A new Procurement Law was passed by the government in 2000 to streamline and standardise the procurement practice of governmental organisations and that all procurement over 10 millions Tugrigs must be arranged by calling for tenders.

- Nomadic lifestyle requiring an intensive health infrastructure

The state has a responsibility to ensure citizens are receiving full health coverage (from public sector or private sector), but it appears that the quality of services has declined recent years. The number of physicians and the number of beds per person is quite high, but the distribution is uneven, with many of the facilities concentrated in Ulaan Baatar, the main cities and the aimag centers, while many of the rural health centers lack basic amenities. With the proportion of the budget devoted to health services falling, the government is struggling to maintain standards. Often staff are not paid on time, and there are delays in disbursing funds to hospitals.

In rural areas, physical access to services is often a constraint due to lack of transport and communication links. Government policy increasingly emphasizes preventive care over curative services and the training of the country's medical practitioners reflects this new emphasis.

Mongolian health system also, faces many other challenges. These include extreme climatic conditions, a thin population spread over huge areas (with population density of only 1.5 in. per sq. km.), growing health demands, and oversized health system with serious problems in cost-effectiveness and quality of services.

3.2 Health Sector

3.2.1 THE HEALTH SYSTEM IN MONGOLIA

(1) Health Status :

Traditional and modern approach of the health sector

Health beliefs and practices were earlier based on Buddhist traditions, with lamas the principle traditional practitioners. Use of traditional medicine came to an end after suppression of traditional medicine and traditional healers as well as all religious activity in the late 1930s. Traditional medicine was banned until 1989. In resent years there has been renewed interest in traditional medicine based on revival of Buddhist beliefs and practices, fresh emphasis on all traditions as manifestations of Mongolian identity, and increased contact with the traditional medicine in other Asian countries.

Modern health services have been developed since 1921, mainly through manpower

from the former USSR. In the mid 1920s there were only 2 doctors and 25 hospital beds in all Mongolia. From the 1940s, the health infrastructure expanded rapidly throughout Mongolia under the influence of the Soviet Union and modeled on a strong central planning process. This included such features as the use of feldshers as paramedical personnel among scattered populations, and a high degree of specialization of physicians, with no category of general of family practitioners.

Geographical conditions and very low population density make communications, transport and health service provision difficult. Nearly one half of the total population lives in rural areas, and 20% of the population leads a nomadic lifestyle.

(2) Health Status: Present Situation

Advantages:

- Designed and piloted a new financial management system
- Renewed legislation and legal environment
- Transforming to family group practice
- Decreasing infant mortality
- High rate of immunization coverage
- Increased RH education for the population
- Established health private organizations
- Initiated licensing of health professionals

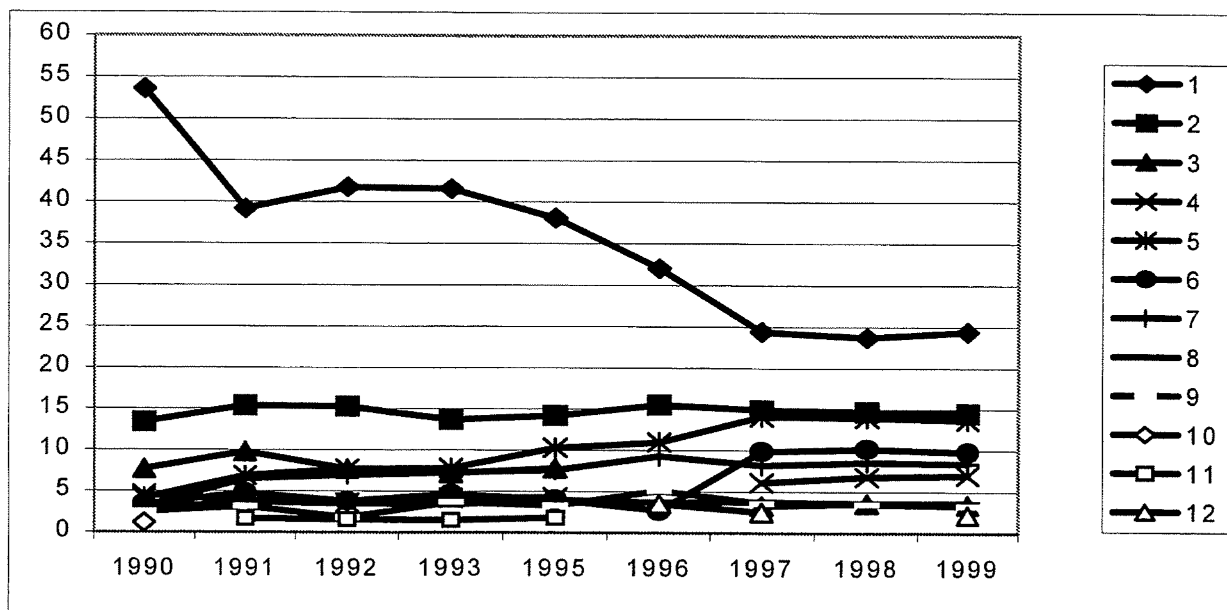
Disadvantages:

