Social health insurance development in Mongolia: Opportunities and challenges in moving towards Universal Health Coverage

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Abstract Mongolia achieved high population coverage under mandatory health insurance relatively quickly. This fact was viewed by policy- and decision-makers as a central issue for health financing reform in Mongolia. Health insurance brought many new features for health service planning, provision, funding and resource management. Based on initial achievements, health insurance came to be strategically considered as the vehicle for achieving universal coverage. The article analyses developments in Mongolia's health insurance over the last decade along with the core policy dimensions of Universal Health Coverage. It examines various reform approaches and the numerous amendments to laws that have been implemented during this period and discusses new opportunities as well as challenges. The analytical review and findings discussed suggest that Mongolia has a need for evidence-based policy decisions and informed political support, with health insurance backed

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by robust institutional and administrative capacities. More generally, it also emphasizes that health policy goals and objectives can be attained by strengthening and making transparent and publicly-accountable all health system financing functions and arrangements. The policy analysis, experiences, lessons and proposed strategies presented with regard to Mongolia intend to stimulate wider discussions on health insurance development as well as promote continuing focused research on specific aspects of health insurance and public financing reform.

Keywords health insurance, health policy, coverage, universal benefit scheme, Mongolia

Introduction

Mongolia is an upper middle-income developing country with its population of 3 million sparsely distributed over a territory of 1.5 million square kilometres. In 1994, Mongolia introduced social health insurance under a political commitment to maintain equity in accessing health services and protect the population from financial hardship during the economic transition from a centralized to a market-oriented economic system. The Government chose to fully subsidize health insurance contributions for low-income and vulnerable populations, such as the elderly, children, students, and those covered by social assistance programmes. In a five-year period, mandatory health insurance in Mongolia was extended to cover almost 90 per cent of the population, and about half of total health expenditure was funded through health insurance. In other words, Mongolia achieved near universal health insurance coverage in a relatively short period of time with the support of a government subsidy. The major successes, challenges and lessons learnt during this period were documented in 2005 (Bayarsaikhan, Kwon and Ron, 2005).

Since 2005, health insurance has become a central issue for health financing reform in Mongolia. Various reform approaches have been discussed and numerous amendments have been made to the health insurance law. Health insurance coverage has been an important policy focus for the government; in 2013, coverage reached 97.7 per cent of the population (SIGO, 2014). However, evidence suggests that reaching and sustaining near universal health insurance coverage in low- and middle-income countries is a challenging task (Wagstaff, 2010; Silfverberg, 2014). Population coverage is only one aspect of health coverage. Countries also need to make progress in expanding the quality of health service benefits and in covering health care costs to reduce the financial barrier and burden faced by households.

For all these aspects, achieving progress represents the core policy objective of Universal Health Coverage (UHC): to ensure equal access to comprehensive and quality health services for every citizen in society and to protect all from financial hardship (WHO, 2010).

Using the example of Mongolia, this article draws attention to the fact that the financing of health care coverage must address three objectives: who is effectively covered; what benefits are provided and which are not; and which financing mechanisms are to be used and how are funds allocated to heath service providers. The next section presents an update[1] on developments concerning the Mongolian Citizens' Health Insurance (hereafter, referred to as health insurance) over the last 10 years with a renewed focus on UHC. The article will then examine and discuss new opportunities and challenges, and address policy-relevant strategies to improve health insurance as well as public financing as a whole to move towards UHC. Policy lessons are then presented.

A renewed focus on Universal Health Coverage (UHC)

The initial coverage achievements of health insurance development in Mongolia influenced policy- and decision-makers to strategically consider health insurance as the method to attain universal health coverage. Here, we review various reform efforts and their results as they relate to the three core policy dimensions of UHC, as presented in the 2010 World Health Report (WHO, 2010). Specifically, these are the extent of *population coverage* (breadth), *health service coverage* (depth), and *cost coverage* (height). These dimension help to identify and examine who is covered by insurance, and who is not, what service benefits are provided or funded with pooled financing, and what proportion of health service cost is paid by individual households.

Population coverage

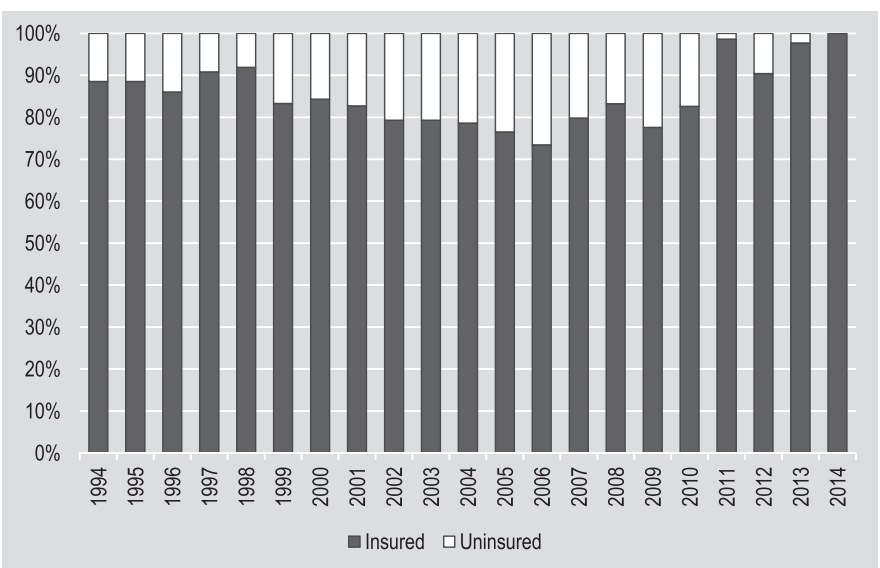
Health insurance in Mongolia is mandatory for all citizens. The law specifies that citizens are categorized according to one of 11 categories that include salaried employees in public and private business and administrative organizations, children younger than age 18, students, pensioners, mothers caring for a newborn child up to age 2, military personnel, herdsmen, low-income people covered by social assistance programmes, prisoners, and others. The government fully subsidizes health insurance contributions for certain population categories such as children, students, pensioners and the low-income group. According to the Health Insurance Office, these subsidized categories accounted for about 60 per cent of all insured in 2014 (SIGO, 2015). As an employer, the Government also pays 50 per cent of health insurance contributions for civil servants. The Government's support and

