MINISTRY OF HEALTH

World Health Organization

Report on resource allocation and purchasing in Mongolia

June 2017

Ulaanbaatar

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Abbreviation

DRG	Diagnosis Related Groups
GDP	Gross Domestic Product
HIF	Health Insurance Fund
HIL	Health Insurance Law
HSIGO	Health and Social Insurance General Office
MLSP	Ministry of Labor and Social Protection
MOF	Ministry of Finance
MOH	Ministry of Health
NCD	Health Center for Development
NCPH	National center for public health
NHIC	National Health Insurance Council
OOP	Out of pocket payment
TB	Tuberculosis
UHC	Universal Health Coverage
WHO	World Health Organization

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General principles of purchasing

In 2005, the 58th World Health Assembly endorsed Universal Health Coverage (UHC) as the main streamline. The 2010 World Health Report, which recognized the importance for low- and middle-income countries to enhance health financing system and financial protection of population.

The purchasing should be considered with the same importance along with revenue collection and pooling at the health financing system *(or Along with revenue collection and pooling the purchasing should be considered with the same importance at the health financing system*). The purchasing firstly, allocates resources at health sector, secondly, is a payment method. Purchasing can be strategic or passive (WHO, 2000). Strategic purchasing involves the on-going search for the best means to optimize health systems performance by deciding which interventions should be purchased, how they should be purchased and from what providers, while passive purchasing occurs by following a pre-determined budget or simply paying bills when presented (World Health Organization, 2010)

Strategic purchasing is resource allocation based on health needs and also a critical factor in health systems performance is the extent to which purchasers are able to influence providers to pursue equity, efficiency and quality in health service delivery. Strategic purchasing can improve health systems performance by promoting quality, efficiency, equity and responsiveness of healthcare service provision and, in so doing, facilitate progress towards UHC (World Health Organization, 2010, Figueras et al., 2005).

Purchasing involves making three sets of decisions: (1) identifying essential health care package list to be purchased while taking into account population needs, national health priorities and cost-effectiveness of those interventions; (2) selecting service providers, giving consideration to service quality, efficiency and equity; and (3) determining how services will be purchased, including contractual arrangements and provider payment mechanisms

In strategic purchasing the government is required to play a stewardship role by providing a clear policy framework and appropriate guidance to ensure that resource allocation and purchasing decisions

Figure 1. Key strategic purchasing actions in relation to purchaser, providers, Government and citizen

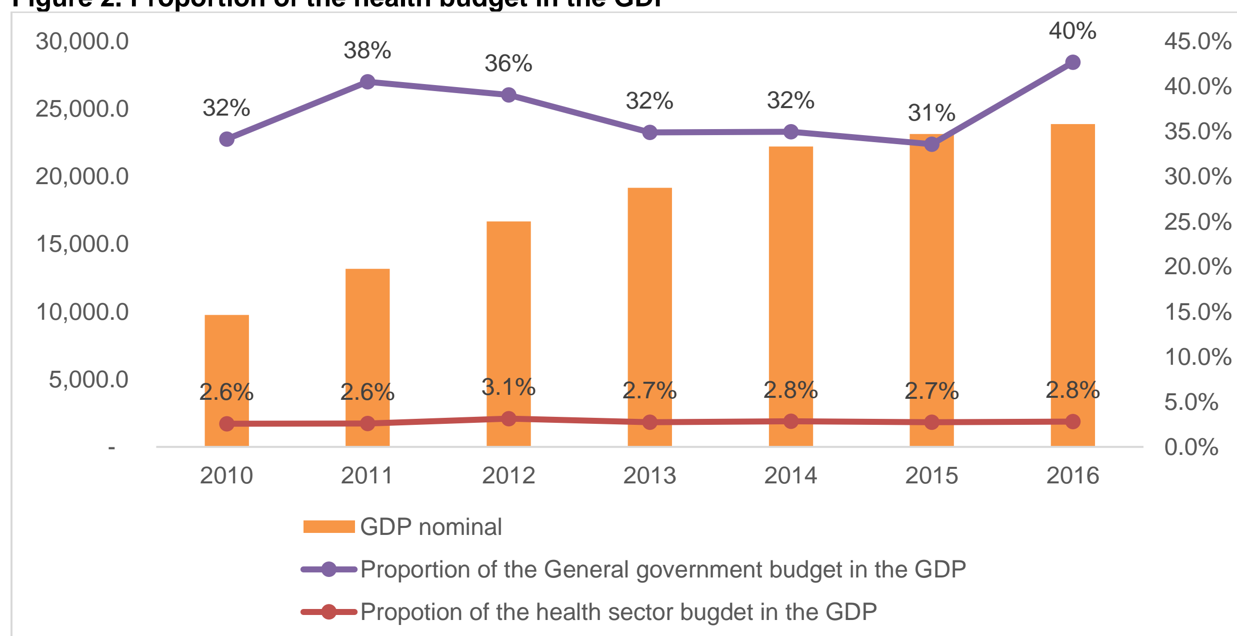
- Select providers considering range, quality, location - Establish service arrangements - Develop formularies and standard treatment guidelines - Establish payment rates - Secure information on services provided - Audit provider claims - Monitor performance and act on poor performance	- Protect against fraud and corruption - Pay providers regularly - Allocate resources equitably across areas - Establish and monitor user payment policies - Develop, manage and use information systems
Health care providers **Purchaser** Government	Citizen
- Establish clear frameworks for purchaser and providers - Fill service delivery infrastructure gaps - Ensure adequate resources mobilised to meet service entitlements - Ensure accountability of purchasers	- Assess population needs, preferences and values - Inform the population of their entitlements and obligations - Ensure access to services - Establish mechanisms to receive and respond to complaints and feedback - Publicly report on use of resources and performance

Source: Strategic purchasing China, Indonesia, Philippines

1. **Overview of health financing situation in Mongolia**

Mining and agriculture sector accounts a significant share of Mongolian economy, the economy in overall as well as fiscal revenue are very much dependent on global commodity price fluctuation. Annual growth of Mongolia's GDP was 17,4 per cent in 2012 but in 2016 it's slammed to 1 per cent. The economic growth led enlargement of public spending but economic setback that has commenced since 2015 slackened budget revenue and caused incapability to fund initiated extended public expenditures. Domination of political goals over specific goals, strict guidance at resource allocation during extended public expenditure period were driving force for economic setback the affect was in cutting public expenditures by reducing staff and halting new public investments.

Figure 2. Proportion of the health budget in the GDP



Source: Ministry of health, 2016

The proportion of the general government budget in GDP fluctuates and has a downtrend in recent years as the government tightens fiscal policy. Fiscal consolidation of off-budgeted expenditures such as Development bank's off-budget corporate lending programs has sharply raised proportion of general government in the GDP. The proportion of the health sector budget is steady in overall and reached 2.8 percent of

GDP in 2016, in other words, a proportion health sector budget directly correlated with GDP changes.