- Existing financial management system (based on the old system) is inadequate
- Total expenditure of the health sector has decreased
- Investment in the health sector has decreased
- Large debt to Emimpex Companies by government health facilities organizations
- Increasing inequity especially between urban and rural areas as well in the cities
- Under utilisation of health care and services especially in the rural areas
- Reduced accessibility to health care and services especially for the urban and rural poor
- Collapse of routine activities in many soum hospitals
- Increase in new and re-emerging diseases

- High morbidity rates for TB, STDs and viral hepatitis
- Large increases in cardiovascular diseases and cancer
- Negative trends (irregular) in maternal mortality rates
- Overextended, large, centralised and expensive health infrastructure with excess capacity

Midterm strategy

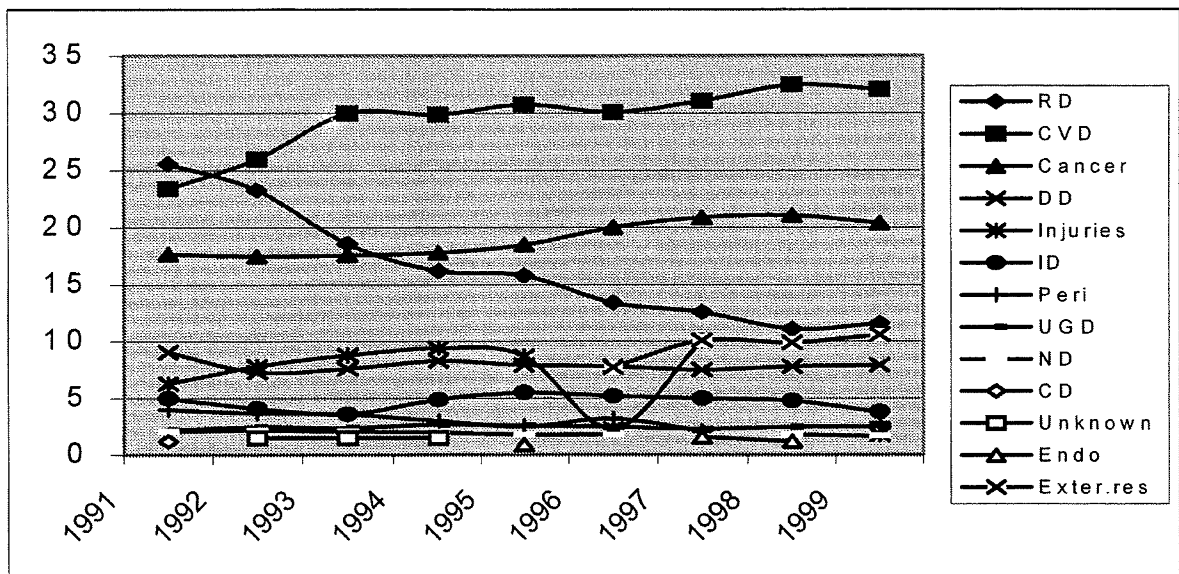
- Improve the population health situation and extend life expectancy through improving health care and service accessibility, equity, quality, efficiency and proper financing.
- Improve health care and service's equity and accessibility
- Develop sum hospitals
- Expand family group practice
- Establish new and improved centres for diagnosis and treatment
- Improve access to care and services for vulnerable people
- Improve health care quality, efficiency and efficacy
- Improve quality of diagnosis and treatment in tertiary hospitals and specialized centres
- Develop and implement appropriate health technology programs
- Systematize licensing and accreditation for doctors and health organizations
- Develop human resource and further improve managerial skills
- Ensure sustainable development of the health sector
- Develop and improve system of health finance and insurance
- Develop appropriate ways to allocate financial resources
- Increase health expenditure in the national budget
- Create immunization fund
- Promote participation of private sector
- Increase provisions for essential drugs
- Rationalize health infrastructure to reduce excess capacity where appropriate



Ten leading causes of morbidity

These are: (as provided by NCHD)

- Respiratory diseases
- Digestive system diseases
- Neurological diseases
- Injuries & trauma
- Urogenital diseases
- Complications related to pregnancy, delivery and post partum
- Cardiovascular diseases
- Skin diseases
- Infectious diseases
- Endocrine diseases
- Psychiatric diseases
- Eye diseases