1. This article continues the debate initiatied in 2005; see Bayarsaikhan, Kwon and Ron (2005).

contribution subsidy enabled the extension of coverage to almost all the population in the first years of operation of health insurance (Figure 1). Government support was required to mitigate the negative consequences of structural adjustment reforms which had cut public budgets during the economic transition period. Individual participation in health financing through prepaid insurance contributions, rather than through direct fees and charges, was the main strategy for the development of health financing. The intention was to gradually reduce the Government's subsidy once individual categories of citizens could afford to pay contributions.

The majority of the uninsured population during the initial years of operation were those without permanent employment or who held indefinite registration in one residential area as a result of the high levels of internal movement and migration between provinces and cities. However, health insurance law amendments introduced during 1997–2003 reduced the contribution subsidy for self-employed nomad herdsmen and part-time students. These changes reduced rates of coverage. For example, health insurance coverage declined from 91.9 per cent in 1998 to 83.3 per cent in 1999 and to 73.4 per cent in 2006. Since 2010, the Government has made substantial efforts to improve health insurance coverage by organizing enrolment campaigns on fixed dates to register uninsured people, without imposing payment penalties on those who were uninsured or who had dropped out the system. Consequently, estimates suggest that health insurance coverage had by 2014 increased to nearly 100 per cent.

Figure 1. *Health insurance population coverage in Mongolia (1994–2014).*



Source: SIGO (2014).

Health service coverage

Mongolia initially introduced a comprehensive health insurance benefit package comprised of out-patient and in-patient health care services and out-patient medicines. Later, health insurance benefits expanded to include also health services provided by sanatoriums and family group practitioners. These benefits were intended to support rural health services and the implementation of newly-introduced government policies on essential medicines and primary health care by promoting the rational use of drugs and family practices in urban settlements. However, a new law amendment introduced in 2006 changed the content of the insurance benefit package. It shifted out-patient health care services and treatment, which were provided by rural hospitals and family group practitioners, from health insurance to budgetary financing. From the previous benefits for out-patient care, only the rehabilitative services of sanatoriums and out-patient medicines remained under health insurance benefits. Since this change, the scope of health insurance benefits has substantially narrowed, shifting to deal mainly with curative in-patient care. Table 1 shows major health service categories that were included and excluded in the health insurance benefit package in different years.

Currently Mongolia lacks reliable information on, and assessments of, the quality of health services at all levels. Efforts are being made to introduce contractual arrangements between health insurance and health care providers that include quality aspects, but these still lack details for quality improvement. Simultaneously, health insurance inspector-physicians are tasked to review claims by checking their accuracy in terms of diagnosis and treatments. If they observe inaccuracies, the health insurance cancels or suspends payments. It is observed that only 1–2 per cent of total claims have been rejected, and this is due to patient bio-data inaccuracy rather than clinical quality. Health insurance offices also receive service quality-related complaints directly from insured patients or the Ministry of Health. In such cases, health insurance inspectors are supposed to visit health care providers and review and assess their internal operations and service quality.

Table 1. *Major health service categories that were included or excluded in the health insurance package (different years)*

Health service categories included (+) or excluded (-).	1993	2003	2006	2007	2015
1. Hospital treatment	+	+	+	+	+
2. Out-patient care	+	+	-	-	-
3. Sanatoriums		+	+	+	+
4. Family group practice		+	-	-	-
5. Out-patient medicine prescribed by family doctors and physicians in rural and district hospitals.	+	+	+	+	+

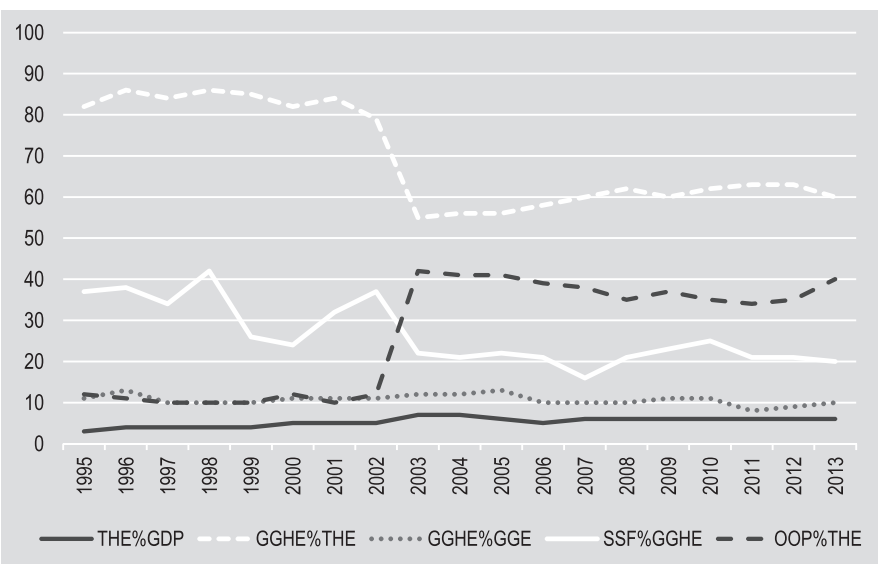
Source: SIGO (2015).