Table 1. Public spending by selected sectors

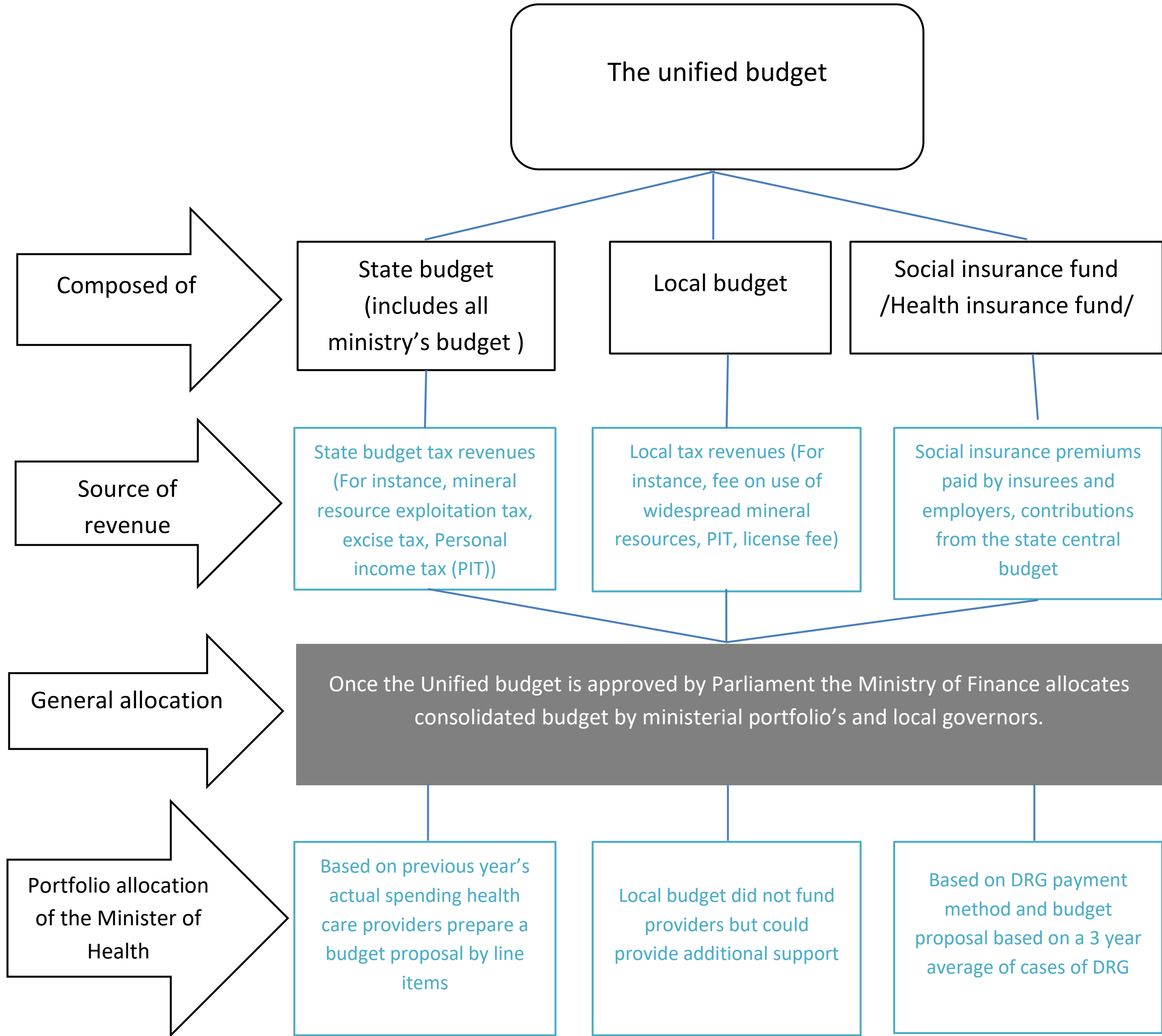
		2012	2013	2014	2015	2016
		Approved	Approved	Approved	Approved	Approved
Health sector	recurrent	362,235	401,621	505,855	526,113	562,162
	capital	72,946	40,816	106,427	90,276	110,127
	total	435,181	463,890	612,282	616,389	672,290
Difference %			6.60%	31.99%	0.67%	9.07%
Education sector	recurrent	828,544	874,304	1,038,271	949,148	191,842
	capital	165,260	116,521	269,145	127,905	1,247,832
	total	1,000,616	1,040,707	1,307,416	1,100,891	1,338,660
Difference %			4.01%	25.63%	-15.80%	21.60%

Source: Ministry of Health, 2016

From 2012 to 2016 an annual increase of health sector spending was 12.1 percent and 8.9 percent for education sector. Even though the government tightens fiscal policy spending on health wasn't cut dramatically due to government's special prerogatives. The sharp increase of budget at health and education sectors in 2014 was due to 20 percent payroll increase of public servants as payroll accounts a significant share in a budget. Despite of a nominal increase of spending at health sector the real growth is less than annual inflation rate.

Mongolia has the unified budget structure composed from state budget, local budget and Social insurance fund/Health insurance fund (recent amendments in the Budget law segregated the Health insurance fund from the Social insurance fund but funds are under single account and managed by the same authority). Figure 2 shows general source of revenue, general allocation and fund allocation within health sector.

Figure 3. Composition of the unified budget structure and resource allocation



A bottom end of Figure 3 provides a general outlook on how the state and local government owned health care providers funded from the state are plan and report budget spending. Furthermore, the Ministry of health shall prepare and submit ministerial portfolio proposal to the Ministry of Finance within predefined annual budget ceiling[1] and also provide budget execution reports and financial statements. The health minister directly concludes the performance agreement with heads of state hospitals and specializes centers[2] and controls allocated state financing. By concluding the special purpose agreement with local governors the minister of health transfers funds

[1] An "annual budget ceiling" means the maximum amount of expenditures and minimum amount of revenues, established in conformity with special fiscal requirements and the Medium-term Fiscal Framework Statement, that guide general budget governors when preparing their budget proposals for the particular fiscal year;
[2] Formerly known as tertiary level health care providers

for primary health care services to local governors portfolio via special purpose transfers, therefore local governors fund the primary health care providers such as soum health centers and family group practices and others. Consequently, local governors conclude the performance agreement with primary health care providers and also with heads of general hospitals and the same level health care providers but funds for the latter are within portfolio of health minister. Although Social insurance/Health insurance fund is formally managed by the Ministry of Labor and Social Protection (MLSP), daily activities have dealt by Health and Social Insurance General Office (HSIGO), the funds under the unified budget are steered by the Ministry of Finance (MOF) in accordance with the Budget law. The direct and indirect actions taken by the MOF are also a challenge for health insurance as the MOF is considering collected health insurance premiums by Health and Social Insurance General Office (HSIGO) as tax revenues and manages it accordingly. This situation with bundle of other challenges prevents HSIGO to develop as a strong purchaser of health services and institutionalize in an autonomous institution.

