technical equipment.

- To develop and proceed on National Program for Health technology within the government program
- Prepared a list of 141 kinds of basic health and medical treatment equipment required for 7 aimags for procurement with the assistance of the Japanese Government.

Also included are intensive and emergency care equipment for Diagnostic and Treatment Centers of Hovd, Dornod and Ovurkhangai aimags. Medical equipments for hospitals of Dornogobi, Bayan-Ulgii, Bulgan, and Gobi-Altai aimags.

MoH will provide 10 vehicles (Japanese jeep) in UB while in the in aimags vehicles will be provided through the assistance of the Japanese Government

GTZ Reproductive Health project will also provide technical assistance on drugs, and equipment for the Maternal and Child Health as follows:

- Doppler fetal heart detectors (20)
- Forceps (uterine double curve)
- Methylergometrine in various dosage forms

MoH has prepared 13 priority projects for further developing the health sector. The focus of these projects is on specialized problems of health technology and equipment and will be discussed at the donor roundtable this year. Projects that address the critical policy priorities with regards to the rationalisation of the health sector, the development of the health systems, the scaling up of the financial management system and the development of the National Health Accounts.

Surprisingly however, programmes and initiatives, pertaining to the shift towards preventative orientation and primary health care and towards the integration of primary health care activities were not included in this round despite the emphasis in the health policies.

(1) SOUM HOSPITAL STANDARDS

Standards for Soum Hospitals were approved by the Minister of Health in February 2001 and should become effective from 1 March 2001. This suggest that the whole area of strengthening the quality of the health care services at the soum level will require medium to long-term support. The standards include:

1. Defining the Aim

2. Determining the target group or coverage
3. Justification for the existence of the soum hospital
4. Designation of the hospital based on the above:
    4.1. Soum hospital determination
    4.2. Inter-soum hospital determination
5. Classification
6. Administration and organization
    6.1. Structure
    6.2. Administration structure
    6.3. Bed number (inpatient service number)
    6.4. Business plan for 1 year
    6.5. Action plan
    6.6. Medical service quality
    6.7. Disinfection and work (labor) safety
    6.8. Motivation and evaluation of workers
    6.9. Financing and resource allocation
7. Finance and budget
    7.1. Government approved standard expenditure for health
    7.2. Financial contract
    7.3. PHC expenditure up to 40%
    7.4. Emergency services provision
    7.5. Capital Repair expenditure
    7.6. Food and diet cost
    7.7. Laundry cost
    7.8. Accounting and financial management
8. Job description (detailed)
9. Reporting and channels of communication
10. Medical service quality
    10.1. Standards for reception procedures
    10.2. Recording disease history
    10.3. Combined (complete) examination of doctors
    10.4. Standards, protocols and common procedures for diagnosis and treatment
    10.5. Referral guidelines and procedures
    10.6. Outpatient service
    10.7. Follow up and outreach after out and inpatient service
    10.8. Reproductive health care service

10.9. Surveillance and monitoring of children in the age group 0-15 yrs
10.10. Immunization
10.11. Health volunteer training and supervision
10.12. Communicable disease prevention and detection
10.13. TB control and treatment
10.14. Communicable disease treatment and diagnosis
10.15. Cancer program
10.16. Surgical care
10.17. Primary ophthalmologic medical care and preventive ophthalmology
10.18. Primary Dental services
10.19. Drug treatment for psychological disorder
10.20. Essential drug list
10.21. Essential diagnostic test list for soum hospital
10.22. Inter-soum hospital lab test list
10.23. X ray

11. Environmental health requirements (detailed)
12. Hygiene and sanitation requirements (detailed)
13. Medical equipment supply
14. Occupational safety requirements
15. Paramedical service

Development of **standards for aimag, district hospitals, specialised centers and state clinics** are in the process of being finalised and will be approved within the next six months.

(2) STANDARDS OF COMMON PROCEDURES OF TREATMENTS & DIAGNOSTICS

Since 15 January 1999 standards, protocols and common procedures for treatments & diagnostics for health and medical organizations for the following groups of medical services (see below) have become operational. The Council of National Standards and Measurements Center had approved these in 1998. All health and medical facilities within the health law environment have to follow these standards.

