Baatar, but administratively they are subordinate to the MoH&SW:

- District Public Health Centres
- District Hospitals
- Obstetrics Hospitals and Maternity Houses

The following organisations are self-financing, but administratively they are subordinated to the MoH&SW:

- Mongolemimpex Co.
- Medicaltechnik Co.
- State Drug Factory
- Garage for Health Service Cars
- Printing House

The aimag Departments of Health (DoH) are responsible for the organisation of public health activities, including health and morbidity surveys, monitoring and inspection of hygiene and epidemiology within the aimag, and delivery of PHC services to the aimag population.

Other health-related institutions and services

Government finances, in addition to health services under MoH, health services under other ministries. The Ministry of Defence has military hospitals, including a military hospital with 305 beds in UB. The Ministry of Interior has a security hospital with 380 beds in Ulaan Baatar. Government finances also operate the MoH&SW itself, as well as medical institutes (under the Ministry of Education) and research medical centres. The state owns the National Railway Company, which operates 5 hospitals (including a hospital in Ulaan Baatar with 271 beds) and a number of health posts for its employees and their families, who receive their services free of charge.

Health care services

Until the 1990s, the Mongolian health system was based on the Soviet model, with an emphasis on narrow medical specialisation and hospital-based services. Priority was given to the physical access of the population to health services.

The structure of service system

Health services are provided at four levels:

- Bag-feldsher (physician's assistant) posts in rural areas and family-doctor posts in aimag centres and cities

- The first referral level institutions are soum hospitals in rural areas and public health centres in aimag centres and cities. Each soum has at least one soum doctor and soum midwife.
- The second-level referral institutions are general hospitals in the aimag centres and the city districts. There are hospitals with at least 200 beds and a public health centre in each aimag.
- The third, or national, reference-level institutions of the health service are general and specialised medical and public-health centres in Ulaan Baatar.

Levels of health services in 1998:			
Level 1	Bag	Feldsher posts	875
Level 2	Soum	Soum hospitals	345
	Intersoum	Intersoum hospitals	0
Level 3	Aimag and city	Aimag and city hospitals	33
Level 4	Central	Specialised centres	11

Source: MoH&SW 1999

A number of changes have been implemented in the health sector since 1990. There has been ***a shift in priorities from curative to preventive health services and from hospital care to primary health care*** delivered by family doctors. During the period 1993 to 1997, the number of hospital beds decreased from 23,445 to 18,436; the number of hospitals decreased from 475 to 407; and the number of professional health workers decreased from 23281 to 20100 (-13.7%). A recent reorganisation or health services in Ulaan Baatar resulted in a bed-reduction of about 2000 beds from 11,267 (-18%).

In 1996 it was estimated that the number of hospital beds per 10,000 population was 2.94 at the soum level (primary care), 4.56 at the aimag/city level (secondary care) and 2.12 in Ulaan Baatar (tertiary level). As there were in addition 0.3 other or unclassified beds per 10,000 in Ulaan Baatar, the ***total number was 9.66 beds per 10,000 population.***

According to international expert evaluations, the ***system is still oversized regarding personnel and hospital buildings,*** especially in aimag centres and in Ulaanbaatar. Furthermore, in spite of recent changes, ***service delivery*** and training ***still rely too much on curative and specialist care.***

Rural health services

Low **population density**, severe **climate**, a very **long cold season**, poor **transportation** and **communication** and **inadequate infrastructure** has made delivery of health services

to rural populations difficult and complex.

In rural areas, primary-level health services are provided by soum hospitals and feldsher bag posts. Each soum is divided into 3-4 bags, each having 5 to 100 families. The bag centre is on average 20 to 80 kilometres from the soum centre. One *feldsher* is assigned to this centre, either working from a fixed post or travelling with the bag herders, depending on the season. The job of the feldsher is to make periodic rounds of all the families in the bag, especially those enrolled in preventive programmes, such as immunisation. The activities include providing simple curative care, helping to transport sick patients, routine preventive care and health education for families.

Feldshers usually have a horse, or less often a motorcycle for transportation. These were provided for in the past by the co-operatives, but now supplied by the soum hospitals. It continues to be difficult to render medical assistance to people far away from the soum centre because of poor roads, poor telecommunication, and often bad climatic conditions (see chapter 7.2.)

Feldshers also supervise the new *community health volunteers (CHV),* who have been organised in rural bags since 1995 (see 5.3.6). The health volunteers are expected to deliver first aid in some common diseases, to dispense essential drugs according to doctors' instructions, to take part in preventive maternal and child activities and family planning, and to promote healthy lifestyles. The volunteers attend a training, which lasts up to three weeks.