Cost coverage

Legally and regardless of their health insurance status, all Mongolian citizens have free access to a publicly-funded primary level of care provided through family group practices and rural and district health centres. Health insurance covers 85–90 per cent of the treatment cost in contracted public hospitals at secondary and tertiary levels, traditional medicine clinics, sanatoriums and rehabilitative recreational centres. It gives an impression that health care costs in Mongolia are predominantly covered by prepaid and pooled financing arrangements in the form of the government health budget and health insurance. Further examination of health financing trends over the years provides a more accurate picture of cost coverage in Mongolia. Health financing data from 1995 to 2013 (see Figure 2) shows that total health expenditure (THE) as a percentage of GDP has doubled from 3 per cent to 6 per cent during these years. However, the share of general government health expenditure (GGHE) in general government expenditure (GGE) did not similarly increase. It was 11 per cent in 1995 with a slight increase to 13 per cent in 2005, but had reduced to 10 per cent in 2013. Substantial reductions of GGHE as a percentage of THE occurred during these years. It decreased from 83 per cent in 1995 to 60 per cent in 2013. However, from 2005 there was an increase from 56 per cent to 60 per cent.

Figure 2 also shows that the role of health insurance in health financing has been continuously declining. The Health Insurance Fund (SSF or Social Security Fund) as a

Figure 2. *Health financing trend in Mongolia (1995–2013)*



Source: WHO (2015). Global health expenditure database.

percentage of GGHE decreased from 37 per cent in 1995 to 20 per cent in 2013. In the last 10 years, it was reported as 22 per cent in 2005, 16 per cent in 2007, 25 per cent in 2010 and 20 per cent in 2013. This overall declining and unstable role of health insurance in public health financing has led to a sharp increase in out-of-pocket (OOP) payments in THE. In 1995, the OOP share was estimated at 12 per cent of THE, and this share has since more than tripled. Since 2005, the OOP increase was discussed at the level of the Ministry of Health to review and limit the range of health services allowed to be charged at public hospitals as well as to reduce user fees and co-payments, but with little success (Dashzeveg et al., 2011). The OOP share as a percentage of THE was reported as 41 per cent in 2005 and was still similarly high at 40 per cent in 2013. As in many other low- and middle-income countries, the high share of OOP in health financing in Mongolia negatively affects equity, access and use of health services (Saksena et al., 2010). In particular, this is because of OOP-related financial barriers and the financial burden experienced, especially by low-income households. In 2009, it was estimated that 27,442 households or 3.8 per cent of total households experienced catastrophic health expenditures, spending more than 40 per cent of their household subsistence income on health. At the same time, 12,682 Mongolian households, or 1.8 per cent of total households, were impoverished due to health payments (Ministry of Health, 2009).

Weakly regulated and coordinated public and private sectors also contribute to health expenditure growth. The private sector in Mongolia is relatively new and has been politically supported since 1991. Notable in this regard was the privatization of the pharmaceutical sector which was followed by the establishment of new private pharmacies, clinics and hospitals. Currently, this trend is moving in favour of tertiary-level private hospitals in urban settings. All these private institutions operate in parallel with existing public health facilities without proper coordination, substitution and supplementation. This creates substantial challenges in implementing national health policies as well as controlling health care cost. At present, the Government has lost control over pharmaceutical pricing and the rational use of medicines. Private hospitals and clinics consider health insurance as a potential funding source and, therefore, they exert considerable effort to gain access to health insurance. For example, during the period 2012–2014, the number of private hospitals contracted with health insurance increased from 136 to 158, and this is likely to be a growing trend (Table 2).

These practices heighten the pressure on all health funding sources and make the health system inefficient to the degree that limited financial resources are wasted because of the poor coordination, control and management of both public and private health expenditure. It was not so long ago that the World Bank assessed Mongolia's health system as being in disarray, albeit not for lack of money. The main faults identified were the low quality of care and the high levels of inefficiency (World Bank, 2007). In the current move towards realizing UHC, these are major obstacles that remain to be addressed.

Table 2. *Number of public and private health care providers contracted with health insurance*

Health care providers	2012	2013	2014
Public providers	***100***	***100***	***100***
Secondary and tertiary hospitals	54	54	54
Rural joint hospitals with upgraded services	6	6	6
Rural hospitals including inter-rural hospitals	35	35	35
Traditional medicine centres (quasi-public)	5	5	5
Private providers	***697***	***729***	***769***
Pharmacies	529	561	576
Sanatoriums	32	32	35
Private hospitals	136	136	158
Total	***797***	***829***	***869***

Source: SIGO (2015).

In spite of Mongolia's health insurance having achieved and sustained almost universal population coverage in the past, it is currently far from UHC. Mongolia has the potential to provide comprehensive and quality health services through its well-established public-sector network coordinated with newly-emerging private practices. At present, health service benefits are clearly defined under health and health insurance laws. However, their financing is split between the government health budget, health insurance and official and unofficial private payments. The limited levels of transparency and accountability of these funds, and poorly-controlled health payments, do not incentivize health care providers to efficiently deliver cost-effective and quality health services. It is beyond question that improvements are needed in health system financing and the delivery of health services. However, new reforms and changes may not produce desired results, especially if policy-makers continue to focus on health insurance alone without considering its role as part of the overall health system and financing policy framework.

New opportunities and challenges

The UHC policy focus and debates at the international level open new opportunities for health insurance development in Mongolia. It is broadly accepted that moving towards UHC means making progress on improving equity in service use, quality and financial protection. All countries have room for such improvements and it is desirable that national UHC-related reforms and changes examine the country-specific situation and formulate own policy goals and targets. In other words, UHC can be

discussed in terms of policy goals and objectives, which can be attained by strengthening health systems and health financing as policy instruments (Kutzin, 2013). It is difficult to make progress towards UHC without aligned action across all health system components. Among these, health financing is a key function to collect adequate revenues, pool funds and purchase quality health services on behalf of the population.

Generally, health insurance refers to a contributory financing scheme that allows people to use a set of health services with financial risk protection. Nevertheless, many other types of scheme, such as the United Kingdom's National Health Service which is largely funded from government revenues, also provide this insurance function. Accordingly, the key policy issue for Mongolia is to discuss and agree on health insurance reforms that would strengthen the overall health financing functions to fund equitable, universally accessible and quality health service benefits to all the people of Mongolia.