There are seven groups of standards:

- Standards for general common procedures
- Standards for internal, neurological, surgical procedures
- Standards for obstetric and gynecological procedures
- Standards for trauma procedures

- Standards for ophthalmologic procedures
- Standards for throat, ear, nose procedures
- Standards for dental service

Inspectors for service and treatment quality, administration of departments, hospitals, and health facilities will be assigned to monitor and enforce these above-mentioned standards.

However, since these standards are new and have not been tested, their efficacy cannot be determined, and their usefulness in addressing Mongolia's need cannot be assessed because, not enough baseline data. In addition, standards for each health infrastructure level have not been developed so far.

(3) INSURANCE FUND AND FINANCING MECHANISMS.

The management of the Social Insurance program is the responsibility of the state Social Insurance General Office (SSIGO). Health Insurance is not separated from the other branches of social insurance. The SSIGO has 30 branches in 21 aimags and districts in Ulaan Baatar.

Under the Ministry of Health working Health Insurance Council (HISC) as a policy making and oversight body for overseeing the performance of the Health Insurance Fund. The HISC has the authority to supervise the utilization and spending from the fund, to make proposals and recommendations on issues related to Health Insurance, and to set standards and fees. At the aimag level the Sub-councils are involved in allocating health insurance funds to the providers.

Payments to providers were retrospective during 1994-1998. The hospital treatments were reimbursed retrospectively to hospitals according to rates per bed days. Since 1999, has introduced prospective and population adjusted geographical allocation of HIF.

According to the Budget Law, the budget of Mongolia comprises of two parts: the central budget and the local budget. The Ministry of Finance and Economy has the authority to regulate and allocate the government budget. The Ministry of Health and tertiary level health institutions are included in the general budget. Hospitals and health institutions in the cities/aimags and districts/soums are under the budget authority of the respective governors.

(4) PHARMACEUTICALS:

Mongolia has implemented a National Drug Policy based on the WHO essential drug

policy for the last 10 years. Mongolian law about drugs states that the National Drug Policy will direct the adoption of appropriate drug use and provide accessible, sustainable and equal provisions through active, quality assured and registered drugs in the state registry for health, veterinary organizations and for the general populations.

Conferences, related to drug law and policy, have been held three times where the priority issues were discussed and recommendations for revision and improvements were made. To implement this drug policy framework, a drug-control agency was established and legislative documents followed. The essential drug project has been supported by WHO. In the project framework, WHO has been promoting the development of acceptable quality drug laboratories and providing rational drug use education for the specialists.

Due to the increasing demand for drugs, importation has increased. With the increased importation of drugs their quality has decreased. Despite government activities the quality and accessibility of drugs is still a problem. In Ulaan Baatar and the other cities, there are many private drug suppliers; packaging factories and pharmacy stores but are very few in the countryside. This is due to lack of suppliers in the countryside thus adversely affecting the availability of drugs. Lack of availability and accessibility of drugs result from poorly integrated management, supply and pricing systems.

Insufficient knowledge about rational drug in the medical profession and the lack of drug management and controls allows people to use drugs without prescription and incorrectly.

Before 1990, the medical and related equipment and their repair were provided completely by the state. During the transition to the market economy provisions by the state have decreased dramatically, therefore supplies and repair of equipment is insufficient. Due to the poor service inadequate implementation of health policies, repair and management of equipment has been adversely impacted resulting in approximately 80% of equipment currently being used as not reliable and outmoded.

Based on the above information and mentioned issues, an integrated policy on medical equipment will be need to be developed in 2001.

Revolving Drug Fund

The Community – Health project is being implemented by the Ministry of Health of Mongolia in cooperation with UNICEF. It has been implemented, since 1994, with the financial support of the " Nippon Foundation " of Japan. Since June 1995, the Community – Health project has implemented one promising pilot for the improvement of drug supply to communities at the soum level. This is called the Revolving Drug Fund (RDF) initiated by UNICEF.

The aim of this project is to increase drug supply and sufficiency at the soum and bag level and to involve individuals, community and institutions through a RDF committee so as to establish required financial basis for the operation of the RDF and to work regularly and to coordinate activities.

