, at a high rate: it has been estimated that 50% of hospital outpatients have gone directly to hospitals. It is apparent that people still rely on hospitals for primary care.

Other reforms included the introduction of licensing and accreditation. While licensing of FGPs has been established and applied systematically nationwide, blanket hospital accreditation was granted to all public hospitals in January 2003 to ensure that those hospitals could continue to receive payments form the Health Insurance Fund (HIF) under revised funding arrangements. Such action reflects weak reform in the public hospital sector. Accreditation of private hospitals is being implemented in a more rational manner and may result in the closure of many sub-standard facilities and the upgrading of others.

In terms of services quality, HSDP provided comprehensive support to FGPs when the FGP system was set up: (i) introducing a capitation payment and performance-based contract; (ii) application of licensing for FGP quality assurance; (iii) training and provision of equipment; and (iv) establishing a good working environment by rehabilitating/rebuilding facilities. However, the training consisted of only one short course and was not followed by supervision or on-the-job advice. Similarly, training impacts were not analysed. Therefore, surveys reported a limited level of knowledge and practice of standard protocols.

Bayanzurkh District Hospital

Evaluation reports prepared by the Ulaanbaatar Health Department and Bayanzurkh District Hospital Board of Management indicate that Bayanzurkh District Hospital has been successful in improving the use of available resources, in particular, financial resources. However, strong anecdotal evidence suggests that health services quality and range has not improved and that services to outpatients have declined due to the HIF's funding regime, which encourages inpatient treatments. Further, there is evidence that access to the poor and vulnerable groups has diminished and the hospital has developed a reputation of only providing treatments to the wealthy. The Hospital still receives some local budget monies for fixed costs, but has had to significantly increase its financial dependence on the HIF and patient co-payments to the detriment of its' client base.

Soum Hospitals

Management contracts for Soum hospitals were cancelled for a multitude of reasons including, tyranny of distance etc. However, the three most apparent important reasons were the fact in many Soums, local budget support was withdrawn from the hospitals and the majority of the Management Contracts were awarded to the incumbent management, or to doctors who lived and worked outside the Soums. Without the provision of proper hospital administration and business training, it was most unlikely that the incumbent operators would be able to operate the hospitals in a more efficient manner. Similarly, that is true for doctors who reside outside the Soum as well as those doctors not having a "hands on" management role, let alone adequate reporting systems from which to make management decisions. Management contracts did not provide for or create the ability to access ongoing post graduate medical training. Health services delivery outcomes did not improve and access to the poor and vulnerable groups was further eroded.

Contracting Out

It is estimated that some 20 public hospitals within Ulaanbaatar have embraced contracting out of non- clinical services, with mixed results. Most claim that the privately provided services are more expensive that in-house services provision. It is not possible to justify these claims for adequate costing of in-house services provision was never undertaken prior to outsourcing/contracting out.

Private Hospital/Clinic/Pharmacies development

Private hospitals and clinics have developed at an alarming rate and without regulation until recently. Private facilities are funded from the HIF and patient co-payments. The HIF is obliged to fund private hospital that gain accreditation from the Directorate of Medical Services. The rapid growth of private facilities is stretching the HIF's financial capacity; Accreditation Standards need to be strengthened to improve quality and reduce the number of private facilities facilities and encourage competition between hospitals. 80% of pharmacies are now privately operated and appear to provide a good service.

Public Health financing

Health care spending is low by international standards at 4.7% of GDP. Thus it is especially important for the Government to assess if financial allocations are fair and efficient, and whether spending is properly prioritized in light of the health needs. However, there is insufficient knowledge and skills in financial management and lack of understanding in financing sources and flows and use of funds to make efficient and effective decisions. The World Bank will assist in 2003 through the establishment of National Health Accounts to help the Government analyse health expenditures.

Public health financing has two main sources – budget funds and the HIF.

The health budget is now controlled by the MOH but payments are controlled by the MOFE. Budget funds can only be applied to hospitals' fixed costs. The HIF collects premiums and pays public (and private) hospitals accredited by the DMS to meet hospitals' variable costs and cannot be interchanged with budget monies. The DMS is an Agency of the MOH. Reimbursement rates are based on historical input derived funding/cost levels where inpatient treatments have been encouraged under HIF policy. An HIF payment methodology for outpatients is being developed but it appears that it will also be input based. There is no evidence that incentives or penalties will be included in a revised HIF payment system to encourage hospitals to reduce the ALOS and number of admissions.

Currently, an inpatient in a district hospital and an inpatient in a tertiary attract the same HIF reimbursement rate. There is no differentiation between acuity levels. An output based funding system needs to be developed in order to accurately reimburse hospitals for procedure costs. Capital and maintenance issues also need to be addressed by the HIF and the budget if facilities/services privatisation is to be undertaken, to create an attractive business environment for the private sector.

As previously mentioned, the development and implementation of an integrated "Single Pool" of Funds with "Single Purchaser", that allows flexibility in the collection, budgeting and spending of funds, with requisite contract incentives for facility performance and penalties for performance failure is essential if sustainable privatisation initiatives are to be implemented.