Despite some limitations, Mongolia's health insurance has several important features that are conducive to health financing policy reforms and for supporting progress towards UHC. First, the legal basis for health insurance makes it manda-

Table 3. *Health insurance contribution payment*

Categories of insured	Contribution rate	Payment status	Payment share in total contribution (%)
Formal salaried sector employee	4% of salary	Equally shared by employer and employee	91.7
Private business owners	1% of taxable revenue	Self-payment	0.39
Part-time students	670 MNT* per month or 8040 MNT* per year	Self-payment	0.78
Self-employed, including herders			
Children younger than age 16	670 MNT* per month or 8040 MNT* per year	Full government subsidy	7.1
Pensioners living with pension allowances only			
Poor and vulnerable covered by social assistance programme			
Military personnel			
Full-time students			
Foreigners and people without citizenship	6% of minimum wage	Self-payment	0.03
Total contribution	N/A	N/A	100.00

Note: *In 2015, USD 1.00 = MNT 1,950.00 approx.

Source: SIGO (2014).

tory for all citizens. This has enabled the initial achievement and then a sustained high level of population coverage, while also providing legally-defined health service benefits nationwide.

Second, the high political commitment to extend insurance to all citizens, especially the poor and vulnerable, has been maintained. In practical terms this is seen in the government budget transfer to the health insurance fund in the form of contribution subsidies. Table 3 shows that about 7.1 per cent of health insurance revenue was derived through the government budget transfer in 2013. In 2014, the government contribution subsidy for the population category of the poor and vulnerable was only 670 Mongolian Tugriks[2] (MNT) (less than USD 0.40) per person per month, or MNT 8,040 (about USD 4.1) per person per year (Table 3). However, it is expected that future economic growth and greater fiscal capacity in Mongolia will enable the government to increase health insurance contribution subsidies for the poor and vulnerable.

Third, following global and regional health financing policies and strategies, Mongolia recently developed and adopted a number of important policy documents that support developments in health insurance (WPRO, 2009). These include the *National Health Financing Strategy* (Government of Mongolia, 2010) and the *Long Term Strategy for Health Insurance Development for 2013–2022* (Ministry of Population Development and Social Protection, 2013). These documents clearly noted the important role of health insurance in health financing for UHC in Mongolia.

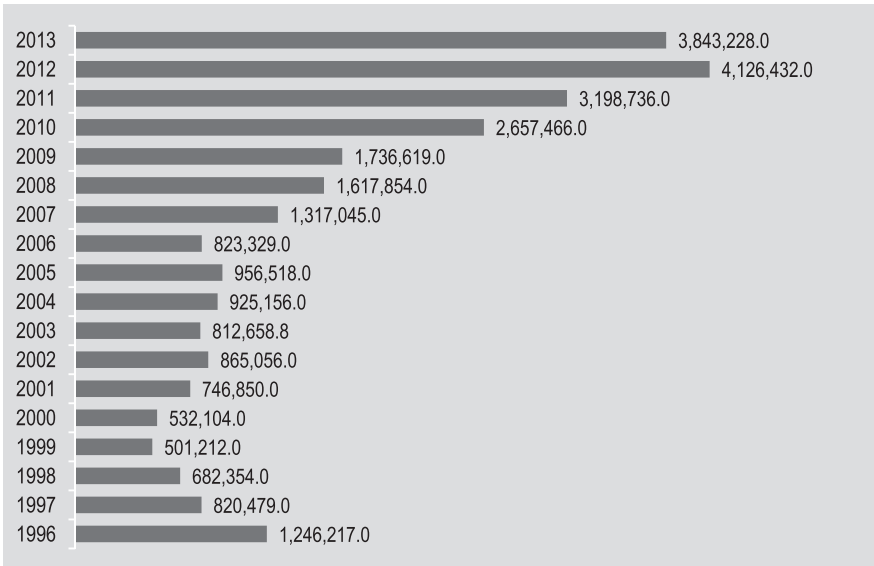
Fourth, the Mongolian people largely support health insurance. A study undertaken in the capital city of Ulaanbaatar and four other representative provincial centres revealed that among 3,548 survey respondents health insurance was rated the second (45.5 per cent) most important factor for health after public health organizations (Bayarsaikhan and Nakamura, 2009). This is also reflected in the utilization of health insurance benefits by the insured (Figure 3).

Fifth, Mongolia's health insurance has demonstrated financial sustainability during its operational years (Figure 4). Surpluses have accumulated since 1999 and reached MNT 83.2 billion (about USD 42.7 million) in 2013. On the one hand, however, it indicates missed opportunities to use the surpluses to expand the benefit package, improve service quality, or increase the health insurance support value, especially for medicines.[3] On the other hand, it presents a new opportunity for policy- and decision-makers to rationally use the reserve for health financing without jeopardizing the future financial sustainability of the fund. In addition, the population age structure and labour market situation in Mongolia is positive relative to formal-sector employment and workforce increases in the near future (Figure 5).

2. In 2015, USD 1.00 = MNT 1,950.00 approx.

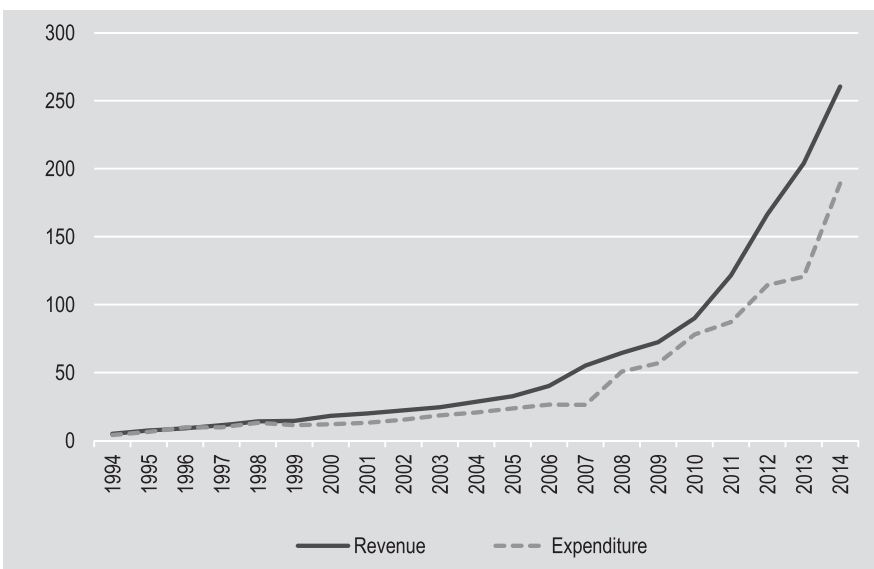
3. Previously, health insurance supported 50–100 per cent of essential medicine prices set nationwide. With the change of centralized price setting practice, the support value for pharmaceutical benefits has been substantially reduced.