The objectives of the RDF are the following:

1. Supply essential, quality and inexpensive drugs in accordance with the WHO and MoH approved essential drug list for the appropriate level.
2. Decide with community participation health related problems.
3. Teach health promotion methods to people about their health.
4. To fully use the opportunities and resources
5. Protect patient's and consumer's interest.
6. Foster rational drug use.

Presently, the RDF is implemented in 99 soums of 6 different aimags which are Arkhangai, Uvurkhangai, Bulgan, Dorno-Gobi, Khentii and Dund-Gobi through sponsorship of the " Nippon Foundation " from Japan. This year the RDF will be organized in all soums of Sukh-Bataar and Khuvsgul aimags. Further, the Ministry of Health is planning to organize RDFs in 4 additional aimags, namely Zavkhan, Omno-Gobi, Bayankhongor and Hovd with the support of the " Human Security Trust Fund " of Japan.

The core elements of the RDF are as follows:

1. a seed stock of drugs is given to the soum only once.
2. a RDF is established from the money from the sale of these drugs.
3. the exchange of drugs and money received and spent is monitored at the national level.
4. a replenishment cycle for new drugs established, taking into consideration the costs for purchasing the new drugs and maintaining the RDF.

Difficulties with the RDF:

- Constantly increase in debt because Health Insurance financing of soum hospitals does not come on time and is often directed for other costs
- Differences of costs in giving prescription by 50 per cent discount for the customers being served at the polyclinics, as they do not get reimbursed from the Citizens Health Insurance Fund.
- Unsatisfactory understanding about the RDF regarding its purpose and operations in a number of areas.
- Could not set up definite control mechanisms resulting in incomplete or poor understanding and operation, activities and services of the RDF.

Further suggestions and comments

- Improve information dissemination about RDF
- Provide handouts for the soum councils who are implementing drug revolving fund
- Involve soum governor, insurance and bank officers into revolving drug fund activities
- Warn and advise on the proper and rational use of drugs
- Warn to improve benefits and increase of the drug revolving fund raising
- Improve essential drug supply at the soum level

(5) PARAMEDICAL RENT

The Government has approved paramedical rent in 22 May 2000.

To improve quality, effectiveness and accessibility of health care services should expand the involvement and role of NGOs and private sectors. The hospital administration will contract out certain to business entities and individual citizen and expect a certain percentage of the profits. The business entity or individual citizen will be responsible for providing qualitative services meeting the standard requirements and the hospital administration will account before the Ministry and the local Government foe the ultimate outcomes of the contracted services.

Services to be contracted are:

- Laboratory tests
- Screening
- Laundry

- Cleaning
- Kitchen
- Disinfection

(6) PUBLIC HEALTH SECTOR DEPARTMENTS

National Center for Health Development

Brief introduction and activities

Good human resource capacity is essential for the operation and development of the health sector contributing to national development. The National Center For Health Development was established in 1996. Since its establishment, it has collaborated with national and international NGO and governmental organizations to advance health programs and policies at the national and regional levels.

The NCHD has six departments:

- Health Management Department
- Health Promotion Department
- Licensing & Accrediting Department
- Postgraduate Training Department
- Department of Administration & Service

Health promotion department

The department is in charge of:

- Health Education and Promotion researches for the policy makers
- Health Promotion, Educational Programs, & Media campaigns for the population

The "ESS-TV" studio is one unit of this department and distribute health programs and information through out the country

Vision: to develop activities to support public health education to ensure governmental and non-governmental organizations with highly educated professional staff, to provide population by information about health, conduct researches on changing behavior, improve methods of realization IEC programs.

Mission: to promote health development through improved health education of the population, and disseminate correct, appropriate information about health of population using by mass media in health information and communication.