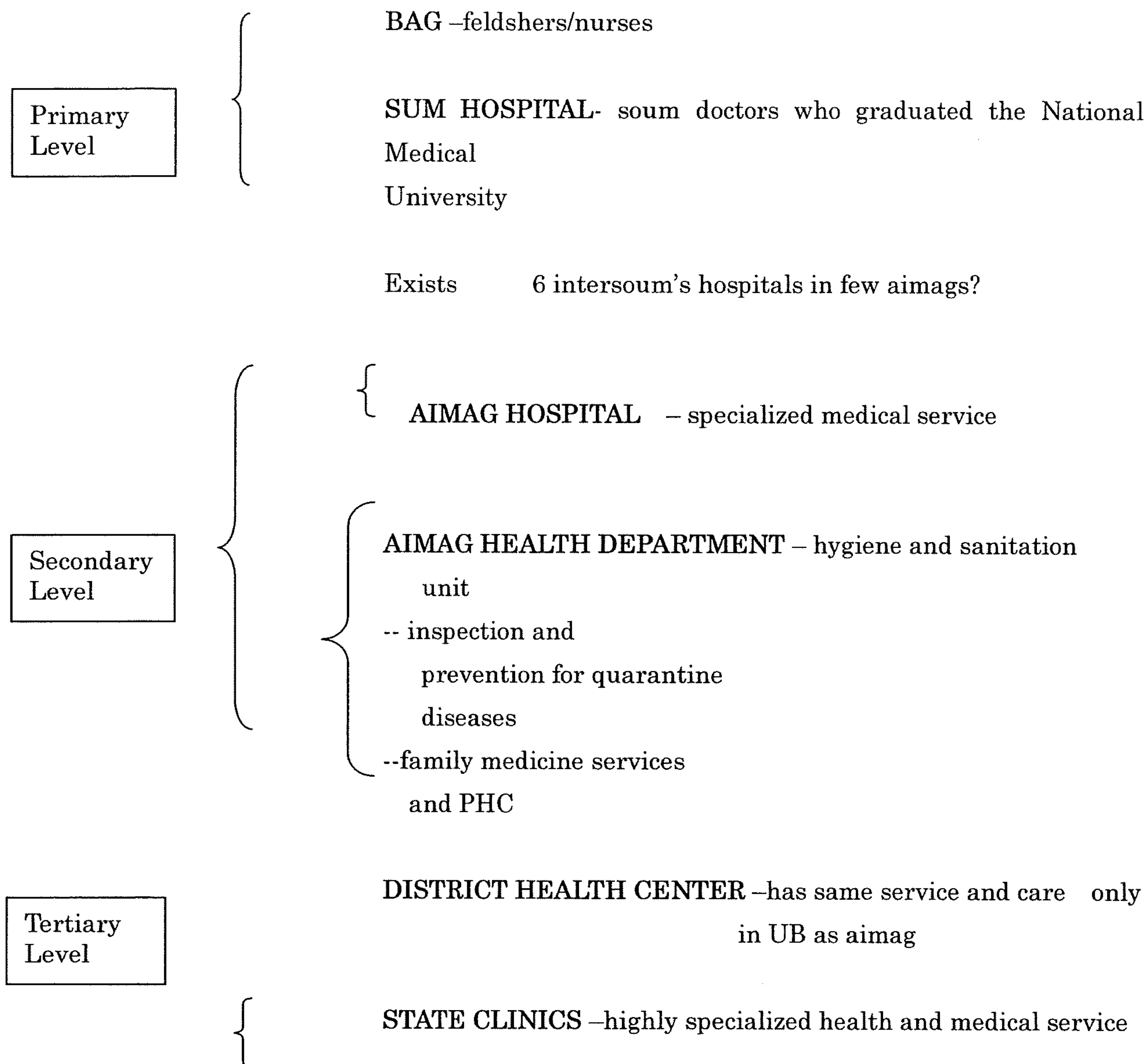


Ten leading reasons of mortality

The graph shows CVD, cancer, and digestive system diseases are the leading 3 reasons of mortality. In order to increase life expectancy it is very important to organize activities directed to decrease maternal mortality and prevent cardiovascular diseases, cancer and injuries. The government strategic program in tends to make decisions regarding these issues. Also the health sector is concentrating on issues of decreasing STD, TB and infectious hepatitis.

(SPECIFIC CAUSES WOULD BE PREFERRED RATHER THAN STATEMENT OF GENERAL CATEGORIES OF DISEASES)