A typical *soum hospital* has up to three physicians, one for general internal medicine, one for paediatrics, and one for obstetrics. They are assisted by two to four Feldshers (one of whom may have received special training to serve as a midwife), three to four nurses, one pharmacist, an accountant and support personnel. Soum hospitals have 10 to 30 beds, a delivery room, and can provide services to an average of 2,500 people within a radius of 80 kilometres. These services include ambulatory diagnosis and treatment of common diseases, obstetric care and normal deliveries, transport to aimag centres for referral cases, inpatient treatment, health promotion, family planning, supervision of bag Feldshers, public health co-ordination and control for the whole soum, as well as hospitalisation for social reasons (for example, to give warm shelter in winter).

In the past, 32 of the soum hospitals were designated as *intersoum hospitals.* They

averaged 40-70 beds and included a dentist and surgeon on staff. They were intended to treat patients who had been referred from surrounding soums. Recently, the policy of the Ministry of Health has been to convert all intersoum hospitals into soum hospitals.

The *privatisation of health care* has also started in soum health services, where the first step is to make *management contracts* with private business or individuals without privatising the properties. At the beginning of 1999, 37 soum hospitals were in operation through management contracts, which are based on the order of the MoH&SW and the MoF in 1997. Management contracts between the contractor and the aimag mayor's office allow the contractor to rent the hospital rooms and other properties to others without disturbing the everyday activities in the hospital. If a hospital is profitable, it will pay one third of profit to the contractor, one-third to hospital workers and the rest will be spent for medical supply and equipment.

The government is in the process of restructuring local health services below the aimag level to *create first referral units (FRU) serving several soums.* The remaining soum hospitals would be downgraded to *health centres providing outpatient services*, with only a few beds for observation purposes. The first referral units will only be located between the soums and aimag centres, where the travel time between the two is too long for patients to reach the aimag centre in time in case of emergency. The need for first referral units (FRU) will thus depend on each aimag. *The first referral units would be staffed by general practitioners trained in emergency care.* The FRU will serve as a soum health centre for the people living in the soum in which it is located, and it will provide an additional service package for emergencies.

Any patient who cannot be treated at the soum level is to be referred to city health centres. Patients however tend to select their own level of care. In some cases, this leads to bypassing (patient does not enter the health service system at the most appropriate level but goes directly to a higher level without referral). *In practice, many patients bypass the relatively inexpensive and often poor quality primary services and make excessive demands on specialist services.* This problem is less acute in rural areas because of the physical distance to the referral level. The *referral system in primary health care requires development.* The new health care financing system has now built in certain incentives to control bypassing.

Rural development is an integral part in the *National Poverty Alleviation Programme*

(NPAP) and *follows a decentralised and participatory approach across sectors.* Its objective is to mitigate the major transitory, adverse effects of economic reform on poor members of vulnerable groups. The ***rural health*** component has provided critical inputs for maintaining and restoring the ability of rural health services at soum and bag levels *to provide equitable access to primary health care through improvement of transport, heating, equipment and training.*

Urban health services

Ulaan Baatar has many different hospitals, both at secondary and at tertiary levels. Secondary care services are organised, mainly by **four** district hospitals (providing internal medicine), **four** paediatric hospitals and 3 maternity homes and some non-MoH&SW facilities also providing secondary care. Tertiary level care is provided in the **three** clinical hospitals, MCH Centre and in the specialised hospitals. Altogether there are 10 hospitals providing tertiary care services, 15 hospitals providing secondary care services and **three** non-MoH&SW hospitals in Ulaan Baatar, with a total 9 200 beds.

Each aimag has a general hospital with 250-400 beds serving the local population and acting as a referral centre for the rural population. They also have mobile services, laboratory and radiological facilities and dental treatment. **Aimag departments of health provide outpatient services.**

Emergency services are available in hospitals at aimag and city levels. In Ulaan Baatar there is a special emergency station, with 150 doctors working round the clock to attend emergencies. Health administrations in aimags and cities are responsible for running hospitals and preventive health units, including nurseries and milk kitchens.

A serious weakness of the system arising from ***overspecialisation*** has been ***a shortage of general practitioners.*** In urban areas (aimag and city centres) primary level care was, until the mid1990s, provided by ***hospitals outpatient departments***, usually staffed by an internal medicine doctor, a paediatrician, and an obstetrician-gynaecologist. ***Patients were seen by specialists***, as there were no general practitioners.
To address the lack of general practitioners, in 1993 the MoH&SW passed guideline No. 180, which serves as a major policy document in the transition to a *system of family doctors* in Mongolia. By 1998, more than 1000 family doctors had been appointed. Half of them work in aimag health centres and another half in district health units of the capital city. In a given community, *one family doctor is assigned 1200 persons (in the*

city one per 1500). Primary health care is now provided in cities mainly by this recently introduced family doctors scheme.