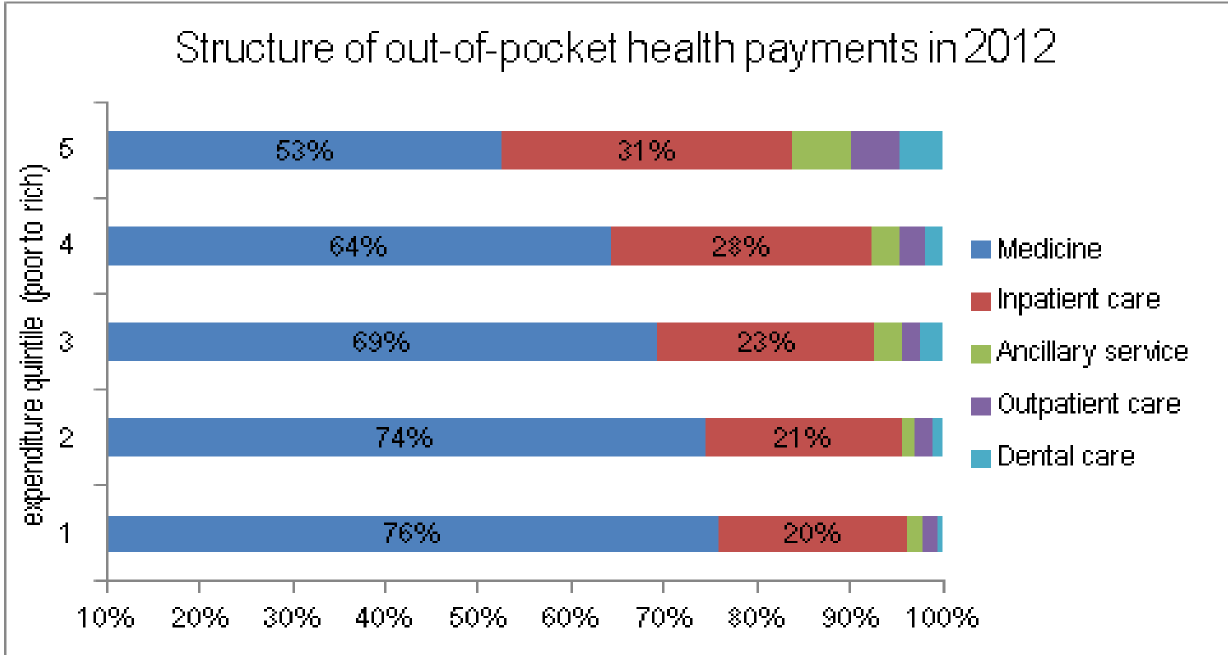
Prior amendment to the Health law there were a three levels of health care and three levels of health care providers, nowadays, health care service considered as primary and referral/specialized, the latter includes secondary and tertiary level health care providers. State and private owned enterprises deliver health care services to population. The primary health care delivered by state owned soum health centers and privately owned family practices and solely funded from the state budget.

Strategic documents on health system prioritize public health, primary health care and stand for it's strengthening but predominant share of the health expenditure is not for primary health care. In 2005, 26 percent of total health expenditure was spent on primary health care but it shrunk to 17 percent in 2015. The drop by 9 points suggests that there is a lack of financial support on prioritized health system goal. Aimag general hospitals; district hospitals and health centers; tertiary hospitals and specialized institutions are funded from state budget, health insurance fund and out of pocket payments (OOP).

In 2014, 42 percent of total expenditure on health was OOP according to WHO estimates. The limited means to monitor whether private entities (private clinics,

hospitals, unregulated wholesalers of medical goods and supplies, pharmacies) numbered up to 1200 are inappropriately charging out of pocket costs to patients and medical goods that have been brought by patients upon request of state owned health care providers greatly affect on rise of OOP.

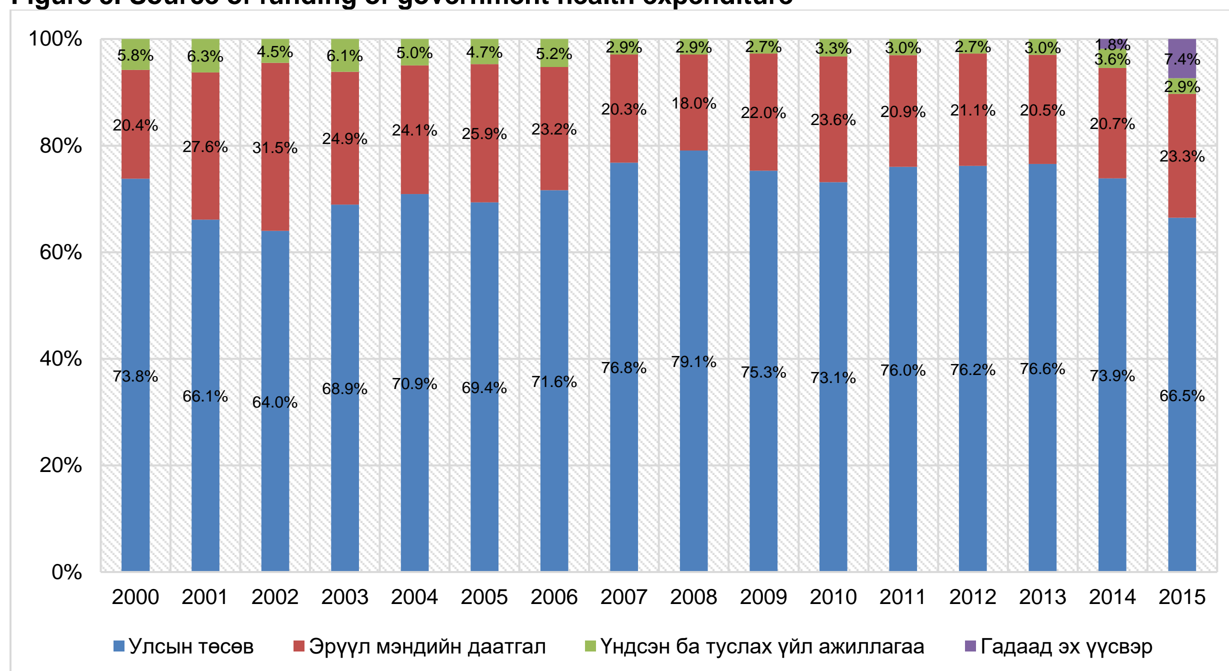
Figure 4. Structure of out-of-pocket health payments in 2012



Source: Analysis of Catastrophic health payments and Benefit incidence of government spending for health n Mongolia, Tsolmongerel.Ts

Health insurance covered 90.5 percent of population in 2013 but spending from health insurance fund (HIF) as of total expenditure of health accounted only 13 percent, which indicates limited benefit package offered from HIF and inability to cover financial burden caused with health. High load of public health care providers and long queues are one of the reasons that push the insured to visit private health care providers.