(3) Health Administrative Levels



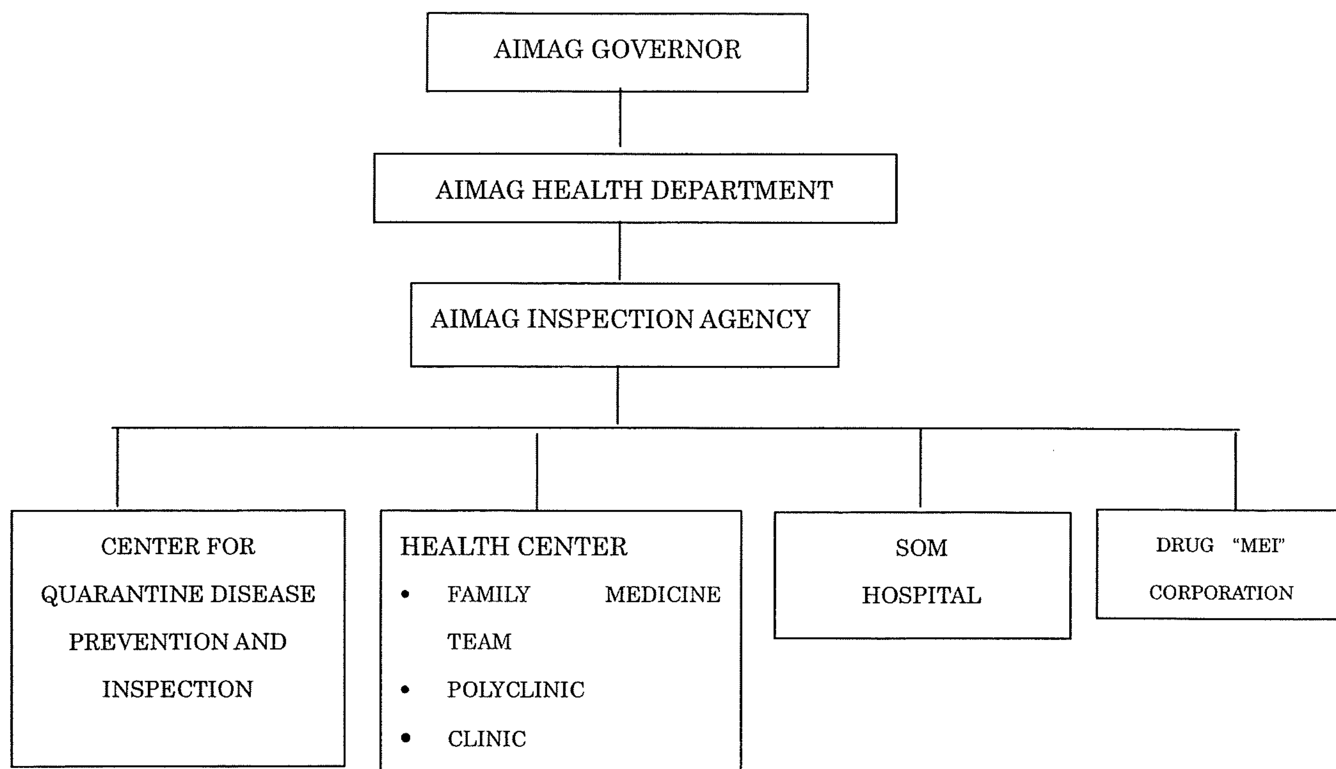
(4)Health System Components, trends and reforms

- The organization should reflect and relate with the strategic aim of the Government and MOH
- The organization/structure should determine power/position/ and responsibilities clearly within the units
- Outward appearance of the strategic management
- Structure should not excel 3 levels of administration and should be simplistic

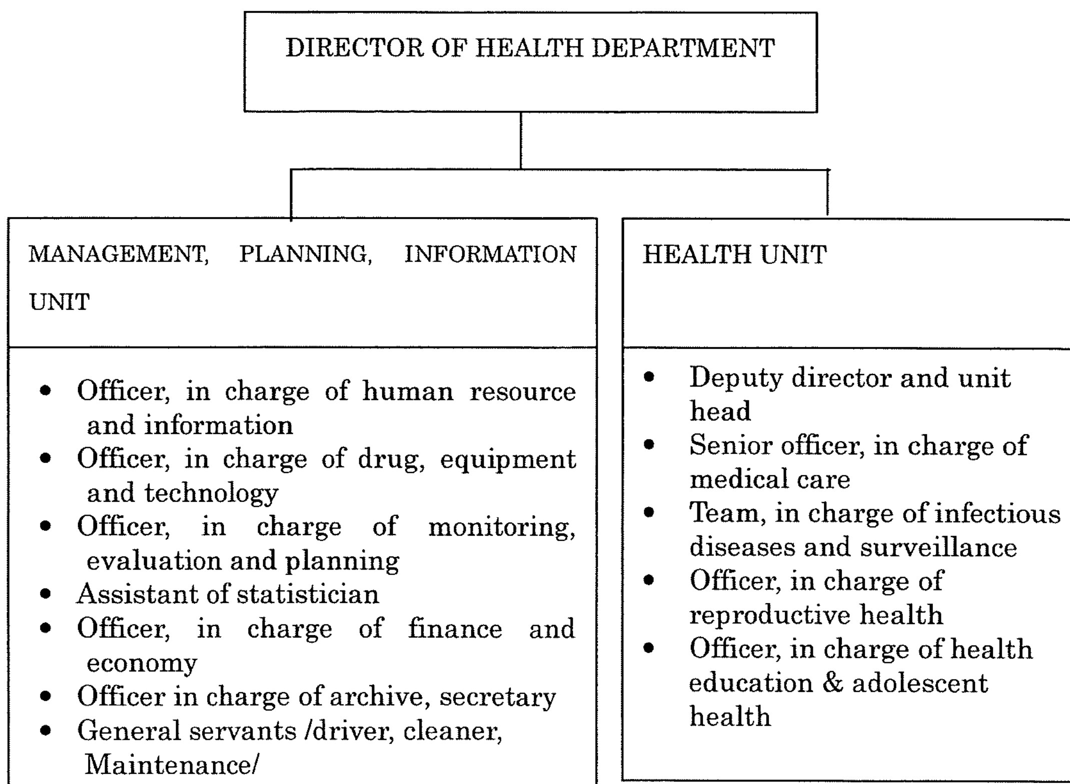
- Structure/organization should be controllable and relates with the strategy to manage and distribute tasks equally
- Politically, should be neutral
- Structure should be implementable and capable