Activities:

- Upgrade methodology and the quality of health education for the education of the general population.
- Improve methods of carrying out IEC program among adolescents and teenagers.
- Conduct IEC activities in the areas Reproductive Health and HIV/AIDS prevention and implement policies in the areas of human development, family planning, and gender.
- Conduct IEC activities among elderly people, disseminate information about health, and conduct surveys.
- Conduct IEC programs among the general population on issues of protection from accidents and negative environmental factors and evaluate the implementation through use of controls.
- Conduct IEC activities on mental health issues (drug abuse, violence) in the population.
- Develop methods of carrying out the educational program of appropriate nutritional system and hygiene.
- Conduct IEC activities on issues of communicable, non-communicable diseases and fitness evaluate the implementation and organize surveys.
- Behavior change communication and IEC activities by using Mass Media for the whole population provide monitoring of IEC methods.
- Ensure activities support of health promotion management; conduct activities, which described in the resolutions of Mongolian Government and Ministry of Health.
- Registration and licensure of personnel
- Control over supply and training of health personnel
- Control over financing mechanisms such as hospital budgets, payment rates, levels of income, etc.

3.6 Donor Coordination in medium to long-term planning

A number of initiatives are currently underway for the development of the health sector: ADB HSDP, Tacis HSFP, ADB Decentralization TA, GTZ Reproductive Health Project, UNFPA activities, HIV/AIDS control, etc. Coordination and integration are major concerns as the capacity for planning and coordination is weak and what exists is ineffectual when contrasted with the enormous influence wielded by the donors, both bilateral and multilateral.

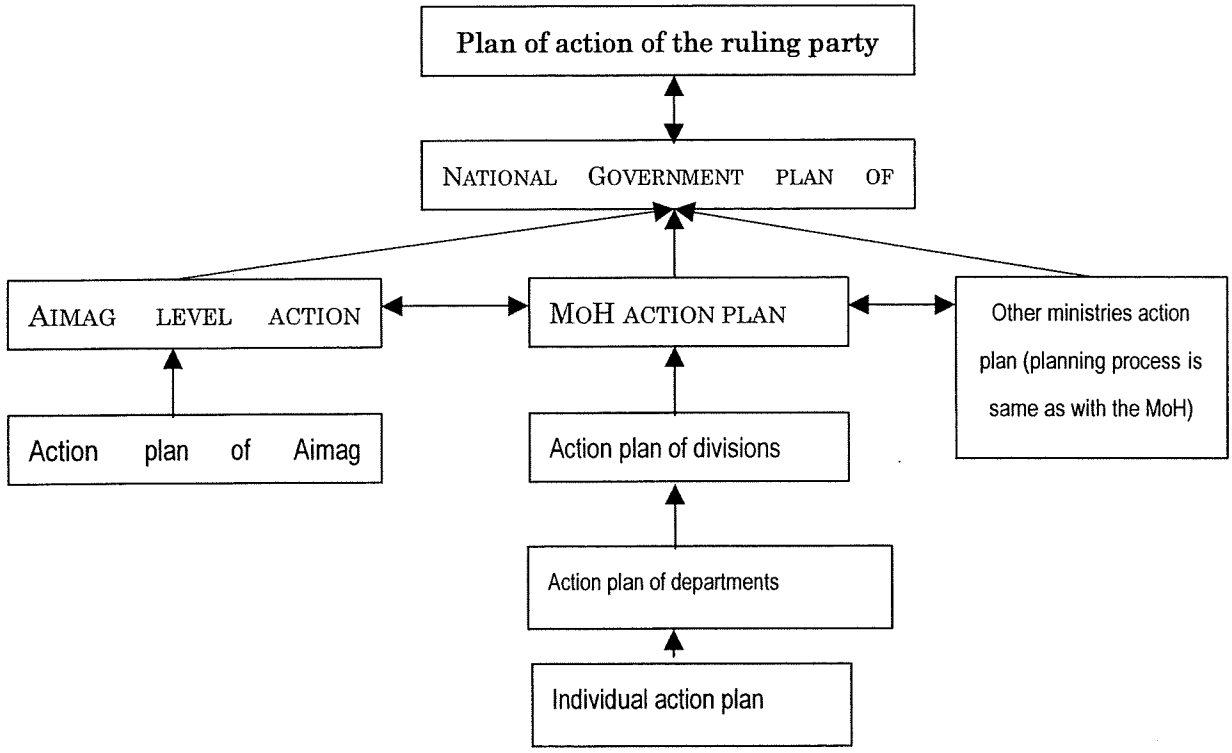
The capacity to negotiate with the donors regarding support for projects that are in keeping with the overall development of the health sector is severely limited because of a **lack of a sector wide master plan**. Instead, the MoH often finds itself effectively steered into a piecemeal development approach. However, there exists a government action plan, which is in a sense goal a number of statements formulated by the new government developed as part of election manifesto. These action plan elements describe the desired state of affairs and direction, but by themselves, do not contribute to developing capacity, referred to earlier. This capacity is crucial for facilitating and strengthening planning and policy development which in turn becomes the basis for negotiation with donors for an integrated approach to development of the health sector over the medium to long-term.