Figure 5. Source of funding of government health expenditure

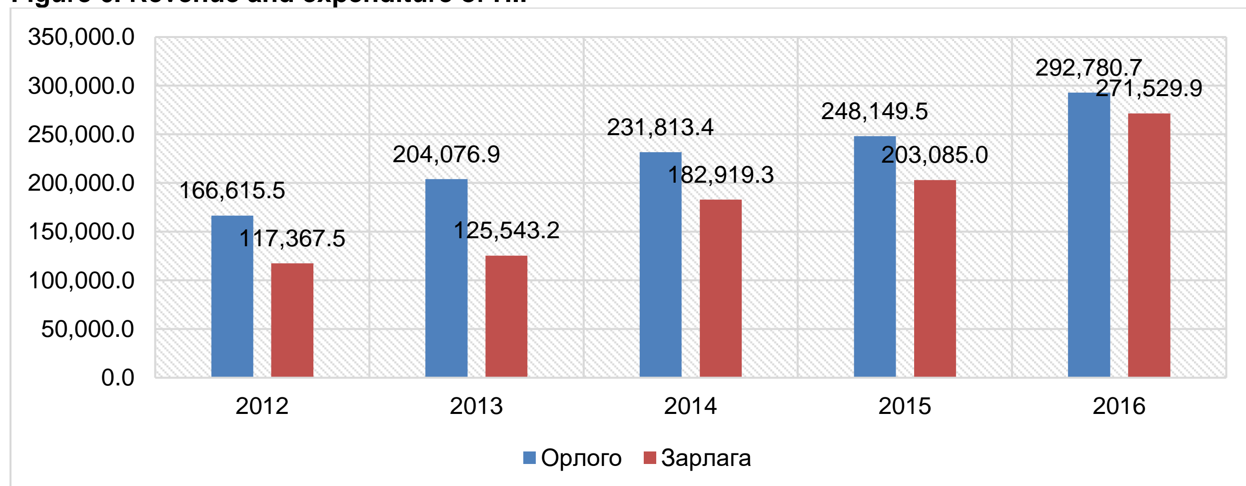


Source: Health indicators 2015, Center for health development.

The state budget spending as share of the total government spending on health was 66.5 percent in 2015. The HIF spending at secondary and tertiary level hospitals which provide inpatient health care services varies from 50 to 95 percent of the total budget of health care providers. As mentioned before referral level health care provided by secondary level health care providers such as aimag general hospitals; district hospitals and health centers; and tertiary level hospitals such as central hospitals and specialized institutions. MOH, Health Center for Development (NCD), National center for public health (NCPH) and other administrative premises account 14[3] percent of the total state budget spending on health.

[3] Health financing review, 2015-2016, MOH

Figure 6. Revenue and expenditure of HIF

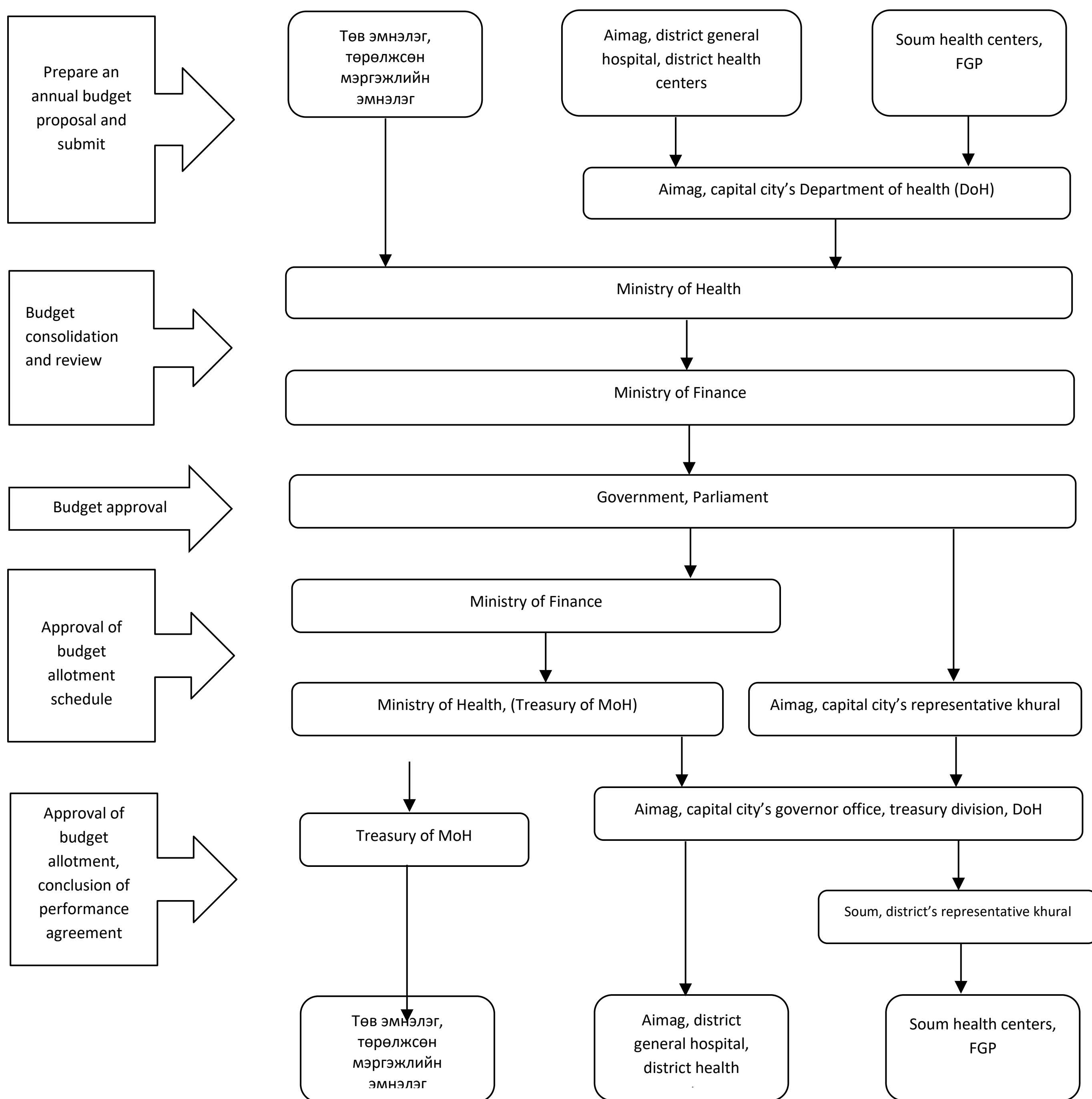


In recent years HIF has had/had a large accumulated surplus but Health insurance law amendment in 2015 added additional services in benefit package to be covered from HIF. These include selected high cost items, medical goods which have eased population's financial burden related to health expenses. Also amendments have increased the state contribution to HIF as the monthly contribution amount to be provided from the state centralized budget of the citizens whose premium is paid by the state has been changed from the flat rate to the certain percentage of minimum wage rate. Furthermore, the content of HIF also has been shifting from mainly curative in-patient care towards again out-patient health care services provided by primary health care providers as HIF will provide funding to primary health care providers. The latter law amendment has special consequences at health sector output and efficiency of HIF.

Overview of purchasing function in Mongolia

Purchasers of health care in Mongolia are the state budget, HIF and citizens. Figure 4 describes steps of budget planning, approval, allotment/allocaton/ and conclusion of purchasing agreement.

Figure 7. Budget planning, purchasing steps and parties involved



The parliament of Mongolia has the authority to discuss the Unified budget execution and approve the state budget execution, the MOF has the authority to review proposed budgets submitted to and allotment of approved budget, the MoH purchases health services from the state and local government owned health care providers by concluding the performance agreement.

Table 2. Benefit packages by source of funding(general classification)

State budget	HIF	Out of pocket (patient)
• Labor/Maternity care • Infectious diseases including TB • Mental health care • Cancer • Intensive care • Emergency care • Primary health care • Public health • Health care at natural foci • Immunization/Vaccination	• Inpatient care not funded by the state budget • Ambulatory services • Diagnostic and testing services • Discounts on drugs prescribed by family, soum and bagh doctors • Selected high cost items, medical goods	• Selected diagnostic and testing services • Addendum services Luxury service, cosmetic surgery...)