(5) Structure of the aimag health department and the local government

STRUCTURE OF THE AIMAG HEALTH DEPARTMENT UNDER THE AIMAG GOVT



INTERNAL STRUCTURE OF THE AIMAG HEALTH DEPARTMENT



(Notes)

- The Director of Health Department has duty to be responsible for the planning management, information unit head
- Aimag Governor has to negotiate with the Minister of Health when he/she hires and fires the director of health department
- Soum Governor has to negotiate with the Director of Aimag Health Department when he/she/ hires and fires the Soum Hospital Director
- To have a right to manage related health organizational finance, independently
- Based on above mentioned, suggests to add legal addition into local unit administrative law

(6) Resource allocation to each state health level

State Health Organizations

Service level	Services	Organization names	Number of organizations	Number of doctors	Number of mid-workers	Total
Primary level	PHC and General Health Care	Soum hospital	347	752	3208	6722
		Bag health unit	982		572	609
		Family hospital	991	1973	2973	4946
Secondary level	Specialized Care	General hospital	29	1734	4121	9003
		Children's hospital	3	244	495	4429
		Other specialized hospitals	5	321	831	2106
		Specialized dispensers	11	222	306	753
		Health centers	17	989	1129	2599
Tertiary level	Highly Specialized Care	State clinics	3	317	468	1572
		Highly specialized health centers	16	321	831	2106
		Drug facilities	628	11	202	1810
		Public health centers	31	688	707	1495
		Quarantine inspection and prevention center	14	45	112	303
		Sanatorium	6	19	38	200
		Private clinics	998	701	985	2547
		NGOs				
		Others	105	360	185	1506
		Total	4022	8697	17163	39402

Health system weakness & strengths

Strengths	Weakness
• have an opportunity to develop policies and implement them after decentralization of health system • 96% of population have covered under the health insurance system • have started to license doctors, nurses and pharmacists • have established legislation and approved health law • have had health statistics and information system registration about population morbidity and mortality • have had enough human resources • have had good equal health care service • have implemented national health programs to decide health problems • have eliminated poliomyelitis and had high rate of immunization • have had good reproductive health knowledge of population	• have declined health expenditure in GDP in each year • have had underdeveloped health insurance system • have had incomplete coverage of vulnerable population • have established debt network among health facilities • have breaked proper intervention of countryside hospitals • have had underdeveloped postgraduate training program • have had old technology and medical equipment • have had insufficient essential drugs and equipment • have had poor quality of medical care • have had improper health financial and accounting system • have had high rate of communicable diseases • have had high rate of maternal mortality

(7) Private sector review

Since 1990, private and public health facilities have established and conducted health services. The government has created legal environment for the private sector to develop and set up within the aim to support and spread health insurance system financial source for the private sector, to increase private sector participation in health service and raise its responsibilities.

Currently, there are over 900 private health facilities and 490 of them are private clinics, 320 pharmacies, 42 drug providers, 23 drug fabrics, 75 private hospitals that have inpatient service. 596 doctors, 264 pharmacists, 434 pharmaceutical chemists and totally 2219 people are working in the private sector in Mongolia.

2/3 of the private health organizations is locating in the Ulaanbatar city, 6 private health organization are collaborating with the forieng organizations and 4 of them are clinics, 1 is optical facility, 1 is medical equipment company. 35% of total private hospitals is dental clinics, 21.9% is traditional clinics, 15% is gynecological clinics. 85% of total national dental clinics is conducting their service in the private sector.

3 staged Council has been licensing health organizations which is intended to

conduct activities:

- Ministry of Health Council

  Licensing, extending and invalidating the license of health organizations, which have external/foreign/ investment
- City Govern Council

  Licensing, extending and invalidating the license of health organizations to conduct their service in the UB city
- Aimag Govern Council

  Licensing, extending and invalidating the license of health organizations to conduct their service in the aimag/province

Also State Inspection Agency has been controlling the private health organizations.

The United Association of Mongolian Private Health Organization was formed in 1993. Three associations about 850 health private organizations are included in this united association. Its administrative department has 13 members. The association has a branch in each district and aimag. The 10th anniversary of the first was celebrated in 2000. The first assembly of private health organizations' managers was held the same year and the main trends of such organizations development were determined for the period 2001-2004.
The Association has established and determined their problems as followed:

- Lack of proper buildings
- Lack of finance
- Lack of modern medical equipment
- Health insurance system underdevelopment
- Insufficient postgraduate trainings and programs
- Insufficient information on private sector based management, financial management, human resource development, health and medical services

The Health Sector Development Program with the ADB support has set aim to improve PHC quality and accessibility and reforming health sector since 1998 within the MOH.
In the framework of this program have established new cooperatives of family doctors which have loan repayment budgets for the PHC service until 2002. Currently, 4 UB districts, 3 aimags have established cooperatives and in 2001

will cover 9 aimags, Bayangol and Sukhbaatar Districts. By the 2002 there would be 240 family doctor cooperatives. One cooperative has to conduct service for a population of 4800 with 3-4 nurses and doctors. These cooperatives have received finance from the state/local/ budget based on per capita expenditure and further they would have finance from the health insurance fund.