- Citizens' participation in the planning and/or management of the statutory health system.

The participation of the citizens is through their elected representatives at the national and provincial khurals. However there is little o no participation in the operations (planning and management) of the health facilities. The previous government has mandated the formation of Hospital Management Boards but the operationalisation of the responsibilities of these boards is still awaited.

There is no patients' charter and the consumer of the health services does not have any clearly defined or systematic channels to make their concerns, preferences and grievances known to the system. This could be legacy of the centralized, prescriptive, highly specialized curative oriented health care delivery system that operated on the perception of the providers rather the community they were trained to serve.

3.7 Planning Framework of the Government and the MoH.



GOVT ACTION PLAN

- Increase of health expenditure in the government budget on annual basis
- Revise and renew the package of health services covered by health insurance and provide free of charge preventive, diagnostic laboratory services in public hospitals, and develop independent health insurance system
- Transfer to the basic health service system through family clinics and soum hospitals financed by capitation payment scheme
- Establish "Immunization Found" to decrease VIDs /vaccine preventable diseases/ step by step leading to their full elimination.
- Free medical service to the vulnerable group of the population including elderly, families with many children, children under 16 years old, and disabled
- Implement program to protect child and maternal health and reduce their mortality
- Improve supply of essential drugs and strengthening quality assurance within the drug policy
- Develop and implement National Program "Health technology"
- Establish Diagnostic and Treatment Centers in the economic development

regions with modern equipment and specialized doctors

- Renovation of car park up to 40% of soums and 60 % in capital city respectively.
- Develop sum hospital development program, improving accessibility and quality of health services for the rural population through providing incentives for rural doctors, ensuring conditions for their professional development and provision of appropriate premises and equipment.
- Encourage and accreditation of private health organizations and expand their financing framework by health insurance
- Assure the quality of health services through strengthening the licensing and accreditation system of medical institutions

AIMAG-LEVEL ACTION PLAN

- Aimag governor offices are in charge of developing Aimag level action plan. More specifically, aimag governor office functions with a departmental structure where each department formulates its own plan and they are integrated as aimag level plan. Although each soum develops its own action plan, it is not integrated to make aimag level action plan.

SECTOR/LINE MINISTRY ACTION PLAN

- Action plans of other line ministries are developed in a similar manner as of the Ministry of Health. All policy officers are required to draft their annual plan of action according to their responsible areas or sectors, which shape departmental plans. Action plan of all departments then developed into action plan of divisions that is further integrated as a Ministry action plan.

- **Input/timing and support to Health Sector Action Plan**
  - As mentioned above, health sector action plan is developed at the Ministry of Health and designed to meet the Social objectives of the Government of Mongolia Plan of action. Aimag level action plan also aims to contribute to the Government Plan of Action.
- **Integration at all levels**
  - However, plans of action that are developed to meet Government Action Plan there is a lack of conjunction and integration between the administrative levels.

4 Over-arching principles and objectives of the study

4.1 OVER-ARCHING PRINCIPLES

- *Consistency between the various legislation and policies to support development of the primary health care approach*

  There is an urgent need to review and analyse the various legislation and policies to determine areas of conflict between legislation and policies in clinical, management, procurement, health manpower, health technology, occupational health, pharmaceuticals and other health related areas.

- *Promoting integration of primary health care activities and programmes*

  Every effort, conceptual and operational, must be made to integrate the various PHC initiatives so that PHC does not become another vertical programme and is well integrated within the other aspects of the health care delivery system. One key element in promoting such integration is the development of an overall health master plan to guide and coordinate national and donor inputs into the development of the health sector.