Source: Provider payment assessment 2014 MOH, WHO, WB

Purchasers fund health care providers according to benefit packages described above and the source of financing to health care providers depends on services provided. The state budget benefit package that defined without due consideration of cost inputs and quantity of provided services drives inefficiency of resource allocation.

Description of purchasers

Public funding

Ministry of health: the MOH defines health sector policy and health minister manages the health sector budget according to the Budget law. The health minister concludes the performance agreement with the heads of Central and specialized health care institutions and also delegates his purchasing power to aimag, capital city governors by concluding the performance agreement with them. The performance agreement includes only types of health services to be delivered, allocated total budget and performance indicators. The decision for purchasing is based on evaluation of the quality and performance of delivered services done by the department of monitoring, evaluation and internal auditing of the MOH but also based on assessment of specialized agencies and audit reports made by National audit office and it's branches. However, results of these assessments do not impact on budget planning and quantity of health services to be purchased in the next financial year. The state professional inspection agency under supervision of the deputy prime minister assures the quality of health care services provided by health care providers within given standards but also monitors environment safety and assures quality of medical goods and equipment. The

agency submits proposal, conclusion on state of implementation of a law, regulations, rules and standards for a review to the cabinet and delivers recommendations to MOH. However, these inspections have more administrative focus and not interfere a financing of an institution.

Ministry of finance: the MOF allocates by line-item the health minister portfolio's funds including monies allotted to health care providers, approved by the Parliament through the treasury single account which managed at the treasury department. Branches of state treasury at MOH, aimag capital city disburse funds according to allotment schedule approved above. Although the MOF is responsible for the allotment and disbursement of funds but its' functionality does not include monitoring the quality of care and performance, wouldn't be categorized as the purchaser of health care.

Health and social insurance general office/manages health insurance fund/: the HSIGO is responsible for the revenue generation of the health insurance fund and purchasing of health services on behalf of an insured person according to the Health insurance law. HSIGO concludes the Health insurance contract with accredited public and selected private health care providers. The contract includes types of health services to be delivered and it's quantity, tariff and the total budget. The purchase of health service is managed by HSIGO staff and it's software system. The contract includes a clause where HSIGO has a right not to fund health care services which not agreed and services that not passed quality assurance. The HSIGO also may change next years' financing. The HSIGO has a branch per aimag and totaling 21 branches are dealing with the purchase but the HSIGO also purchases health care services at capital city level as there isn't any branch. These branches purchase health care services from locally contracted health care providers and monitor the quality of services delivered and it's performance.

Aimag, capital city governor, local treasury division: Aimag, capital city governor concludes the special purpose agreement and becomes the fund manager or the central budget governor. Governors conclude the performance agreement with health care providers which deliver health care services locally. The agreement generally includes total budget, goals to be reached locally. The agreement has no impact on budget allotment of aimag/district general hospitals, intersoum hospitals, general rural

hospitals as allotment is solely prerogative of MOF and MOH. Due to geographic location of health care providers funds are being allotted via aimag, capital city's treasury divisions. Governors have a right to re-allot soum health centers and family practice group budget and adjust allotments by approval of local Citizen's Representative Khural.

Citizens: Citizens have a right to select health care providers and have free of charge health care services at primary level but obliged to pay co-payment for the health care services funded from HIF at specialized health care providers. There are also direct payments for a certain types of screening and health care service. Once a hospital has booked in financial records an accrual from direct payments and it has been accounted as the revenue at affiliated treasury only then the execution right of accrual will take in place. Government does not regulate price list and tariff set up of private sector. Although citizens make payment for purchasing of health care services it doesn't serve as the special purpose tool nor improves efficiency, same to state budget and HIF purchasing. It's a challenge to target these accruals into specific purpose. When health care providers offer health care services for a fee this service type has accounted as a source of funding as the purchasing occurs only if services are being offered. Therefore, citizens are neither purchaser nor strategic purchaser.

Private insurance: There are several private insurers in market that reimburse overseas treatment cost, and services provided by high end private health care providers. Besides of very low coverage this type of service is underdeveloped in Mongolia but population group with high income are using this option.

Additional financing: Aid and support of various donor organizations, donation from citizen, households and enterprises are addendum source of financing and it includes expenses of investment, equipment and specific purpose projects and programs. There is no relation to purchasing.

The purchasing is a system to strengthen a performance of provided health care services. As purchaser purposely allocates funds into predefined health care benefit package and disburses funds according to reached targets of performance indicators that stipulated on contract. Although there are purchasers such as the HSIGO/HIF, the state budget and citizen, health care providers are being financed within predefined

budget ceiling and sources of financing set up by MOF in accordance with the Budget law. Therefore, purchasers of health care in Mongolia are acting as passive finance institutions due to allotment of funds are not based on actual execution of funds nor needs.

Description of health care providers

Health care providers

The Mongolian health system is one statutory system divided in principle according to two main administrative divisions: aimags and capital city. 21 aimags are further divided into 330 soums, and 93 soums into baghs. The capital city is divided into 9 districts, and districts into 152 khoroos. These administrative divisions are represented by a two-tier health system: primary care and specialized care, including secondary and tertiary care. The tertiary level care mostly based in Ulaanbatar city the capital city of Mongolia. A general hospital, regional diagnostic treatment center is located at aimag level. Every district has a district general hospital, every soum has either soum health center or intersoum hospital.

Soum health centers, family practice group, intersoum hospital: An average distance from aimag to soum is 100 km. The delivery of health services has specific challenges due to extremely low population density over a large territory. Such as a provision of primary health care services to rural population that are too far from services and some form of specialized health care has provided at soum health centers and intersoum hospitals. The lowest administrative unit of Ulaanbaatar city, aimag centers is khoroo and every khoroo has family practice group. Soum health centers and family practice group provide same type of health care to catchment area where some specialized care provided by soum health centers. Currently, the primary health care is solely funded from the state budget but due to recent amendment in the Health insurance law the primary health care is allowed to be sourced from HIF. Intersoum hospitals provide specialized health care services within its catchment area soum health centers which located too far from aimag center. For instance, labor, dental care and surgery. Intersoum hospitals are financed from HIF.

Aimag, district general hospital, health centers: There are in total 32 general hospitals, health centers that located among 21 aimags and 9 districts. These health

care facilities provide 7 major medical services including internal medicine, paediatrics, surgery, obstetrics and gynecology, neurology, infectious diseases, intensive care and funded from the state budget and HIF. There are also specific health care providers located in Ulaanbaatar such as Mental Health and Narcology center, "Enerel" hospital. These providers are funded from the state budget by line items. **Specialized centres and tertiary-level central hospitals**: These facilities provide specialized health care and located in Ulaanbaatar city. The share of funding depends on provided medical services. Tertiary level hospitals provides general medical services, specialized centers provides specialized health care on selected disease. For instance, National Centre for Mental Health, National Centre for Infectious Diseases, National Centre of Traumatology and Orthopedics, National Centre for Mother and Child, National Cancer Centre. According to the Health law the state budget covers the provision of infectious diseases, neurology, cancer, maternal and child care and 60-90 percent of the total state budget goes to these facilities. 60-70 percent of the total HIF goes to tertiary level hospitals and National Centre of Traumatology and orthopedics. **Public health institutions**: It is responsible for implementation of public health policies and cooperates with health care facilities at national wide level. There is a public health division within aimag department of health and district health centers which implements public health policies in its' catchment area. At grass root level soum health centers, family practice groups are responsible in conducting day to day public health activities. National Centre for Zoonotic Diseases is responsible in control and management at spread of zoonotic diseases in Mongolia and has it branches in aimags.