3.3. Financing of the Health Sector

Since 1924 to 1994 financing of health sector was exclusively from the government budget. The Ministry of Health was responsible for the allocation of resources and based on the norms, and existing infrastructure. During the last decade, two changes took place in Health Sector Reform.

The first change was the implementation of decentralization since 1993. The second change was the introduction of the Health Insurance System /HIS/

The Ministry of Health followed Government directives on Decentralization and gave local Governors more authority to implement health services since 1991.

After these changes, the Health Sector in Mongolia is mainly funded by the following 2 sources: the Government budget and the Health Insurance Fund /HIF/.

To a small extent health activities are funded by raising revenues from health facilities and from patient contributions. Donor contributions are not officially added to the resources of the health sector, although they form an important source of finance.

The government responsible for funding outpatient facilities, emergency services, immunization, treatment of chronic infectious diseases, some mental diseases etc.

Government health financing is based on the contributions of the Ministry of Finance /MF/ to the decentralized cities, aimags, which have power to further, allocate to district and Soums.

Financing from the HIF is based on the contributions of the central SSIGO to the city and aimag branches, than to the district/ Soum units.

The HIF is responsible for funding the inpatient services, some selective outpatient services and 50% for necessary drugs. Consequently, more than 90% of expenditure of the HIF is related to the hospital treatment.

Until 1999, the HIF paid to health facilities retrospectively, for those services,

which are covered under the HI according to rates per bed-day established by the Ministry of Health for the different types of hospitals.

Since 1999, introduced within the HIF, prospective payment based on capitation rate.

(1) HEALTH EXPENDITURE

In the last decade the share of health has been nearly 4% of the GDP, and about 10% of the state budget. (Table 1) In the current 2001 year the share of health planned to be nearly 10,2% of the state budget, and around 3,9% of the GDP.

This comparatively high share of health expenditure in GDP shows the commitment of the government to improve the health status of the population. But given the high inflation rates and the small real GDP growth rates in these years, the real contribution to the health sector have decreased over the last years.

Table 1 Health expenditure and health care financing

Years	Health expenditure Mln.Tug	Distribution in %			Health expenditure	
		Government budget	HIF	Other	In % of budget	In % of GDP
1990	560,3	100,0	-	-	9,3	5,5
1991	1078,9	100,0	-	-	12,0	5,8
1992	1863,3	100,0	-	-	15,0	4,1
1993	6751,2	100,0	-	-	10,9	3,8
1994	11754,7	53,6	41,5	4,9	11,6	4,1
1995	16930,8	53,1	44,2	2,7	11,3	3,7
1996	26053,0	58,6	37,8	3,5	12,3	3.6
1997	26154,1	59,8	35,8	4,4	8,9	3,8
1998	32320,3	47,0	50,0	3,0	10,9	3,3
1999	32752,2				9,5	3,7*
	Source: NSO 1998,1999, 2000				Source: NSO 1998,1999, 2000	Source: HDR 2000 *calculated

Source:NSO 1998,1999, 2000

- % GDP
- % Government expenditure
- Trends
- Types of funding
- Proportion for curative/preventive.
- System of funding the Health Sector, including Decentralization.

Payment of facilities

	Central Budget	Local Budget	SSIGO	Out of pocket
Feldscher posts		●		
FGP's		●	○	
Soum hospitals outpatient		●		
Soum hospital inpatient			●	○
Aimag and district hospitals outpatient		●	○	
Aimag and district hospitals inpatient	○	●	●	○
Centrally funded hospitals and institutes outpatient	●			○
Centrally funded hospitals and institutes inpatient	●		●	○
Outpatient drugs			○	●
Private hospitals			○	●
Private outpatient				●

● = main funding

○ = some funding

Source : Axel Weber : Financial Information System for the Health Sector in Mongolia . Tacis, P22. Feb 2000.

(2) DECENTRALIZATION

This critical component of the development of the health sector has been defined " as changing relations within and between a variety of organizational structures/bodies, resulting in the transfer of authority to plan, make decisions or manage public functions from the national level to any organization or agency at the sub-national level."

Decentralization of Governance started in 1990 after democratic change in political system was not held synchronically with the management capacity building and lacking prior consideration of the following:

- Clear definition of roles and function to be delivered by the local Government
- Accountability and obligation issues and supervision issues even to whom local governments should be accountable /Human Development Report of Mongolia, 1997/
- No piecemeal approaches in delegation of authorities
- No assessment held for existed managerial capacity and plan and step by step activities towards capacity building
- Lack of standards and guidelines to be used by managers in their daily management work
- Training modules and courses for health managers are not being designed specifically to Mongolian situation. Short- term training courses which are less than one month of duration may lead to an unjustified decision making.

- Lack of access to information by local governments and health managers. It is double constrained by language barrier/
- Staff turnover is high especially for those holding power at local level due to frequent Government change in the past and
- Legislative environment for decentralized function are not supportive for the managers for example: regulations and decrees made by different governing bodies are in conflict.

(3) PLANS FOR PURSUING FUTURE DECENTRALIZATION POLICIES.