Figure 3. *Number of insured who obtained health insurance benefits (1996–2012)*



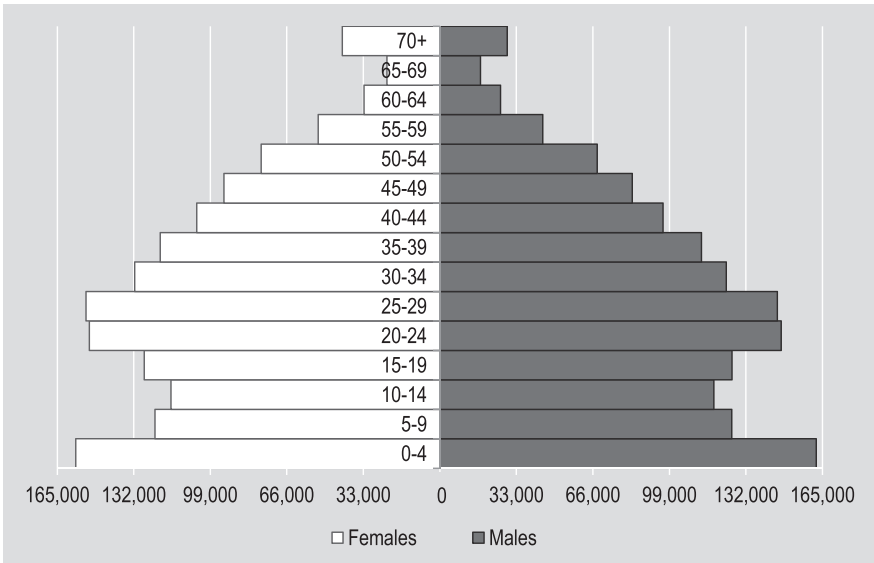
Source: SIGO (2014).

Figure 4. *Health insurance revenue and expenditure (MNT billion), 1994–2014*



Source: SIGO (2014).

Figure 5. *Population pyramid of Mongolia, 2013*



Source: Mongolian National Statistical Office (2014).

Sixth, there is a relatively stable and growing number of health insurance workers and professionals that represent a new insurance cadre with needed specialist knowledge. Currently, 122 health insurance workers and professionals work at central, district and provincial health insurance offices. The health insurance administrative cost is estimated at 2.4 per cent of health insurance annual revenue (SIGO, 2014). The expectation is that this human resource capacity can be further developed and expanded as needed for the successful operation of health insurance in Mongolia.

Last but not least, Mongolia's system of health insurance has fostered the development of a national health insurance information system since 1994, which has produced relevant annual data and information on population coverage, revenue, expenditure and benefit utilization by different population and health service categories. Such an information system and data are essential to analyse and understand the current situation, formulate new policies and interventions as well as to monitor and evaluate their implementation and progress against UHC-related policy goals and objectives.

In terms of remaining challenges, Mongolia has a need to analyse, identify and address certain obstacles that would limit government efforts to sustain health insurance developments guided by UHC-related goals and objectives. By examining the development trajectory of health insurance in the country, several barriers are identifiable. These are related to the administrative and operational environment

of health insurance and are influenced by politically-vested interests, inappropriate legal interventions, poor governance, communication, policy coordination failures between government ministries, and the underdeveloped technical and analytical capacity of the health insurance office. The major barriers that we identify are discussed below for further analysis and policy action.

Political involvement

Since 1991, Mongolia has shifted to a multi-party political system. The Mongolian Parliament is the highest legislative body with one permanent chamber, which consists of 76 seats formed through parliamentary elections held every four years. Across the recent period, political power has mainly shifted between two major political parties. The government, formed under the Mongolian People's Revolutionary Party (now named the Mongolia People's Party) introduced health insurance in 1994.[4]

After 1994, all political parties came to recognize the potential of universal health insurance for their respective political and election campaigns. Politicians have raised different insurance concepts and tried to introduce reforms by criticizing the existing system. Areas of criticism have included: the provision of equal benefits for unequal contributions or the unequal use of insurance benefits by citizens (resulting, inevitably, in less-frequent service users in the "risk pool" subsidizing more-frequent service users); the selection procedure for private providers (especially where the support value offered by private hospitals is limited); incomplete coverage of health and health-related services; non-transferability of health insurance benefits to other family members who need more expensive medical services; and the non-portability of health insurance benefits abroad. Accordingly, some politicians and opinion leaders have promoted:

- the privatization of health insurance,
- the free choice of public and private providers which would by-pass the need for health service referrals,
- the introduction of individual medical savings accounts,
- the tightening of the benefit package only to include high-cost medical services or expanding the package to include the cost of fitness activities,
- reducing the health insurance contribution rate to alleviate the tax burden on households, or offering a partial pay-back of contributions if the insured did not use health insurance benefits for several years.

Although most of these suggestions were not well supported by the technical evidence, nevertheless, they have been included into election agendas and some of them did lead to amendments to the law.