Facilities/Services Master Plan

The current list of health entities targeted for "privatisation" includes the leading tertiary hospital -Shastin, Aimag hospitals, health centres, spas and resorts. Proposed privatisation models include outright sale, the establishment of Joint Venture Stock Companies and performance management contracts of various types. Government has not decided whether it will continue to purchase any public health services from these facilities (in whole or in part).

The Shastin Hospital is the public referral hospital for neuro and cardiac surgery for the whole country. Withdrawal of budget support post-privatisation would substantially increase HIF dependence and patient co-payments (a la Bayanzurkh District Hospital). Access to the poor and vulnerable groups would be affected to the extent that they could not afford such services. Without budget support, it is unlikely that Shastin Hospital would be able to provide its current services.

Government needs to undertake a facilities/services master planning exercise with particular emphasis on Ulaanbaatar to determine what services it wishes to purchase and from which facilities. This task is complex due to hospital "ownership" issues between Government and the City but must be urgently addressed prior to implementation of major privatisation initiatives.

Policies/Procedures/Contracts

The draft State Property Committee generic rules for tendering/privatisation require substantial revision to address the issues involved in privatizing social services. There are no transaction documents, meaningful performance indicators and hospital contracts and the licensing and accreditation system are in their infancy. There appears to be Government recognition that the regulatory, institutional and procedural framework needs strengthening, if the various health initiatives underway and being planned, are to have sustainable long-term development impacts.

The MOH and DMS are understaffed and inexperienced in privatisation implementation. The SPC, whilst more experienced with privatisation issues and the responsible agency, has little knowledge of the health sector and does not have health services planning capabilities. Policies, procedures and contracts need to be developed in a collaborative manner rather than in isolation to ensure appropriate outcomes. Staff need to be trained in their application and management.

2. RECOMMENDATIONS

A. Health sector privatisation initiatives should be delayed until Government has:

- Developed a single transparent payment mechanism with appropriate incentives and penalties.
- Created a Master Plan for health facilities and services delivery/outcomes.
- Developed transparent and robust policies, documents and tender procedures for privatisation initiatives.Developed meaningful performance indicators.
- Recruited and trained additional appropriate staff for MOH and DMS.

- Developed contract management capabilities. Developed market interest – preferably international to improve the quality of service outcomes.

- Achieved the political will and commitment, including financial support for redundancies and facilities closure necessary to implement meaningful reforms.

- Developed a mature dynamic licensing and accreditation system, to be applied systematically, transparently and without discrimination,

B. It is therefore recommended that the World Bank give favourable consideration to the establishment of a Technical Assistance facility to enable the Government of Mongolia to strengthen the regulatory, institutional and procedural framework.

III. OPTIONS FOR UB MASTER PLANNING

A. Option #1: More of the Same Strategy

The most obvious option is that the GOM will continue along same process with a broad-brushed strategy to demand specific cuts in hospital length of stays combined with further movement of expenses to the outpatient areas. This will **not** result in significant cost reductions as this can only come from consolidating and closing facilities, turning off the heat and electricity, and reassigning personnel, which seldom happens without the needed financial incentives at the facility level and at the larger system level. The easy bed closures, expense reductions, personnel retirements, and length of stay changes have already been done, and the probability of large decreases without systems changes is highly unlikely. It is not possible to estimate to any degree of accuracy the financial implications of this option, but probability of any significant savings is small or negligible over 3-5 years.

B. Option #2: Improvements in Utilization Review and Some Reorganization

If is not possible to bring about a shared vision and strategy of restructuring, rationalization, and privatization, then there are a number of possible options to consider instead of just more of the same, as outlined below.

Option #2 is a midway option or a sub-optimal option that has a number of variations. One possible effective tool is improved utilization review activities. These controls could reduce utilization of services is the implementation of both incentives and penalties on inappropriate admissions, length of stay, referrals, and discharges, with improved licensing and accreditation criteria and standards. If the HIF developed incentive to reduce length of stay, an improved case-mix system, a gate-keeping function at the primary care level, with improved controls and an enforced "bypass fee," then utilization could be reduced significantly. Combining these utilization review changes with a more effective Licensing and Accreditation process, could reduce admission rates, and eventually reduce costs. However, this means

changing physician behavior through new standards and training, and the use of new penalties and incentives. The experiences of other FSU countries in this area, has not been successful. If successful, this might reduce utilization but without closing facilities, merging, consolidating, turning off the heat, closing down the building, and letting the staff go, there will be little significant savings.

Another option organizationally would be to divide the city up into 2-3 districts instead of 6 districts for health services management and governance purposes (including putting all MOH and UB City facilities within that district). This would provide the ability to merge, consolidate, or close facilities across a smaller number of districts (2-3 instead of 6 plus the MOH facilities) and would give added flexibility in restructuring as you could restructure both MOH and UB City facilities within the district. This is not possible at present as the MOH facilities are organizationally separate from the UB City facilities.