The ADB supported HSDP project was the fisrt comprehensive response to the decentralisation initiative undertaken by the government by the enactment of the Territorial Law. However there has been no plan for systematically developing the management competencies at the LG level within the health sector. The Tacis "Improving the Financial Management of the Health System in Mongolia" project along with the forthcoming decentralisation TA funded by the ADB and the next phase of the Tacis project leading to the development of A National Health Accounts framework are some next steps. Considerable inputs are required to strengthen LG capacity and the planning and budgeting capabilities of the aimag and soum health facilities and the department of health at the aimag level along with the scaling up of the financial management and information system and the planning and budgeting framework.

The Government's Management Development was adopted in 1993. The subsequent changes concentrated on modifying the system and structure of the government with an emphasis on streamlining, formulating the law on civil services and putting in place management tools such as the government's mission statement, public agency business plans, human resource policies, job descriptions etc. A controversial draft law on Public Sector Management and Finance reform that has yet to be approved by parliament and passed into law measures the progress made so far in this direction.

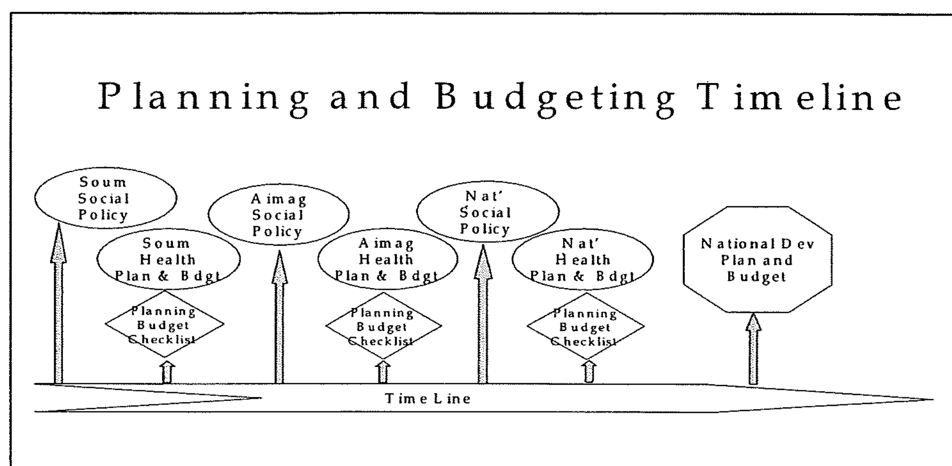
Although many NGO's have been established in the health sector (amounting to 102: Source Ministry of Law and Justice, 2001) most of them face financial difficulties and have limited capacity to implement programs and activities. The Government of Mongolia faces also difficulty to allocate funds to support NGOs form the Government budget and other resources, which is already insufficient to cover currently running health programs and activities. On the other hand NGO's professional capacity to deliver quality service and health programs is major issue.

3.4 Planning, management, regulation and legislation

(1) NATIONAL HEALTH PLANNING

Since the earlier centralized, health planning ended at the beginning of 1990s, no new regular long term or medium term national level planning mechanisms have been introduced. A comprehensive plan for national health development has not been developed. However, objectives and targets have been defined in specific health programs. No defined targets are available at aimag and soum levels. There also deficiencies in the co-ordination of health activities between ministries, agencies and local administrative entities. The roles and responsibilities of different levels are not clear.

The following chart is from the Tacis HSFP Presentation to the Aimag MoH Leadership Conference held in Ulaan Baatar 15-17 Feb 2001



There is a need to define roles and functions of MoH and to ensure that the central functions are fulfilled. Such functions performed by the MoH could include the following:

- Preparation of policies, strategies, priorities and guidelines to improve the effectiveness of the health system.
- To be able to implement the policy, the MoH should regain the political and financial authority to direct public health policy.
- Monitoring the overall system to ensure that desired outcomes are achieved, that particular groups or areas of the country are not being neglected, and that the health care rights set out in the Mongolian Constitution are being properly fulfilled.
- This implies that the MoH should be responsible for the monitoring of health expenditure at all levels.

- Quality assurance functions to protect the public from unqualified practitioners and unlicensed organizations, and to provide quality drugs and safe medical equipment.

Government actions to improve the health situation are reflected in the following national programmes:

1. National programme against AIDS, 1992-2001
2. National immunisation programme , 1993-2001
3. National programme against tuberculosis, 1994-2001
4. National programme against IDDs, 1996-1998
5. National programme against brucellosis, 1996-2001
6. Teenage health programme , 1997-2001
7. National programme against cancer , 1997-2001
8. National reproductive health programme , 1997-2001
9. Health education programme, 1998-2001
10. National programme on labour security and hygiene, 1997-2000
11. National programme on women's development, 1996-1999
12. National Youth programme , 1998-1999
13. National programme on children's development untill 2000 , 1997-2000
14. Elderly health progarmme, 1997-1999
15. National programme for prevention of cardiovascular diseases, 2000-2020

Implementation of national programmes has suffered from lack of resources both at the central and local levels.

The MoH has following priorities:

- Improve cost effectiveness and efficiency of MoH.
- Update health sector organization (structure/)and management capacity
- Support private health sector and achieve an appropriate and manageable public and private health sectors
- Provide equitable and accessible health and public health care to the population and assign capable human resources equitably.