4. The name of the other party is the Mongolia Democratic Party.

Legal environment

Political interest and involvement has resulted in a process of continuous legal amendments. Since 1997, the law has been amended many times, with substantial changes introduced in 1997, 1998, 2003, 2006, 2007 and 2015. The amendments introduced in 1997–2003 reduced health insurance contribution subsidies for certain categories of the self-employed, such as nomad herdsmen and part-time students. In 2007, in the year before a general parliamentary election, an amendment reduced the health insurance contribution rate from 6 per cent to 4 per cent of salary. It also abolished the referral system required for insured persons to obtain needed health services at designated health care provider levels. The main concern here is that frequent changes to the health insurance legal environment is occurring almost every three years without sufficient analysis, evidence, and monitoring and evaluation of the results of the previous amendment.

That said, the new law amendment adopted in January 2015 introduced several positive features. It supported the introduction of a personal magnetic insurance card for all insured persons to strengthen the functioning of the health insurance database as well as improve transparency in financial transactions among the insured, insurer and health care providers. The amendment specified the minimum wage as the base to define the contribution level for certain categories of citizens, including those receiving the government subsidy, which will increase the revenue of the fund. It also enshrined that increased income from contribution collection will not be used as grounds to decrease the government health budget.

However, there are some problematic issues too. The 2015 amendement introduced the term of "family insurance", which allows individuals within the same family to transfer their own individual health insurance maximum threshold to another family member, if the treatment costs of one family member exceeds the cap set per person per year. Currently, the cap is set at MNT 1.8 million (about USD 923) per year per insured. This new arrangement may give a false impression that every insured person is entitled to a certain threshold regardless of whether they have received health insurance benefits or not. In fact, the cap was intended to provide the maximum possible benefit to the insured based on population health risk, health service cost, service utilization, health insurance fund expenditure and revenue, and also to prevent the health insurance fund from bankruptcy. Since the new arrangement will increase the number of people using the cap, it will soon affect the fund and may force a decision to take other measures that may reduce or freeze the cap in order to protect the fund's sustainability. In turn, such short-sighted changes, often coming one after another, make health insurance rules extremely difficult to follow, heightening the challenge to implement long-term development policies and strategies.

Heath insurance governance

Governing health insurance is often considered a challenge because of the many conflicting interests among the insured, insurers, and government ministries (Kwon, 2015). In practice, insured people often want to have a free choice of provider with high quality and comprehensive health care benefits, but to pay low contributions (Ron, 2013). Health insurance in Mongolia is governed by a health insurance sub-council, which consists of tripartite representatives of insured people, employers and the government. Members of the health insurance sub-council are appointed by the national social insurance council on a part-time basis.

Under the law, the sub-council bears several important responsibilities. The law specifies that it is the responsibility of the sub-council to control and monitor the health insurance fund, develop policy and technical recommendations, approve decrees related to law implementation and enforcement, and set health insurance support values. The sub-council also has the responsibility for developing and proposing the health insurance contribution rates for salaried employees and setting levels of government subsidies. It has the right to initiate evidence-based policy debates and to monitor and evaluate the need for legal amendments or to develop research findings by establishing technical working groups or "think-tank" task forces as required. Unfortunately, the sub-council has been unable to adequately perform the tasks given to it by the law, owing to a lack of experience, expertise and competence. The sub-council's voice has not even been heard in certain previous health insurance reform-related discussions and debates. For over a decade, this has acted as an underlying obstacle to efforts to discuss and agree on health insurance governance and the terms under which health insurance development issues are debated. This includes addressing fundmental questions such as "where to go?" and "how to get there?" (GIZ, 2013).

Communication and policy coordination

Communication and policy coordination between the key government ministries, including the Ministry of Health (MOH), Ministry of Population Development and Social Protection (MPDSP), and Ministry of Finance (MOF), have to be improved. In Mongolia, the MOH plays a triple role in making health policy, managing health services through its public health provider network, and financing specialized tertiary hospitals. Initially, health insurance was operated under the MOH, but later it was moved to the MPDSP after the adoption of a package law on social insurance. This administrative change has provoked communication and policy coordination issues between these two ministries. The MOH, which determined health policies, service benefits and controlled public providers, is strongly interested in the rapid growth of health insurance and funding to the health sector. In return, the MPDSP, which sets social insurance policies and controls the insurance fund, has been more

concerned about fund sustainability. Accordingly, the large accumulated surplus of health insurance has been one of the hot debates between the two. Excessive revenue surplus is not a good indicator for health insurance, especially when health insurance offers limited benefits and financial protection. Therefore, it is desirable for both ministries to recognize that health insurance is not only about contribution collection and fund management, but about ensuring equal access to comprehensive and quality health services, providing financial protection for those who need it and incentivizing health care providers with effective payment methods to improve their performances.

The conflicting interest of, and actions taken by, the MOF were also a challenge for health insurance. The MOF considers health insurance as an additional new funding source supplementary to the government health budget. The Public Finance and Administration Law adopted in 2002 provided contradictory legal provisions that resulted in the centralization of the health insurance fund under the MOF. Although health insurance is formally managed by the MPDSP, the health insurance fund is steered by the MOF, which can reduce the government health budget at the expense of health insurance, if necessary.

Currently, there are efforts to strengthen social dialogue and consensus among the key stakeholders on health insurance development. There is an ongoing effort to improve the legal and institutional framework and strengthen organizational capacities to ensure universal access and quality care for the population in the future (GIZ, 2013). Primarily, this would refer to budget and health insurance laws to improve their policy coordination and implementation, to make progress on the path towards UHC.

Health insurance administration

In 1994, health insurance in Mongolia was launched in collaboration with a commercial national insurance company. In 1996, the operation of health insurance was transferred to the Social Insurance General Office (SIGO), under the direct supervision of the MPDSP. With this transfer, the SIGO created a new unit known as the Health Insurance Office to administer health insurance and implement the health insurance law nationwide. The new office needed first to develop its own capacities to play a key role in health insurance development, but the opportunities to do so were not fully realized because of the above mentioned limitations – in particular, the extensive involvement of people with political power in making administrative decisions.