A possible variation of this option is the possibility of allowing the UB City to operate the primary care facilities, and the MOH to operate all the secondary and tertiary facilities. This is also a sub-optimal option, as it would not allow management to restructure toward more and better primary care, which is badly needed, and would not allow the incentives to reduce hospital expenses and to reallocate to primary care, preventative, and environmental activities. It is difficult to estimate the financial implications of these changes, as there are so many variables involved, but there could be significant savings if restructuring was applied across 2-3 districts and not 6 districts. There would be more savings than in Option #1, but it is impossible to estimate at this time.

C. Option #3: Regional/Territorial Management of UB

The optimal option, with regard to effective planning and control activities in the interest of restructuring, rationalizing, and privatizing across the whole health care sector, is to integrate all management (MOH facilities and UB City facilities) into one regional structure, under one management and with a Regional Governance Board of Directors to oversee management and patient rights throughout the whole city. This has numerous efficiency advantages and has been recommended by many authorities over a number of years - see Appendix. This option, if politically feasible, has the largest probability of success with regard to restructuring, rationalization, and privatization of some sectors of the health care system. Again, it is difficult to estimate the potential savings, but with effective management, it could be in the range of 10-20 Billion Mongolian Tugrig over 3-5 years.

IV. SELECTION OF A POSSIBLE OPTION

It will take many months and possibly years to begin to seriously select one option to restructure, rationalize, and privatize some sections of the health care system in UB. The need to outline a vision and strategy, and to make the needed funding and payment changes are a first priority. Once these changes are implemented, possibly the discussion may get around seriously to changing the governance and management structure in UB City. This is too political a topic to begin with; consequently, it is better to get on with the needed vision, strategy, single pool/single purchaser, flexibility in budgeting and spending at the facility level, as well as the needed capacity building prior to attempting to take on this highly political issue. Option #3 is the preferred option of the consultants, but regardless of the choice, it is not too early to get on with some of the other issues that must be solved before seriously attempting governance and management changes. The key items to be done in the near future are outlined below.

V. KEY COMPONENTS OF A MASTER PLANNING PROCESS

Regardless of the option chosen above, the GOM must move on with the process of developing some type of restructuring and rationalization process for the health system. Outlined below are the key components of a Master Planning process that will take the GOM along the path to successful implementation.

EXHIBIT B on pages 35-38, at the end of this section, presents the various activities, outputs, and suggested timeframes for this process and is in line with the timing of the Poverty Reduction Strategy. This plan is not meant to be followed precisely, but it could form the basis for setting up some work groups and establishing some deadlines with respect to getting specific items done, and moving on to other items.

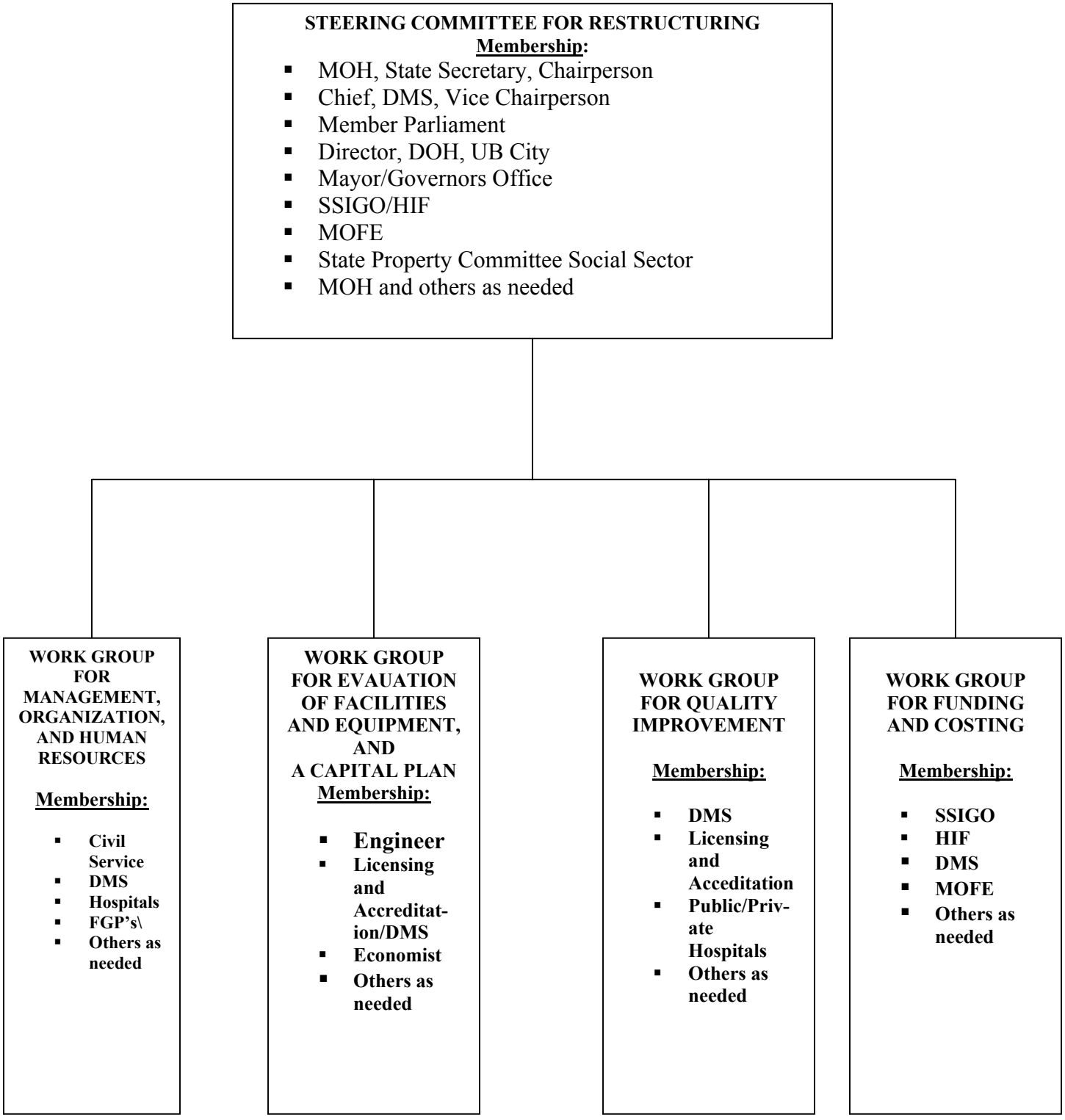
A. Steering Committee and Key Work Groups