The payment methods used by the health purchasers and revenue share by source of funding are summarized in Table 3.

Table 3. Overview of provider payment system and revenue share by source of funding

Type of provider	Purchaser/Payment Methods (% of revenue)		
	MOH	**HSIGO**	**Clients**
Central hospitals and specialized centers	Line item budget (12-83%)	Cased-based payment using DRGs (7-83%)	Fee for service (4-10%)
District health complexes and maternity homes	Line item budget (17-100%)	Cased-based payment using DRGs (0-80%)	Fee for service (0-3%)
Aimag general hospitals	Line item budget (58-60%)	Cased-based payment using DRGs (30-40%)	Fee for service (1-10%)
Regional diagnostic and treatment centers	Line item budget (60%)	Cased-based payment using DRGs (34%)	Fee for service (6%)
Soum and inter-soum hospitals	Line item budget (75-96%)	Cased-based payment using DRGs (4-20%)	Fee for service (0-5%)
Soum health centers	Line item budget or Capitation (100%)	-	-
Family practice groups	Capitation (100%)	-	-
Sanatoria	-	Cased-based payment using DRGs (19-90%)	Fee for service (No response)
Private hospitals	-	Cased-based payment using DRGs (10-30%)	Fee for service (70-90%)
Private pharmacies	-	Reference prices	Fee for service

Source: Provider payment assessment 2014 MOH, WHO, WB

Predominantly the line item budget payment system is employed and used at planning and execution of the budget. However, it's not linked with tariff and cost estimates of health care service. HIF becomes a source of funding as it's considered as a part of the unified budget and allotment of the unified budget by line item allows to monitor budget execution in very efficient way.

Table 4. Payment system

Payment system	Source of funding	Payment method	Current situation	
			Design Features	Implementation Arrangements
Line item budget	*State budget*	*Input based*	Funds are disbursed, used and accounted according to input-based line items	Budget disbursed strictly by 38 line items and expenditure strictly controlled by 38 line items
Case-based payment using DRGs	*HIF*	*Output based*	Funded by 118 DRG case groups	Financed by DRG cases and expenditure strictly controlled by 38 line items
Fee for service	*Patients and HIF*	*Output based*	Fee charged for a service provided	Financed by provided service and expenditure strictly controlled by 38 line items
Capitation	*State budget*	*Input based*	The base per capita rate is set through an allocation formula of the Ministry of Finance	Financed according global budget method and expenditure strictly controlled by 38 line items

Source: Provider payment assessment 2014 MOH, WHO, WB

Specialized health care providers (secondary and tertiary level) are financed from HIF based on 118 DRG cases and tariffs were calculated jointly by MOH, MOF, MLSP based on the costing study. Since amendment in the Health insurance law in 2015, the National council on social insurance has took this responsibility. Depending on specialty of health care providers, patients are responsible of copayments from 10 to 15 percent but there are not copayments for ambulatory health care, testing and screening. The quarterly ceiling amount for testing and screening is 165 000 MNT (roughly 68.7 USD). The MOH, MOF has not jointly approved yet tariffs for health care services to be paid by patients for services received from the state and local government owned health care providers, as a result, providers set up on their own tariffs which differ from institution to institution. According to costing exercise conducted in 2013, fees for services paid by patients are too high. For instance, fee for an ultrasonography was 20 000 MNT but a real cost is 4 300 MNT, therefore patients' overpayment is 4.6 times higher of the actual cost of service. The state budget funding allotment has a cap however health care providers have a tendency to increase their budget annually. Therefore, main sources of funding that avail to increase health care providers budget are HIF and self-generated revenue. If at preparation of annual budget proposal health care providers will increase

accruals from self-generated revenue, then the MOF will possibly support this as it's ease the state budget allocation from tax revenue collected sources. However, the increase of self-generated revenue will burden households, as a result it will increase high level of OOP further, and therefore it's not appropriate option for Mongolia.

Tariffs of benefit package to be funded by the state budget have not yet approved. There is a demand for tariffication and change of payment method which has being used currently for the state budget funding. In comparison, the HIF finances health care providers according to every single medical treatment and intervention done but the state budget funding disregards cost of inputs and quantity of provided services and allotment is based on previous year's actual spending. This leads uneven allotment of funds such as shortage of funds in one and excess in another, eventhough the quality and quantity of health care services provided were the same. The HIF's DRG tariffs increased by 25 per cent due to results of costing exercise conducted in 2013. As a result, the HIF funding of health care providers has increased by 25 percent. The MOF practices residual planning of the state budget, which is usually the residual between total expenditure and health insurance financing, increase in the latter reduce the state budget share. This planning impedes the efficient management of health care providers, the state budget benefit package has paid from health insurance fund burdens it and also insurers fund has not used by initial purpose.

Family practice group is financed on capitation basis. Last tariff update was in 2015, a capitation tariff increase is based on inflation and governments' payroll increase. A financing rule of soum, village health centers was approved in 2015. The rule is mixed financing rule which includes standard inputs and population. This payment method allows a fair allocation of budget to remote hospitals, and also assures that citizen will receive health care service without any hindrance as it takes into account distinct of population.

Health Insurance Fund pays hospitals under DRGs and tariffs based on actual costed exercise of medical services. Government doesn't regulate price list and tariff set up of private sector and private hospitals get paid 50 percent of the DRG tariffs paid to public sector facilities. There are 2 reasons of such difference: first, a weak mechanism to monitor a quality, second, if patient health condition has worsened then the patient is

referred to public health care provider. And also it purposed to reduce supplier side demand. The possibility to eliminate such difference has increased by amendments in the HIL, strengthening HSIGO as a strong purchaser, setting up an autonomous agency, introducing electronic payment system.

2. **Challenges and priorities in relation to purchasing and resource allocation**

The most emerging issues are lack of optimal resource allocation policy, methodology, and also long term planning developed on output base and it acceptance at stewardship level. Although health care policy supports primary and public health policies, public health policy implementation faced challenges: allocated expenditures finance current expenditure of an institution, administrative directives is the most common form of implementation of public health policies. Expenditure on primary health care includes public health expenditures and the state budget spending on primary health care decreased by 9 points within last 10 years.

Health care services which provide efficiency should be a prerogative of funding from HIF. For instance, cases of morbidity from pneumonia are high due to high cases of pneumonia among children. Case: medical screening of a child with respiratory disease is free of charge, however prescribed medicines could cost on average 20 000 MNT/8.3 USD/ where 5 000 MNT /2.1 USD/ covered from HIF. Parents whose child with pneumonia and who can not afford cost of prescribed medicine will look for a medical care from aimag/district hospital and cost of treatment will be on average 254 000 MNT/105.8 USD/ and HIF fully will cover expenses. Therefore, the cost of treatment increases 17 times. This leads inefficient use and allocation of HIF monies. Medicines used to treat hepatitis C, due political influence and decision in recent years, are under list of prescribed medicine to be covered from HIF and few people have benefited with high burden to HIF. Therefore, this impacts on uneven resource allocation and service delivery to population as a whole.