Maternal Mortality Reduction Strategy 2001-2004

The primary goal of new MoH for the next planning period (2001-2004) is to reduce the maternal mortality rate.

Problems and difficulties encountered in reducing maternal mortality

- Poor advocacy, enforcement and monitoring of legislative acts and policy papers
- Insufficient support from decision makers in reproductive health and safe motherhood issues due to a lack of knowledge and information flow
- Predominance of curative subjects in the curricula of medical schools
- Insufficiency of mid-wives and OB/gyn's in rural Mongolia
- Lack of qualified and skilled medical personnel
- Incomplete model for maternal care package
- Insufficiency of necessary drug and medical equipment for maternal care
- Poor communication stance and isolated maternal wards
- Poor knowledge about pregnancy complications and dangers among women, families and communities

Goals:

- Reducing maternal mortality and morbidity through delivering accessible, high quality and guaranteed health care during pregnancy, pre and post natal periods
- Reducing maternal mortality, to 140 per 100,000 live births by 2004
- Decrease percentage of high risk pregnancy
- Delivery arrangements of high-risk pregnant women to be proceeded in the area with specialised Ob/gyns'.

Objectives:

- Involve aimag, soum and district governors, decision makers and policy makers and public in reproductive health training thus changing their attitudes and gaining support.
- Introduce and monitor customer oriented service at all levels of health care to improve the quality of comprehensive obstetric care package
- Develop a standard for mother and child comprehensive care package and introduce at all levels of obstetric care
- In association with media, organize advocacy activities for families and public on safe motherhood issues and more attention to be given to the vulnerable group of population who is not sufficiently involved in delivered services
- Encourage and expand NGOs and public participation in safe motherhood activities

- Review the current regulation of medical care for normal and high risk pregnant women and the registration arrangements of maternal mortality and enforce the outcome at all levels of health care
- Improve professional ability and skills of medical personnel and develop a salary and benefit mechanism to correspond the work performance
- Develop a guidance for referral service of early detection of complicated pregnancy at all levels of medical care

Strategy planning criteria for reducing maternal mortality and morbidity

	200 0	200 1	200 2	200 3	200 4
	Achievement of 8 objectives (in per cent)				
Pregnant women with associated diseases	33.1	30.0	28.0	25.0	22.0
From above: Pregnant women with anaemia	40.0	35.0	30.0	25.0	20.0
Prenatal care	96.0	36.5	97.0	97.5	98.0
Early prenatal care	63.0	64.0	66.0	68.0	70.0
Home delivery	6.0	5.5	5.0	4.5	4.0
Maternal mortality (per 100 000 live births)	158	155	150	145	140
High risk mothers	45.0	40.0	35.0	33.0	30.0

The MoH has, in addition to its planning function, a regulatory function in regard to health related matters. This is concentrated mainly on elaboration and inspection of standards for environmental health, drugs and medical treatments. These functions are responsibilities of new re-organized State Inspection Agency of Health (by merging Inspection Agency for Hygiene & Epidemiology and State Inspection of Drugs & Biopreparations & Quality Assurance) with branch offices in all aimags.

This agency consists of:

- Department of inspection for Hygiene and Epidemiology
- Department of inspection for Drugs and Biopreparations
- Department of Quality Assurance

Substantial increases in the resources allocated to health care not available in the near future. Therefore the available resources need to be used carefully, and there is need for reallocation of financial and technical resources within the health sector. There is a surplus of physicians in UB, but in some rural areas the population is under served. Better methods of allocation and greater operational and technical efficiency could have positive impact on development of health status. To assist health planning, working mechanisms for prioritizing and health technology assessment need to be further developed.

(2) LEGISLATION AND REGULATIONS.

A compulsory health insurance system was introduced in 1993 and a package of health legislation that include the Health Law, the Sanitation Law and the Drug Law. The Health Law defines the system of health organizations and working principles, and the obligations of state organizations, economic entities and health workers. Other important health laws include.

- Law on the Fighting Against Tobacco Hazards, 1993
- Law on the fight Against Alcoholism,1994
- Law on HIV/AIDS prevention, 1993
- Law on Food, 1995
- Law on Air Pollution control, 1995
- Law on Water Pollution control, 1995
- Law on Donors, 2000
- Law on Mental Health, 2000
- Law on Vaccination, 2000

Both the State Great Khural of Mongolia and the Government have passed numerous resolutions for the improvement of health and health services.

In addition, the Government had approved "Programme for Contracting-out of Health Care Services" in May 2000. The eventual aim of this programme is to improve the quality and accessibility of medical services and to improve the economic effectiveness of the sector by increasing the involvement of non-governmental and private institutions in contracting-out health care services.

3.5 Regulatory Environment

TECHNOLOGY & EQUIPMENT

MOH reviewed the equipment inventories in hospitals in 1996 and found that 1/3 of soum hospitals lacked primary and basic level laboratory equipment, 80% had no X-ray units and 1/3 lacked basic transportation. There is no central procurement agency for equipment, and only very small central budget exists for new equipment. Until now there are no standard specifications for medical equipment.

In 2001 the MoH has planned following activities to improve health sector