- *Emphasis on disease prevention and the promotion of wellness*

  This principle guides the development of process that will ensure that in an over specialised health care delivery system, integration of the prevention of disease and promotion of wellness will begin with the training of the health practitioners and through in-service training and continuing education and thr development and implementation of programmes within the curative care delivery system

- *Promote citizen involvement and participation of other stakeholders*

  Participation of the community through a variety of mechanisms is crucial to generate a sense of ownership and commitment to the operation and management of health care activities at the community level. The family and various community level agents provide so much of the health care before the patient makes contact with the forma health care delivery system.

- *Shift from Curative to Preventive orientation*

  This principle highlights the importance of identifying and promoting mechanisms and the use of incentives within the medical profession that will reorient health professionals towards prevention and health promotion.

- *Close collaboration with the international donor community and NGOs*

  The identification of processes and mechanisms for coordinating and guiding donor inputs and the focusing and developing the capacity of the local and

international NGOs to address and cater for the needs of difficult to reach vulnerable groups should be given high priority in the development and implementation of polices and plans for developing the health sector

- *Employ both grass-roots and top down planning approaches*

  Systematic review and examination of a variety of pilots and approaches that have been implemented within the country should be done to clarify the underlying process to determine the cross cutting issues that need to be addressed to enhance the adoption of grass-roots approaches in synchronisation with alternative forms of planning already practiced in the public health sector.

- *Flexibility*

  A system of monitoring and evaluation with carefully selected indicators that would be useful at the operational level will make it possible for health facilities and agencies top be able to respond to community needs and the changing epidemiological and health care delivery context.

- *Inclusion of parliamentarians in the MoH Planning Framework*

  As much of the legislation being reviewed and developed devolves upon the parliamentarians, mechanisms to obtain and engender their participation in the policy development and review framework becomes a critical activity especially in the development of a long-term Health Master Plan.

4.2 OBJECTIVES FOR THE DEVELOPMENT OF THE HEALTH MASTER PLAN PROJECT;

1. *Carry out a detailed review of the health sector using the checklist provided.*
2. *Establish a strategic planning framework in the MoH.*
3. *Establish a donor coordination mechanism to facilitate donor inputs into the planning process.*
4. *Develop appropriate planning and monitoring instruments*
5. *Develop a Health Master Plan for Mongolia.*
6. *Develop a list of projects for the short, medium and long term.*
7. *Develop capacity in the health sector for planning in terms of human resources, research, sector management and planning skills.*
8. *Establish and institutionalize mechanisms for periodic consultative meetings for policy development and strategic planning involving all stakeholders in and outside of the health sector using the process of elaborating the Health Master Plan.*

4.3 SUMMARY OF SITUATION ANALYSIS AND IDENTIFICATION OF THE PRIORITY AREAS AND NEEDS

Geography and Climate

Mongolia, located in the Central Asian steppes, is land-locked by two other big countries - Russia and China. It has a population of 2.4 million occupying 1.56 million square kilometres. Mongolia is one of the most *sparsely populated* countries in the world with a population density of 1.4 persons per square kilometre. With *a weak infrastructure*, this implies *large transport and communication costs*, and does not facilitate the provision of basic and emergency health services to the population. Mongolia is *highly urbanised* - about 30 percent of the population lives in Ulaan Baatar, and 27 per cent of the population lives in the three other cities and in the central towns of the 18 provinces (aimags). The rest of the population lives in rural areas: 20 per- cent in small towns of 324 rural districts (soums) and 28 percent as semi-nomadic herders or in scattered settlements as farmers. The *climate is of a severe continental type* with temperatures ranging from +30°C to -30°C.

Politics and Economics

Mongolia has made important progress since 1990 in consolidating its democratic institutions. In 1992, Mongolia adopted a new Constitution guaranteeing human rights and the ownership of land and other property. The parliamentary election in 1996 resulted in a victory for the Democratic Union Coalition (DCU).

Eight years have passed since Mongolia began the transition from a centrally planned economy to a market oriented economy. The disintegration of the USSR and of the socialist trading system threw the Mongolian economy into crisis. The *huge macroeconomic contraction* and the major dislocations in the economy have given way to positive growth rates since 1994. The market liberalisation and the legislative improvements have led to a rise in the private sector share of value added in the economy between 1990-1998. The Mongolian *economy is vulnerable to external fluctuations* because of a still very narrow trade base, *dependency on natural resources*, and limited foreign investments.