The need for a cross-sectional Steering Committee has been outlined above. This group would oversee the development of the Master Plan and would provide the necessary decisions with regard to policy recommendations to keep the project on track. The group would be made up of key representatives from each sector (MOH, DMS, SSIGO/HIF, MOFE, SPC, Prime Ministers Office, Parliament, and others as needed).

A possible organizational chart for this structure is provided in **EXHIBIT A** presented on the next page:

EXHIBIT A

ORGANIZATIONAL CHART FOR STEERING COMMITTEE AND WORK GROUPS FOR RESTRUCTURING OF ULAANBAATAR HEALTH SECTOR



Reporting to the Restructuring Steering Committee would be a number of key Work Groups for each respective area of concern and where various capacity building is required. These groups are as follows:

B. Facilities and Clinical Equipment Plan

The first major step in a restructuring program is the assessment of existing facilities and equipment. Some of this was done under the HSDP in the three pilot Aimags, and the information developed in this project can provide a model for UB. The objective of the assessment is to develop a list of the good and the bad facilities, and a list of the good and bad equipment, as well as eventually developing a list of new equipment needed and the cost of renovations to facilities. With the assessment of bad facilities some decisions can be taken to merge, consolidate, close and eventually privatize, sell, or tear down the buildings.

The work group should contain at a minimum, an Engineer familiar with construction/renovations, a Licensing and Accreditation Specialist familiar with equipment and facilities standards, and an Economist or Accountant familiar with costing of equipment, renovations, and tearing down facilities.

The various outputs are listed in Exhibit B at the end of this section. The outputs of this group would lead into the development of a Five Year Capital Plan for both Facilities and Equipment.

C. Facility Funding and Costing Plan

The need for development of a Single Pool of Funds and a Single Purchaser System has been discussed in a previous section. The objectives of this work group would be to develop the policies and procedures, as well as a pilot experiment, to bring this about. Another key objective of this group could be to develop more flexibility in the budgeting and spending of funds in order to allow health facility managers to reduce or increase staff as needed, to use fixed funds for recurrent costs, and vice versa, as the needs of the institution dictate.

A second objective of this work group is to develop methods of costing services and products in hospitals so that the full cost of a service or procedure can be determined. These techniques are known as cost finding and cost allocation, and the principles are well developed in western literature and can be easily modified to fit the needs of the Mongolian system.

Other objectives of this group are to develop solutions and pilots for a case mix system, a gate keeping function, an improved by-pass fee, and other adjustments, incentives, and penalties to the present system deficiencies and dysfunctional activities. Other objectives of the group may be the assistance with developing

business plans, improved monitoring and evaluation methods, and other capacity building issues at the various health facilities.

The group should be made up of economists, accounting, and financial personnel and foresighted management personnel who recognize the need for this pooling of funds. The group will also need close coordination with the Project on National Health Accounts. Significant capacity building will need to be applied to this group and to the related groups in facilities on modern cost accounting techniques and methods.

C. Quality Improvement Plan

The need to continue the process of quality improvement is at the center of any restructuring program. Closely associated with the Funding Work Group is the need for a group to work on improving the methods of "Utilization Review", and implementing Clinical Pathways and other improvements. This means that all of the existing protocols, policies, and procedures with regard to referrals, admissions, discharges and the various clinical training issues must be reviewed and improved. The improvement of the existing Licensing & Accreditation process should also be part of this group, including using these standards to remove incompetent practitioners and close poor facilities.

It has been well documented elsewhere that the hospitals in Mongolia have large numbers of inappropriate admissions (estimated at 20-25%), long lengths of stay (11-12 days), simple secondary cases going to expensive tertiary facilities, as well as the lack of a "gate keeping" and strong "bypass" fee for self-referrals to higher levels of care. This work group would work closely with the funding work group to develop new and effective controls and training in this area. The Accreditation standards should also be used to identify and close facilities that are unlikely to meet appropriate standards in the future.