Accordingly, the Health Insurance Office organized as an internal unit of the SIGO had limited authority to make health insurance-related policy decisions. Therefore, it was extremely difficult for the office to fulfil its role to implement health insurance policy nationwide. The office also lacked capacities to undertake analytical study and research to produce evidence to lead reform-focused debates and changes. Strategically, the office needs to develop and put into practice more independent operations with minimal political influence and ministerial bureaucracy. This is expected to

improve its responsibility and transparency in decision-making concerning health insurance development as well as its public accountability as regards its performance.

Discussion

Mongolia introduced mandatory health insurance with a single national insurance pool. Unlike many other low- and middle-income developing countries, this single mandatory insurance scheme achieved high population coverage from the outset with support from a direct government contribution subsidy and a budget transfer. In line with likely future improvements in household income and living standards, the government contribution subsidy is expected to be reduced gradually with the development of health insurance.

Health insurance introduced many new features for Mongolia's health financing, resource planning, service provision and health-sector management. To some extent, it separated financing from the provision of health services. With the development of health insurance, the concepts of health service purchaser and provider payment methods were familiarized. Along with the line item budget, health insurance introduced "fee for service" for out-patient services, "bed day" tariffs for in-patient care set according to hospital referral locations, and capitation payments for family group practices. To reduce the adverse economic incentives facing providers resulting from these retrospective payments, the bed day tariffs were replaced with prospective payments in the form of a global budget differentiated by fixed and variable costs (Bayarsaikhan, Kwon and Ron, 2005). Following this policy, Mongolia introduced case-based payments for in-patient services in 2006. This new payment model started with 22 case groups and expanded to 115 groups in 2010. A recent assessment of the provider payment method in Mongolia led by the Joint Learning Network for UHC in collaboration with the World Bank and WHO revealed that, overall, the general direction of provider payment policy was effective and many pitfalls observed in other middle-income countries have been largely avoided (Cashin et al., 2015). Likewise, health insurance opened new reform opportunities for the health system, which had been operated on the basis of centralized planning with strict budget rules and regulations for many decades.

The introduction of health insurance in Mongolia aimed to achieve universal coverage. However, due to frequent political involvement, regulatory changes, and failures in communication, policy coordination, administration and management, the role of health insurance in health financing and social health protection has been weakening in recent years. As of 2013, health insurance accounted for only 20 per cent of GGHE and it is now only the third most-important funding source after the government health budget and direct OOP payments, which alone account for 40 per cent of total health expenditure in Mongolia (WHO, 2015).

Mongolia's health insurance was successful in extending coverage to the population, but this coverage is still far from the concept of UHC to provide equitable, comprehensive and quality health care with effective financial protection. Health

insurance development in Mongolia in the last decade shows that population coverage alone without advancements in health services and cost coverage is insufficient to make progress towards UHC. International evidence also suggests that public revenues consisting mainly of the government health budget and social health insurance are central to financing progress towards UHC in low- and middle-income countries (WHO, 2014).

The range of health services to be funded by Mongolia's government health budget and health insurance are legally well-defined, but there is a need for greater transparency regarding how they are delivered at different provider levels. In practice, health care providers often mix or substitute revenues received from these two funding channels. Consumers are not always aware of their service benefits and co-payment obligations under these two fragmented arrangements. It is commonly the case that patients pay OOP even for publicly-funded health services and medicines.

The sharp increase in OOP payments in total health expenditure is a major concern for Mongolia. Efforts are needed to reduce such payments by controlling and eliminating the main driving factors, such as the irrational use of medicines and pricing practices, at least for essential drugs included in the health insurance benefit. Private-sector regulation is needed to contain cost escalation and the growing pressure on all revenue sources. Previous research identified and discussed how the uncontrolled growth of the private sector was a critical challenge for Mongolia (Bayarsaikhan, Kwon and Ron, 2005). However, no concrete policy actions were taken in this area, and now the private sector is becoming more powerful with the establishment of many new clinics and tertiary-level hospitals. If the poorly-regulated private sector with its strong lobbying power continues to grow, it may be difficult for the health financing system to sustain and ensure the equitable distribution of health care. Health insurance may soon become pro-rich by serving better-off people who will predominantly use private clinics and hospitals in the country and abroad.

Currently, the Health Insurance Office of SIGO does not play a leadership role in health insurance reforms because of the limitations mentioned above. In fact, health insurance reforms and legal changes have been initiated mainly by non-technical and non-professional actors with administrative power or by individual politicians such as Ministers and Members of Parliament. Most often, these initiatives have lacked long-term goals, vision, objectives and justifications for proposed reforms and changes. Such as a situation is always risky – even when good political will exists – because health financing laws and regulations may be inadequately designed or socially suboptimal if they have been created to serve the interests of those with strong bargaining power (Mathauer and Carrin, 2011).

All these issues require Mongolia to re-examine the current status of health insurance and to redefine its role in moving towards UHC by promoting all positive contributing factors while addressing and eliminating barriers. The UHC-related concept and discussions that have followed the World Health Report

2010 (WHO, 2010) are helpful for decision-makers to shift their focus from that of a narrower health insurance scheme orientation to one of broader health system-oriented reforms aimed at improving and sustaining stable funding arrangements. In this regard, critical analysis and aligned actions are necessary to strengthen the core health financing functions to collect and pool revenues to purchase quality health services from public and private providers. The government should welcome expert reviews and technical discussions on various policy options and choices for financing reform to make nationally-defined, comprehensive and quality health service benefits available and accessible for everyone. One option is to increase the role of health insurance in health financing and to permit it to manage revenues collected from contributions as well as government subsidies and budget transfers. In this way, health insurance will gradually become a single purchasing agency able to provide nationally-defined health service benefits to the population. It would mean that health insurance will cover the cost of coverage with a partial government subsidy and individual (health insurance) contributions. To assume this function, the current health insurance administration should undertake certain improvements. In principle, health insurance is organized in many different ways (Normand et al., 2009). However for the above-mentioned purpose, health insurance requires a certain degree of autonomy. This is necessary to strengthen technical and administrative capacities, improve its performance, transparency and accountability, and to form the most-suited independent organizational and managerial structure to confidently assume a predominant role in the financing and provision of quality health care services.