3. Эрүүл мэндийн тогтолцооны худалдан авах үйл ажиллагааны үнэлгээ, тулгамдаж буй асуудлыг тодорхойлох нь

Бодлогын зорилт

Institutional arrangement

Mongolian health sector is sourced primarily from the state budget and HIF. There are fragmentations at resource allocation, purchasing and institutional arrangement. Institutional arrangements of institutions that have been involved are described below.

Table 5. Institutional arrangements of purchasers

Institutions	Institutional arrangement at resource allocation and purchasing
MOH	• To plan, organise the implementation of health care services delivered to population at the sectoral level; to define the location, organizational structure, types of health care services and level of health care provider, and also upper limit of number of beds for hospitals and sanatoriums • To monitor in the implementation of health services quality policy • Approve jointly with the MOF the instructions on providing services funded by the state budget, the package of health services, volume and quality indicators of services and procedure on payment amount and financing and monitoring of services • Approve jointly with the MOF the procedure of fee for services along with the list services of the state owned health organizations and shall approve the standard payment rates of services • Ensure appropriate and efficient use of budget expenditures and revenues, and performance execution, and be fully responsible for the budget execution before the MOF
MOF	• Prepare amendment for the state budget, Social Insurance Fund budget and Future Pension Fund • The treasury based on monthly and quarterly budget allotment schedule, issue authorization to finance and spend to budget entities' accounts
National Health Insurance Council	• To expend or depositi in the bank the health insurance fund surplus
HSIGO	• To conclude contracts with health care providers on behalf of the insured to reimburse the cost of healthcare services and monitor and evaluate the implementation of contracts • To organize the selection of health care providers in consideration of the health care quality, safety and accessibility among licensed and accredited health care providers of any ownership type • To monitor the health expenditures provided to the insured persons and issue recommendations and instructions to health care providers on improving the quality of care • To receive and resolve complaints raised by insured persons on issues related to health care quality and accessibility • The health insurance organization will establish a contract with health care providers qualified through the selection process and shall monitor and evaluate the execution of the contract.
Aimag, capital city's representatives khural, governors	• In consultation with the MOH, it shall improve structure and organization of health organizations in the territory, locate them appropriately, and distribute human, material and financial resources properly • Ensure appropriate and efficient use of budget expenditures and revenues, and performance execution, and be fully responsible for his/her budget execution before representatives of khural.

Institutions	Institutional arrangement at resource allocation and purchasing
Aimag, capital city's Department of Health	• To regulate matters of adjusting the number of beds in hospitals within the limits defined by the central state administrative body in charge of health matters;
Insured	• Choose a health care facility of any type of ownership contracted by health insurance organization and receive health care services • Choose a health care facility of any type of ownership contracted by health insurance organization and Health insurance benefit package

The MOH has following responsibilities: identifies national policy and development tendency of the health sector; improves health laws and regulations and organizes its' implementation; provide professional and technical assistances to health care providers; conduct monitoring and evaluation on health activities.

The minister of health concludes the performance agreement with heads of central and specialized health care providers and also aimag, capital city governors. Although the performance agreement bases on output specifications the implementation was not satisfactory as specified outputs were difficult for measurement and not realistic.

The performance agreement is concluded annually and annual performance appraisal is conducted at a beginning of calendar year and the next agreement takes place in March of every year. A process of conclusion of the agreement takes time as outputs set out at the agreement are measurable in midterm and targets include a few strategic goals and outputs. Regardless of annual performance appraisal a budget governor receives financing therefore the performance agreement is not linked with outputs. Next years' annual budget has already been approved when parties conclude the performance agreement and financial year has already started, therefore there are not any accountability mechanisms which link output and budget execution with next year budget planning.

The performance agreement is not linked with deliverables nor financial execution. Regardless of performance appraisal, health care providers keep receiving funds through treasury system in accordance with approved budget allotment. Therefore, the performance agreement is not linked with financing.

HSIGO has branch offices in every aimag, these offices are responsible for collection of contributions, and conclude the "Contract for delivering health care services and

purchasing" with aimag general hospitals, accredited private health care providers which located at aimag center and finance them all.

Contract appraisal team consists from representatives of social insurance organization, pharmacies, insured and family practice group federation, according to regulation of head of HSIGO. The contract performances has evaluated by the team that assessed health care providers performance by points then the report verified by head of social insurance organization and delivered to HSIGO

If health care provider is not fulfilled obligations stipulated in the contract then social insurance organization advances a claim requesting to improve its activities. If a claim requesting to improve its activities has been demanded 3 and more times, penalty is not paid on time then a state inspector has a right to terminate contract.

The terms of the contract stipulate, a certain proportion of advance payment to contracted health care providers can be made according to claims received by HIF, a remainder is paid according to performance but within the monthly allotment after review of submitted claims.

The health insurance organization selects health care providers who qualified through the selection process, concludes the contract with them and monitors its implementation, also it lacks in monitoring quality of care due to shortage of human resources and finances health care providers within approved budget, in overall indicates that purchasing is limited. Therefore, the current health financing arrangement of health care providers in receiving funds from the treasury does not act as a leveraging mechanism in improving quality and output of delivered health care.

Although aimag, capital city's governors conclude the Cooperation agreement with the health minister have no real role in purchasing of health care services.

Institutional capacity

Although current purchasing functions of social insurance organization has some features of strategic purchasing, there are challenges in implementation of HIF fund. The institutional capacity of HIF addresses 3 main issues described below. It includes:

- To define **what** services need to be purchased is based on population need, priority of national health care policy and taking into consideration the efficiency (health care service package);
- To define **which** services need to be purchased, one should consider satisfaction increase and improved health of insured and trust to the HIF by improving accessibility, efficiency and quality of health care service through applying the contracting and payment methods (purchasing of health care service);
- To define from **whom** to purchase health care services is based on quality of provided health care services and level of efficiency provided services (to select health care provider, hospital)

Therefore, the institutional capacity of organization in charge of health insurance is shown at Table 6.

Table 6. Institutional capacity of organization in charge of health insurance

Decision	Enacted laws and regulations	Implementation	Challenges
To define health care service package	- Health care services to be funded from the HIF's benefit package is specified by the HIL - HIL stipulates, NHIC shall approve the list of health care services to be included into the benefit package of the health insurance fund	- Organization in charge of HIF decides what services will be provided by whom - Benefit package revision and improvement go slow .	- Lack of positions and personnel
Purchasing of health care service	- Organization in charge of HIF concludes the contract with health care provider, hospital - HIL stipulates, NHIC shall approve the payment method and tariff	Organization in charge of HIF concludes the contract with health care provider, hospital. The contract is improved constantly. -NHIC approves the payment method and tariff. Revision and improvement go slow	- There is no unit that calculates a cost of health care service for tariff update - Due to residual nature of budget planning, increase of HIF spending do not affect on quality, accessibility of provided health care services. -This impacts negatively to purchasing of health care services
To select health care provider,	-To select and conclude contracts with health care providers according	-Organization in charge of HIF has started to select health care prvodiders since	-To improve a selection process of health care providers and overview

Decision	Enacted laws and regulations	Implementation	Challenges
hospital	regulation approved by NHIC	2016 according to HIL	international best practices

Although the HIL has certain provisions which promote the organization in charge of HIF as the purchaser but actual implementation is not satisfactory. As of today, Health insurance department is structured within HSIGO and has no autonomy, nor operational budget or power to make a decision on administrative and human resource matters.