This group should consist of mostly physicians, especially clinicians, and specialists from the Licensing and Accreditation Section of the DMS. Significant capacity building in terms of training of clinicians in primary, secondary, and tertiary facilities would be a major responsibility of this work group.

D. Governance, Management, Organization, and Human Resources Plans

As highlighted in the previous section, the need for governance, management, organization, and human resource changes in the existing system of operating the health care system in UB is clear. Once again, the need for these changes has been well documented in other reports. Governance is very different than management, and the need for one responsible group of individuals with broad community representation is clear and has been discussed and implemented in Mongolia over the last few years. This is also discussed elsewhere and need not be repeated here.

This work group would focus on the various issues surrounding the development of an effective governance and improved management system for UB. This would include a large number of human resource issues surrounding the reduction of personnel and would include reassignments (urban to rural areas), retraining (hospital practice to primary care practice), as well as retrenchment and redundancy pay issues for those who do not want to be reassigned or retrained. The funds for this type of program would also need to be found or allotted in some way. The need to improve the performance bonus system in facilities is also one of the responsibilities of this group. The need to develop flexible staffing standards and guidelines also falls under this group.

The need for board training and management training is a key capacity building issue and a responsibility of this group. Improved performance appraisal and the improvement of Performance Contracts, and Employment contracts for key staff is also a responsibility of this group. One issue from other FSU countries, is that most of the facility directors will need to be replaced in the new environment as they can not perform to the requirements of a lower resource/higher quality environment.

This group needs a wide variety of participants, including personnel/human resource professionals, facility directors from all types of facilities, training personnel and others related to management, organization, and human resource issues and concerns.

Outlined in the Executive Summary is **Exhibit B** is a proposed beginning outline of the activities, outputs, and timeframes for the Steering Committee and various Work Groups. The items outlined are not meant to be a detailed list, but rather a starting point for each work group. Each group will need to meet, select a chairperson, and develop their own Terms of Reference, objectives, outputs, work plan, and timeframe for completion.

VI. NEXT STEPS

A. Establish a Multi-Sector Steering Committee and Key Working Groups

As previously highlighted, the process should begin with the development of a cross-sector Steering Committee including all the various sectors that must be involved in finding a solution to the existing problems of restructuring, rationalization, and privatization. This would include the development of the key working groups for the four areas as previously outlined. The issue of long-term capacity building, which essentially means information, education, and communications (IEC), combined with extensive training has proven to be the key to success. Large quantities of training and capacity building should be a major part of the restructuring efforts.

The major issue to understand is that the process needs to be both top/down and bottoms/up at the same time. Only by developing incentives at the facility level (primary, secondary, and tertiary) for generating savings and making changes in personnel, heat, electricity, and other reductions will change really begin to happen. In this process it is very important to establish "pilots" to experiment with the changes before full implementation.

The larger issue is that the MOH must lead the process from the top, and while the DMS can do most of the technical work, the MOH needs to provide the leadership that is necessary to keep the process moving forward. There will be many political reasons to give up the process, but the MOH must exhibit the patience and persistence to keep moving ahead.

B. Secure Donor Assistance and Build on Previous Work Done

As previously highlighted, and listed under key documents in the Appendix, there has been some great work done previously by HSDP, WHO/UNICEF, EC/TACIS, JICA, The World Bank, and many other donor programs. This experience needs to be built upon and continued.

Most important, the MOH will need to find significant donor assistance to help fund the Master Planning process. Significant capacity building will be required and a consulting group, who can provide technical assistance, and who can work closely with the personnel at the MOH, DMS, SSIGO/HIF, MOFE, SPC, UB City Government and Health Department, as well as many other groups, will need to be identified. To be effective, this group will need a Program Implementation Unit (PIU) or its equivalent on the ground working every day in Mongolia to keep it moving forward. It is possible that the ADB Funded HSDP2 may assist with some of this support. It is also possible that JICA and other donors not yet involved, such as USAID, may be willing to assist with some of the capacity building issues (privatization, communications strategy, and business plans). International donors want to

assist, but they want to ensure they are getting "value for money," and this means that the MOH will need to get much more involved in this process than previously.

C. Develop a Shared Vision and Strategy with Effective Communications

The development of a shared "Vision and Strategy" for Restructuring, Rationalization, and Privatization is the beginning point to understanding the process of developing a Communications Strategy. Attempting to outline any strategy to communicate all of this to the various stakeholders is highly premature. However, it is clear who are some of the major stakeholders, and the GOM is certainly the major one. If a vision and strategy is to succeed the Prime Minister and the Parliament will need to be part of the process, and will need to develop a statement to this fact, and support the process when it gets politically difficult. The multi-sector roundtable on Lessons Learned From FSU Countries, conducted by the consultants, was the first step in an effective communications strategy. The vision and strategy is the second step.