The goal of the Government of Mongolia is to intensify the economic structural reforms, to consolidate the stabilisation at the macro-economic level, to facilitate the revival of national production through the increase of investment and to provide certain

guarantees in living standards.

Health Indicators

The *infant mortality rate (IMR) was 35 per 1,000 live births in 1998* showing an impressive improvement in spite of the transitional process in comparison to its mean of 71.0 for 1985-1989. Nevertheless, countries with comparable health expenditure per capita such as Sri Lanka have a significantly lower IMR (15/1,000). *Respiratory infections, diarrhoea, and malnutrition are the major causes of death in infancy.*

Maternal mortality is of great concern to health officials and the public in Mongolia, especially because it *increased* to 212 deaths per 100,000 live births in 1994 from an average of around 114 per year for the period of 1985-1989. The transitional problems responsible for *dramatic shortages of medical supplies, severe transport problems, poor communication*, socio-economic hardship, climatic conditions and *inefficient use of health services* contributed to this increase. *Poor quality of care* by doctors at secondary referral level, and a *lack of modern knowledge and training* are additional factors.

Mongolian *life expectancy at birth has dropped to 57 years* in 1997 (mean for 1985-1989: 61.0) and is lower compared to China - 71, Sri Lanka - 72, and Albania - 72 years (Population Reference Bureau, 1998). This is a poor outcome, taking into consideration the coverage indicators such as the number of hospital beds and doctors. Major contributing factors to the low life expectancy are the *high under five mortality rate, severe socio-economic hardship*, and *insufficient utilisation of health services*. In this context, a shift to accessible quality primary health care is important.

The country's health statistics show a *transitional epidemiological profile*. Respiratory infections and diarrhoea diseases are responsible for 60-70% of the children under five mortality. Infectious diseases, such as neonatal tetanus, polio and diphtheria have almost disappeared due to a successful immunisation program.

The most common causes of mortality reported in 1997 by the Ministry of Health were (order in regard to incidence):

1. Vascular diseases
2. Cancer
3. Respiratory diseases
4. Injuries and poisoning

5. Gastro-intestinal diseases
6. Infectious diseases,
7. Perinatal causes.

The four most common causes of morbidity in 1997 were (as percent of the total):

1. respiratory diseases: 24.5%
2. gastro-intestinal diseases: 15.0%
3. genito-urinary diseases: 8.2%
4. injuries and poisoning: 6.1%

The following table shows Potential Years of Life Lost (PYLL) for the most common diseases in Mongolia. PYLL is particularly high for respiratory diseases, as most deaths occur within the age group of 0-5 years. The equally high PYLL for gastro-intestinal diseases reflects the important mortality rate of small children due to diarrhoea diseases.

Table 1: Potential years of life lost by commonly occurring diseases

Number	Disease Classification	PYLL	% in total
1	Respiratory diseases	54010	21.2
2	Trauma and poisoning	46805	18.4
3	Cardiovascular diseases	32370	12.7
4	Gastro-intestinal diseases	28373	11.1
5	Cancer	27778	10.9

Source: MoH, Mongolia

Unhealthy life styles, including behavioural patterns like consumption of *alcohol, tobacco, poor nutrition, sedentary way of life*, are becoming increasingly important risk factors.

Current Organisation of Health Care[3]

The health sector in Mongolia followed the Soviet model and provided universal access to health services, which were delivered free of charge. Main characteristics of such a health system a were:

- extensive reach and access to services

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18 Adapted from "Mongolia, Health Sector Review", June 1999, Government of Mongolia and WHO, Mongolia

- hospital-based services,
- full government financing and inflexible central planning,
- top-down management with no local involvement in decision making,
- high coverage indicators: high supply of doctors, nurses and hospital beds,
- low cost-effectiveness,
- insufficient quality of services, unsatisfactory health outcomes,
- overspecialisation of doctors and compartmentalisation of labour, shortage of general practitioners,
- inadequately developed primary health care system,
- inadequate health promotion and disease prevention activities.