The health insurance department has a few officers in charge of health insurance policy and planning, who deals on daily basis with fiscal framework statement, detailed allotment, organizes enforcement of laws and regulations and provides a methodological guidance to local branches. There are approximately 40 doctors at nationwide in charge of quality assurance of delivered health care service and annually a doctor reviews on average 210 thousand claims. A work load of officers in charge of of health insurance will increase as benefit package funded by HIF is expanded, and also the health insurance organization will purchase some health care services included into the benefit package funded by the state budget.

Although the health insurance organization uses a software to monitor a quality of delivered health care services, employees are also pressed by checking medical histories; prescriptions of prescribed medicine via sampling method; day to day control of contracted health care providers; conduct customer satisfaction survey, analyze data; and receive and resolve complaints raised by insured. A clerck receives invoices from health care providers and does verification of received invoices by every single insured person who has received a treatment but also consolidates a financial reporting with the contracted health care providers.

Health insurance department has neither human resource nor financial power to implement purchaser functions but also limited as a strategic purchasing, as there is a methodological inconsistency in funding public health care providers from the state budget and the HIF.

Conclusion

1.The government spending on health increases annually but the increase is not targeting preventive nor and primary health care. As the increase is predominantly salary and inflation adjustment of goods and services, it's not supports a quality of health care and health care service expansion.

2.The MOH defines and leads health sector policy but the MOF is responsible of resource allotment in accordance with the Budget law which creates incoherence between the health policy and it's financing.

3.There is neither purposed budget planning nor allotment to the public health which is the health policy prerogative. Health care providers implement the public health activities within the provided budget or implement the public health activities from ad hoc sources of financing, this shortage of financing creates shortage in implementation of policy goals. In another word, due to such short-sighted budget planning, the state budget and the HIF are financing predominantly primary health care services, this weakens funding on preventive care and hinders its activities which bring results in a long term

4.The state budget benefit package financing is not linked with outputs delivered by health care providers, there is no single methodology on budget planning and it's allotment, some economic factors aren't taken into accout and all above mentioned conditions limit an equal budget allotment and purchasing of health care service at planning

5.There are four payment methods to finance health care providers but predominant is the line item budgeting. Consequently a passive purchasing is predominant as this payment method is input based and disregards output or performance,

6.Although HIF fund manager has it's own organizational structure, personnel, information technology system but in terms of financing it's within the unified budget where funds allocated as a part of the state budget and expenditures accounted accordingly, therefore the purchasing is passive in Mongolia. In other word, autonomy at the purchasing does not act as a leverage mechanism to improve quality of health care.

7.Inpatient care is accounted 80 percent of total funds allocated from HIF, which is ineffective fund utilization, and disbursed funds will not act as a leverage mechanism to

reduce cost in future. Some high cost treatments have been included in benefit package as HIF revenue increased, and the important step to ease financial burned of households was expansion of HIF benefit package, but also the benefit package includes hight cost treatment of few insured with chronic disease and this initiates improper resource allocation.

8.Althougth the OOP payment accounts a big share of total expenditure on health the government policy on health and its regulation is weak. Tariffs, unnecessary admissions of private health care providers and also improper use of drugs and its purchase scale up OOP and efforts made by policy makers to mitigate negative consequences of mentioned challenges barely meet expectations but also reforms are desirable.

9.The base of resource allocation and purchasing of health sector is regulated by the Budget law, which is cause a passive purchasing. Although benefit package, tariff, payment methods are defined clearly in the health and the health insurance laws but implementation struggles as regulations supporting laws have not passed yet, and it's still unclear how these will interact with the Budget law which is the base law of the state financial management in Mongolia.

10.The base health laws and its regulations that coordinate financing, resource allocation and health sector activities have changed frequently but the process of drafting a law or amendment to a law is not evidence based. There is a little or no consistency at all regarding other legislations, and also there are common tendency to increase own ministerial power. Although the “Medical service law“ has enacted, the law implementation not started yet and there is no clear understanding, on how the law will interact with other laws.

Recommendation

1. To revisit health sector resource allocation policy, implement a balanced policy oriented towards on improving system efficiency.
2. To amend the Budget law, so every sector will have a right to allocate resource according their policy and priority.
3. To align and refine programmes implemented at health sector with budget planning system and line item budgeting; and to support primary health services which impement various programmes but also promote policy which oriented to strengthen the structure of public health.
4. To develop the methodology that will link financing of the state budget benefit package with outputs and purchasing should be based on quality of delivered health care services.
5. To conduct purchasing with support of organization in charge of health insurance and other institutions and strengthen a system that links provided services with allocated budget and considers accountability of outputs. This is a way to change current passive purchasing system.
6. By splitting the HIF from the unified state budget; provision of autonomy, selection of services based on needs of insured; and provided health care services account the quality and output of delivered service are the preconditions for strategic purchasing.
7. The MOH should conduct a comprehensive assessment of private health care providers. It should review a total number of private health care providers, number of beds, personnel and assess performance. As a result the MOH should develop a policy which reduces number of private health care providers but supports merge of private health care providers into bigger facilities and the latter will compete with public facilities.
8. In order to decrease OOP payment, current tariff segregation used by HIF to fund public and private health care providers should be eliminated. To diminish a state monopoly via funding private health care providers if the latter provides health care service that substitute public service.

9. To mitigate political influence on resource allocation and decisions made regarding management of HIF, promote performance based financing, special attention should be paid on improving fund efficiency at the long term.
10. Following options could be considered for improving resource allocation and purchasing at health sector:

    Option 1. 2 separate purchasers: the state budget purchaser, the HIF purchaser

    - To strengthen autonomy of health insurance fund, to improve purchasing capacity by developing a phased program.
    - Establish a state budget purchaser formation which will locate at implementing agency of the MOH. Implementing agency's arrangements are fitting to be set up as a purchaser. Also smart card could be introduced for health care services funded from the state budget.

    Option 2. Conduct costing exercise of health care services funded from the state budget and tariff them. Stop transfer funds directly to health care providers account but transfer funds to health care providers through organization in charge of HIF by shifting to a single purchaser model and to expand activity in linking quality with output.
11. To keep the current system by solving issues those have been raised due to the Budget law restriction, and to improve the system providing mutual coherence.
12. To improve performance evaluation and monitoring of the performance agreement concluded with a direct budget governor and the HIF purchasing contract concluded with health care providers by setting realistic performance indicators and take measures to improve the purchasing mechanism.
13. To develop a comprehensive methodology which will include budget planning, monitoring and performance assessment but also economic indicators.
14. To clearly identify a purchasing functions and it's arrangements at legal provisions, and to develop a phased programmes for personnel capacity building.
15. To expend HIF resources by giving a priority in health care services that will maximize a structural gain in future and to ensure an optimal resource allocation of HIF.