The keys to developing a Communications Strategy are well known and need not be repeated here to any great degree. One key is the definition of the "key stakeholders", and this is never as obvious as it appears. The other key issue is "what is the message you want to deliver," and again this is not always clear and both items will need a good deal of discussion over many months, and Public Relations professional should be brought in to assist with the process. Dissemination of the strategy is a key component, and there are a number of excellent non-governmental organizations (NGO's) that can assist with the process. This includes the Public Health Professionals Association as well as the other medical professional groups and can play a key role in this area. At this beginning stage of the Master Planning process, the key Communications Strategy should be the establishment of the Steering Committee and Work Groups, as well as the development of a "Vision and Strategy" Statement. These two items will take many months to implement and once the vision and strategy are clear, then a more detailed communications strategy can be developed. Without a vision and strategy, it is not possible to determine the stakeholders or the message to be delivered.

Experience in other FSU countries has shown that the single best message or key communications strategy, in the context of restructuring efforts, is the development of a new Capital Plan to improve the quality and provision of equipment and medical services over the long term. The population will understand merging, consolidating, and closing facilities, if they can see for themselves visual improvements in the remaining facilities. Attempting to restructure without a new capital plan for equipment and renovations will be a wasted effort, and will not succeed, as has been proven time and time again in other FSU countries.

VII. ANNEXES/APPENDIX

A. Annex A - List of Contacts, Interviews, and Facility Visits

Dr. N. Udval, Vice Minister for Health
Dr. Sodnompil, State Secretary of the MOH
D. Chimeddagva, Director, Strategic Planning Division, MOH
Mrs. Erdenechimeg, Head of Policy Planning and Coordination Department. MOH
Dr. Bolormaa, Head, International and Public Relations Department, MOH
Mr. Michael O'Rourke, Team Leader HSDP 1
Mr. Barry J. Hitchcock, Country Director, ABD
Mr. Toshiyasu Tshuruhara, Resident Representative, JICA
Mr. Joanathan Addleton, Mission Director, USAID
Mr. Robert J. Hagan, WHO Representative in Mongolia
Dr.Reijo Salmela, Medical officer, WHO
Mr. Enkhtaivan, Deputy Minister, MOFE
Mrs. T. Gandi, Chairman of Standing Committee on Social Sector, Parliament
Mr. Bailikhuu, Senior Adviser, State Property Committee
Dr. Altantuya Jigjidsuren, Head, Economics and Technology Department, DMS
Mr. Ts. Natsagdorj, Deputy Director, Economics, Directorate of Medical Services
Mr. X. Bayanndai, Social Sector Privatization, State Property Committee
Mr. Sandagdorf Enebish, Director Fiscal Policy and Coordination Department, MOFE
Dr. S. Dulamsuren, Director, Directorate of Medical Services
Dr. Tseekhuu Gankhuu, Director, Health Department of Ulaanbaatar City
Mr. Tsendiin Sukhbaatar, Chairman, SSIGO
Ms. Tseyen-Oidov Ariunsanaa, Head of Expenditure Accounting, Treasury, MOFE
J. Jargalsaikahan, Director, Economic Policy and Planning, MOF
Prof. B. Batchuluun, Vice Director Shastin General Clinical Hospital
Mr. Chingunbat, MOFE
Ms Uranbileg, TA Fiscal Coordinator, MOFE
Mr. Jamsranjav Battsengel, Project Assistant, WB Capacity Building in Public Sector
Dr. Ts. Mukhar, Director, Clinical Hospital #1
Dr. Ganbattar, Director, Maternity #2
Dr. Chimge, Director, Sukhe-Battar District Hospital
Dash-Yandag Buddorj, General Director,"MHM" Co. Ltd Bayanzurkh Hospital
Dr. R. Batsuuri, Consultant, HSDP
Irg K. Murat, Consulting Engineer, HSDP
Dr. Ravi P Rannan-Eiya, National Health Accounts
Ms. Nilufar Eganberdi, Social Development Specialist, World Bank, Wash, DC
Jamsranjav Battsengel. Project Assistant, World Bank
Mr. Saha Dhevan. Meyanathan, Country Manager, World Bank Mongolia
Mr. Raja Iyer, Lead Management Specialist, World Bank. EAPR
Ms Xiaoquing Yu, Sr Economist, World Bank, ECAR
Ms Vera Songwe, Senior Country Economist, PREMU, WB, Washington

B. Annex B - List of Attendees for WB Presentation on Health Restructuring,

April 10, 2003

	Name	Institution	Phone
1	Dr. Susantha de Ien	IPS, MOH	
2	Dr. Ravi P. Rannan-Eliya	IPS, Sri Lanka, MOH	
3	Prof. Alejandro Herrin	University of Philippines, MOH	
4	P. Altankhuyag	Project 'Capacity Building Management Health expenditure in public', MOH	
5	B. Dash-Yandag	Bayanzurkh hospital	
6	S. Lkhagvasuren	Traumatological clinical hospital	
7	D. Baast	Khan-Uul district hospital	
8	Ya. Buyanjargal	Medical Assistance Supervisory body	320738
9	D. Otgonbaatar	MOH	321014
10	T. Bolormaa	MOH	321569
11	B. Batsereedene	Shastin hospital	99150611
12	Ts. Gankhuu	City Health Authority	99116690
13	Ts. Mukhar	I Clinical hospital	99117739
14	Ts. Bumkhorol	Advisor to the Minister of Finance and Economy	319137
15	J. Altantuya	DMS	328889
16	Ts. Natsagdorj	DMS	325540
17	S. Dulamsuren	DMS	328801
18	D. Chimeddagva	MOH	322901
19	Kh. Bayandai	SPC	312476