Ministry of Health and Social Welfare

The main strategic objective of the Ministry of Health is "To provide timely advice and service for strategic planning and provision of policy guidance on issues related to population policy, health, labour, and social welfare policy".

The Ministry of Health includes four departments, the main functions being policy formulation, planning and monitoring/evaluation. The provider function is being decentralised to the local government level. In 1997, the government undertook a massive organisational restructuring exercise, which produced a general model of business strategy and organisational structure reform of the Ministry of Health and Social Welfare. Following the general election the MoH&SW was split into the MoH and the Ministry of Labour and Welfare. Then the MoH was again reorganised as follows:

- Dept of Public Administration
- Dept of Strategic Planning and Management
- Dept of Policy Coordination
- Dept of Evaluation and Monitoring

The MoH *has regulatory and policy responsibility* over the development of the health sector and the implementation of its programmes and activities. This responsibility extends to *determining the competence and duties of government, persons and business organisations on matters of health protection*. Policy and regulatory powers of the MoH have been quite broad, covering the activities of all central and local authorities.

Since decentralisation, the MoH has shifted its role towards *development of national health policy* and *associated training* and *management initiatives*. It also maintains an important role in *liaison with international agencies*. In financial matters, the MoH

reviews and proposes the tariff schedule of the Health Insurance Law to the Ministry of Finance and *reviews and approves major contracts on services* and supplies to the health sector.

In October 1997 MoH&SW established the *Health Management, Information and Education Centre (HMIEC)* to assist the Ministry in creating an efficient health care management system. HMIEC, now called the National Centre for Heath Development (NCHD) consists of five teams working together to ensure that through education and training the local health officials will get the necessary skills, which they need, in their work. These teams are on 1) research and training, 2) health education, 3) licensing and registration of personnel, 4) health statistics and 5) Publicity and Information (TV) Team. (See more details above)

Health Institutions

National Health Centres, Institutes and Specialised Hospitals

Health institutions of Mongolia can be grouped structurally into four categories as follows:

- MoH and institutions subordinated directly to it form the central health institutions with the aim of development and implementation of the health policy of the country, elaboration of standards and technical guidelines to be followed in all health related matters, as well as co-ordination and regulation of all activities in regard to the health of the population.
- Local health institutions intended to deliver actual health services to most of the population. These are subordinate to the local (city, province and district) governors.
- Special health institutions subordinated administratively to some other line ministries, like Ministries of Defence, Education and Justice, or to some independent (mostly joint venture) corporation like "Ulaanbaatar Railway" Mongolia-Russian Corporation, and "Erdenet" Mongolian-Russian Copper-Molybdenum Corporation.
- Private health institutions

The following institutions are administratively and financially under the Ministry of Health and Social Welfare:

First General Clinical Hospital
Second General Clinical Hospital
Third General Clinical Hospital

Specialised Clinical Centres in Ulaan Baatar, namely

- Oncological Centre
- Tuberculosis Centre
- Centre for Mental Health
- Centre for Dermatology and STDs
- Centre for Infectious Diseases
- Mother and Child Health Centre
- General Traumatological Centre
- General Traumatological Hospital
- National Centre for Health Development
- The Traditional Medicine Science, Technology and Production Corporation of Mongolia
- Children's Hospital
- Centre for Prosthetic and Orthopaedic Services
- General Hospital of Infectious Diseases
- Centre for Psychological Disorders and Narcosis
- Resort "Orgil" Sanatorium
- Haematological Centre
- Tuberculosis Research Centre
- Inspection and Prevention Centre for Quarantine Diseases
- Centre of Pathology and Forensic Medicine

The following organisations are under the Government of Mongolia and are administratively subordinate to the MoH&SW (but financed from the central budget and not from MoH&SW):

- Inspection Agency for Hygiene and Epidemiology
- State Inspection Agency of Drugs, Bio-preparations and Quality Assurance
- Employment Regulatory Office
- Social Welfare Office
- Labour and Social Welfare Inspection
- State Health Insurance General Office
- National Sports Centre
- Medical Research Institute
- Institute for Postgraduate Training
- Centre for Nutritional Research

The following organisations come under the local government budget of City of Ulaan