Conclusion

Mongolia is a sparsely populated country with an extensive public health provider network and where strong political commitment made it possible to provide comprehensive and free health care. Availability, equity and accessibility of health services, rather than efficiency, were for decades the leading criteria for health system development.

The situation has changed since the country moved from centralized planning to a market-oriented economic system. Health insurance was introduced as a mechanism to support a multi-funded health system and political commitment was critical for the development of health insurance which covered almost all the population with a decent benefit package. This led to the broad acceptance of health insurance as a strategic route to attain universal coverage. However, heavy political involvement and influence in the last 10 years have resulted in frequent changes to the legal environment for health insurance. Numerous amendments to the law were made, but mainly for political reasons that diminished the role of health insurance in health financing and its potential to sustain and expand health care coverage, quality and

financial protection. Now, more than a third of health expenditure is directly paid by individual households in various forms of OOP payments.

Mongolia can learn from its own and other country experiences that reveal that politically-driven reforms do not necessarily produce desired outcomes, especially when they lack comprehensive analysis, evidence and long-term development goals. Political support is needed for health insurance development, but the political independence of the health insurance fund is also needed.

Currently, Mongolia is passing through a critically important period of economic and social development by revitalizing the UHC concept in its own context. Past experiences and lessons suggest that Mongolia is on track moving towards UHC. There are important opportunities to make more rapid progress towards UHC, but there are also obstacles. By stabilizing governance and improving accountability, this should help drive reform efforts to control cost and reduce inefficiencies in the financing of health care services which offer necessary financial protection. Health system and financing experts would agree that Mongolia has the potential to improve its health financing system to support movement towards UHC. The main lesson offered by this review of recent develoments in Mongolia is that future health insurance and financing reforms involving legal changes should be backed-up with critical assessments and impact analysis, solid evidence and information to review, assess and monitor UHC advancements.

Bibliography

Bayarsaikhan, D.; Kwon, S.; Ron, A. 2005. "Development of social health insurance in Mongolia: Successes, challenges and lessons", in *International Social Security Review*, Vol. 58, No. 4.

Bayarsaikhan, D.; Nakamura, K. 2009. "Health promotion financing with Mongolia's social health insurance", in *Asia-Pacific Journal of Public Health*, Vol. 21, No. 4.

Cashin, C. et al. 2015. *Assessment of systems for paying health care providers in Mongolia: Implications for equity, efficiency, and universal health coverage.* Washington, DC, World Bank.

Dashzeveg, C. et al. 2011. *A health financing review of Mongolia with a focus on social health insurance.* Geneva, World Health Organization.

GIZ. 2013. *Brokering social consensus. Germany's support to social health insurance reform* (German Health Practice Collection). Bonn, Deutsche Gesellschaft für Internationale Zusammenarbeit.

Government of Mongolia. 2010. *Health financing strategy for Mongolia: Government Decree 63 dated on 17 March 2010.* Ulaanbaatar.

Kutzin, J. 2013. "Health financing for universal coverage and health system performance: Concepts and implications for policy", in *Bulletin of the World Health Organization*, Vol. 91, No. 8.

Kwon, S. 2015. *Improving health system efficiency: Republic of Korea: Merger of statutory health insurance funds.* Geneva, World Health Organization – Health Systems Governance and Financing.

Mathauer, I.; Carrin, G. 2011. "The role of institutional design and organizational practice for health financing performance and universal coverage", in *Health Policy*, Vol. 99, No. 3.

Ministry of Health. 2009. *Policy brief: Distribution of health payments and catastrophic expenditure in Mongolia. Ulaanbaatar.*

Mongolian National Statistical Office. 2014. *Annual statistical report of Mongolia, 2014.* Ulaanbaatar.

Ministry of Population Development and Social Protection. 2013. *Long term strategy on the development of the health insurance of Mongolia, 2013–2022.* Ulaanbaatar.

Normand, C. et al. 2009. *Social health insurance: A guidebook for planning* (second edition). Bad Homburg, VAS.

Ron, A. 2013. *Main financing mechanisms: Partners and expectations.* (Presentation made at ILO training course on social health protection, Turin, 11–22 March). Turin, International Training Centre of the International Labour Organization.

Saksena, P. et al. 2010. *Health service utilization and out-of-pocket expenditure at public and private facilities in low-income countries* (World Health Report background paper, No. 20). Geneva. World Health Organization.

SIGO. 2014. *Internal report on health insurance activity. Ulaanbaatar,* Social Insurance General Office.

SIGO. 2015. *Statistical data on health insurance coverage for 2014.* Ulaanbaatar, Social Insurance General Office.

Silfverberg, R. R. 2014. *The sponsored program of the Philippine national health insurance – Analyses of the actual coverage and variations across regions and provinces* (Discussion paper, No. 2014-19). Makati, Philippine Institute for Development Studies.

Wagstaff, A. 2010. "Estimating health insurance impact under unobserved heterogeneity: The case of Vietnam's health care fund for the poor", in *Health Economics*, Vol. 19, No. 2.

WHO. 2010. *World Health Report: Health system financing: The path to universal coverage.* Geneva, World Health Organization.

WHO. 2014. *Fiscal space, public finance management and health financing: A collaborative agenda* (WHO meeting report, Montreux, 9–11 December). Geneva, World Health Organization.

WHO. 2015. *Global health expenditure database.* Geneva, World Health Organization.

World Bank. 2007. *The Mongolian health system at a crossroads: An incomplete transition to a post-semashko model.* Washington, DC.

WPRO. 2009. *Health financing strategy for the Asia and Pacific Region (2010-2015).* Manila, Philippines, WHO Regional Office for the Western Pacific.