C. Annex C - Bibliography, References, and Key Documents

1. ***Mongolia Health Sector Review***, June 1999 – presently being revised and updated by the MOH.
2. ***Health and Poverty in Mongolia: A background report for the National Poverty Reduction Strategy Paper,*** MOH Working Group PRSP for the Health Sector, Draft, 2002
3. MOH of Mongolia, ADB, ***Health Sector Development Program 1998-2002, Advancing Health Sector Reform in Mongolia***, March 2003.
4. ***Mongolia Public Expenditure and Financial Management Review***, World Bank, June 2002.
5. Rice, James, Mongolia's ***New Health Economics:*** A New Era of Increased Performance via New Transparency and Accountability for Money Flows within the Health Sector of Mongolia, November 30, 2002.
6. ***Report and Recommendation of the President to the Board of Directors on a Proposed Loan to Mongolia for the Second Health Sector Development Project***, January 2003.
7. Kotilaninen, Helina, ***Preliminary Report on Master Planning,*** HSDP, May 1999.
8. Pekurinen, Markku, HSDP, ***Assessments of the Impact and Achievements of the HSDP,*** March 2003.
9. Kelly, Paul, ***Hospital Sector Rationalization in Mongolia,*** HSDP, SMEC, October1999.
10. D. Tsegeenjav Davaagiin, ***MOH Hospital Sector Rationalization,*** October 2000.
11. Deville, Leo, et. al., Health Sector Resource Development, ***Rationalisation of Health Services,*** HERA, ADB, March 1997.
12. ***Guide to the Role Delineation of Health Services Ministry of Health and Social Welfare***, Mongolia, SMEC, September 1999.
13. O'Rourke, M. and Don Hindle, ***Mongolia's system-wide health reforms: lessons for other developing countries***, Australian Health Review, 2001.
14. Kotilainen, Helina, ***Rehabilitation of the Hospital Infrastructure in a Developing Country,*** World Hospitals, Vol.37, No.2
15. Janes, Craig R., Market Fetishism, ***Post-Soviet Institutional Culture, and Attenuated Primary Care: Producing Poor Medicine for Poor People in Post-Transition Mongolia,*** October 2002.
16. Ulrich, Lynton***, Report and Recommendation for Health Sector Public-Private Partnerships,*** May 2002.
17. Kutzin, et. al., ***Health Sector Reform in the Kyrgyz Republic: Lessons Learned and Implications for the CIS-7 Countries***, World Bank, October 2000.
18. Atun, Rifat, et. al., ***Kyrgyzstan Hospital Rationalization Project***, DFID, February 2001.
19. Eurohealth***: Implementing Hospital Reform in Central and Eastern Europe and Central Asia***, Vol 7, No.3, Autumn 2001.

20. Policy Brief*: **Hospitals in a Changing Europe, European Observatory***, 2002.
21. Policy Brief: ***Health Care in Central Asia, European Observatory***, 2002.
22. Mongolian Statistical Yearbook 2001, National Statistical Office
23. Hindle D. 1999. Health financing and resource allocation.
24. MOH website and evaluation indicators.
25. Mongolian Health Sector Development Program – WHO
26. Clinical Laboratory Consulting Report for WHO, June 2002.
27. MOH, Health Sector Development Strategies 2002, with WHO UB 2002.
28. Policy Matrix for PRSP, draft 3/22/03
29. O'Rourke M. *Health Sector Development Program implementation issues.* Feb 2001.
30. Mongolia Public Expenditure and Financial Management Review, World Bank, June 2002.
31. ***Infrastructure Design and Construction Report***, No. 2,1999, No. 3, 2000.
32. ***Medical Equipment Consultant Final Report and Recommendations,*** 1999
33. Contracting Out Program in Delivery of Health Services and Assistance, SPC
34. MOH Newsletter, February 2003, Funding to be Provided by HIF
35. General Managers Output Agreement, Jan 1- Dec 31, 2003, Mayor's Office
36. Performance Agreement between DMS and Shastin Hospital, 2003.
37. Municipal Finance Discussion Document, April 3-4, 2003
38. National Public Health Policy Paper, November 2001.
39. Health Indicators 2001, National Center for Health Development
40. Public Sector Management and Finance Act 27, June 2002.
41. GOM, Civil Service Reform, Draft Medium Term Strategy, April 2003.

KEY DOCUMENTS IN SUPPORT OF HOSPITAL RESTRUCTURING:

1) ***Health Sector Resource Development, Rationalisation of Health Services,*** **ADB, March 1997:**

   This 1997 document developed under the HSDP funded by ADB, was an attempt to provide comparisons and experience between Mongolia and other countries, primarily Western Europe. It developed statistics on the various levels of hospitals, referrals, and rationalization issues in Mongolia. Some basic data is presented on the hospitals in UB and some comparisons are presented. However, no specific recommendations are made, but some Next Steps are listed in Chapter 6, that include the need for cost analysis of secondary and tertiary services, better capitation system, training of FGP's, decision of a Basic Benefit Package (BBP) , licensing of medical practitioners, need for a Hospital Management or Advisory Board, and the need for costing of services at the SSIGO level.

2) ***Guide to the Role Delineation of Health Services,*** **Ministry of Health and Social Welfare, Mongolia, September, 1999:**

   This guide, developed in 1999, using the Queensland, Australia Guide as a model, is a presentation of the various Clinical Support Services, Core Services,

Integrated Community & Hospital Services, and Primary Community Health Services. The guide provides definitions of all types and levels of health and medical services and can be utilized to evaluate all the various quality, clinical, medical, nursing and other role delineation issues in various types of facilities.

3) **MOH Working Group PRSP for the Health Sector, *Health and Poverty in Mongolia: A background report for the national Poverty Reduction Strategy Paper,*** Draft, 2002
This paper, prepared for the PRSP, is the best and most recent presentation of the various issues and data to clearly portray the problems and opportunities in the Mongolia environment for improved health and poverty reduction. Many of the key findings are presented in this paper and need not be repeated here.

4) Kelly, Paul, ***Hospital Sector Rationalization in Mongolia***, HSDP, SMEC, October1999; and companion document: D. Tsegeenjav Davaagiin, *MOH **Hospital Sector Rationalization**,* October 2000.These two companion papers, one done for Mongolia as a whole and the second one on just UB City presently the various issues, findings, and recommendations for hospital restructuring and rationalization, but appears not to have be utilized by the MOH or the GOM to any extent to further the restructuring efforts. Much of the data presented in these papers was updated for inclusion in this report.

5) Kutzin, Joseph, WHO, Sheila O'Dougherty, Sarbani Chakraborty ***HEALTH SECTOR REFORM IN THE KYRGYZ REPUBLIC: LESSONS LEARNED AND IMPLICATIONS FOR THE CIS-7 COUNTRIES,*** , Zdrav Reform Project, The World Bank, September 26, 2002 USAID
This paper was developed by the three parties involved in the successful Kyrgyzstan Health Reform Project, that began in 1994. It outlines the process needed to attain a successful restructuring effort in Central Asia, and lists a number of key lessons learned from the project. These lessons learned are quoted in this paper and need not be repeated here.

6) Atun, Rofat, Dr Akaki ZoidzeYevgeniy Samyshkin, **Report to Department for International Development, *KYRGYZSTAN HOSPITAL RATIONALISATION PROJECT: FINAL OUTPUT*** ,February 2001
This paper done by DFID and the Institute of Health Sector Development in 2001 outlines the difficult task of trying to restructure the capital city of Bishkek in Kyrgyzstan. The paper clearly outlines the lessons learning including the pooling of funds which is a key issue for Mongolia. The lessons learned are presented in this paper and need not be repeated here.

7) Ulrich, Lynton and Dr. Altantuva Jigidsuren, ***Report and Recommendation for Health Sector Public-Private Partnerships,*** May 2002.

This report completed in May 2002 clearly outlines the issues and recommendations for and against privatization of health sector facilities. Most of these ideas are incorporated in this report and are not repeated here.

8) Pekurinen, Markku, HSDP, ***Assessments of the Impact and Achievements of the HSDP,*** March 2003.

This report done during the period February 24- March 23, 2003 is a review and assessment of the impact and achievements of HSDP, and is an excellent guide to what has occurred over the 5 year period of the design and implementation and covers thoroughly all of the various issues as they relate to restructuring of the health care system in Mongolia.

9) Salmela, Reijo, ***Mid-term Evaluation of the Health Sector Development Program*****,** February 2001, plus a variety of articles, reports, recommendations, and information developed by Dr. Salmela were most helpful in understanding the issues of restructuring and rationalization in Mongolia, especially with regard to Primary Care, and need not all be listed here, and are available directly from Dr. Salmela in the WHO office in the MOH building.

10) Rice, James A., ***Mongolia's New Health Economics***: A New Era of Increased Performance Improvement via New Transparency and Accountability for Money Flows within the Health Sector of Mongolia, November, 2002.

This report focused on the leadership dimension of change that are necessary if Mongolia is to make progress in the new era of Health Sector Performance, and includes excellent material on contracting and performance improvement.

11) Various databases were used in the study, and these came primarily from the MOH/DMS databases, and were developed from existing data – see Ts. Natsagdorj in the DMS offices; the other major database was the one developed and supplied by the HSDP1 under the ADB funded project, and is presented in the appendix. The consultant's were requested not to due extensive analysis nor to spend a lot of time on findings; consequently, the recommendations come primarily from the data analysis of others.

The other annexes are included in a separate file.