Family doctors are supposed to provide a broad range of curative and preventive care, including intensive outreach work. The **scope of services is similar to that of feldshers,** but, in addition, family doctors have to pay attention to specific urban problems, such as environmental pollution, occupational medicine, urban slums and homelessness. Family Group Practices (FGP), which started in 1999 in three aimag centres and in some Ulaan Baatar districts, will be provided with modern equipment kits as one of the main activities of The Health Sector Development Programme (ADB). The purpose is to train and equip family practitioners to provide high-level primary health care services. As patients are not familiar with and do not trust family doctor services yet, some continue to bypass them for better-equipped, but more expensive aimag hospitals.

Decentralisation of health services

The Ministry of Health has followed government directives on decentralisation and has given aimags and cities more authority to implement health services since 1991. Local khurals are responsible for public health, both for curative and preventive services. Decentralisation of functions to aimag and city local administrations has brought government administration close to the people and has allowed each local administration to make decisions on its own affairs within the policy directives of the government.

Decentralisation of finance and budgeting in 1992 gave local agencies authority to negotiate their share of local budget financing directly with the local Government and to decide the size and composition of staff and range of services provided. AN a*brupt transfer of these responsibilities was made with very little detailed preparation or guidelines.* Much *training is therefore needed* for the local health staff to attain the necessary *skills for planning budgeting and management.*

Decentralisation has proceeded without a clear policy that defines the roles and responsibilities and without mechanisms to ensure accountability. These issues are now being addressed in ongoing development projects and there is clearly a need for a well articulated policy and procedures. One essential part of this discussion is *to define the basic and essential package of services for different levels.* Basic package of health services means a selected set of services that are considered most important and essential to be provided to the community. Essential packages of health services include

a selected set of basic health services that are most cost-effective and can be covered at each level of the health service system by the government or by the health insurance provider.

The *essential preventive health services package and the essential curative health services package was formally established by the Minister's Order A/330 in October 1997.* In addition, the latest amendments to the Health Insurance Law have taken steps towards defining which services can be financed entirely and which partly by the insurance system and to what extent co-payments are required by clients to provide an essential package of services.

Decentralisation still has to be translated fully into practice in the health sector so that the local governments can successfully manage quality health services. *Roles and responsibilities need to be defined more clearly at each level,* and *capacity building is still needed* for the managerial staff. More active community participation and the role of the private sector are also issues which must be addressed in the decentralised health care system.

Long-term planning linked to policy review and development is a very urgent need in the MoH to help improve the *ad hoc* donor coordination that is currently the norm. There are government plans of action but there is *no long-term master plan for the development of the health sector to guide national and donor inputs.*

Inter-sectoral collaboration for health

The strategy "health for all by the year 2000" gives intersectoral cooperation a key role in promoting socio-economic progress. Mongolia faces the same problem as other countries of compartmentalisation of ministerial planning. Nevertheless, during the last decade the sectarian approach to developmental activities was replaced by an integrated and collaborative process, which entails more dialogue between planners. The health component has assumed vital importance in planning activities for housing, water, sanitation, environmental activities, nutrition, education, industry, etc.

Overall health status is determined predominantly by behavioural and lifestyle factors, socio-economic status and environmental conditions. *A wider intersectoral approach is required to address these main health determinants.* Policies in areas such as education, fiscal policy, transport and agriculture have a major impact on levels of health.

Intersectoral collaboration is of great importance in building healthy public policies, creating supportive environments and strengthening community action.

Mongolia is developing integrated, inter-sectoral and community-based approaches to improve the working and living environment and lifestyles. These include the *Healthy Cities project* in Ulaanbaatar and Darkhan aimag, *Health Promoting Schools project* in Ulaanbaatar, *Health Promoting Hospitals project*, and more recent projects on *Healthy Marketplaces and Healthy Workplaces*. Improvement in intersectoral cooperation and strengthening of cooperation with city governments, education and environment ministries has been observed through these integrated projects.

More intersectoral and community programmes are needed, such as road safety, drug and alcohol control and further development of services for people seeking treatment for mental illness. However, there exists *no consistent government policy or mechanism to regulate intersectoral activity and coordination* to enhance health yet.

Community participation

As decentralisation is a government priority, local governments have become largely responsible for delivery of health services. Community participation in primary health care through Health Councils and volunteer health workers are two key features of the **1993 Minister's Order on the Structure of Hospitals.** *The Health Council is mandated to coordinate all activities of sectors working towards implementation of health goals, including direction of NGO activities aimed at protecting the health of vulnerable groups.* However, community participation in health system direction and management has not been widely mobilised, and only few Health Councils have been established.

Community participation in primary health care is to be improved through establishing Community Health Volunteers (CHV). Training of CHVs is the responsibility of the family physician according to a specified 21 day curriculum. Training of volunteers has improved community participation in health activities in some soums, and the assistance of volunteers is actively used in these communities. CHVs are assigned to 10-15 families and are responsible for early identification and reporting signs of common diseases and pregnancies to the family physicians. They advise mothers on infant care and weaning, weight infants and young children, assist in immunisation and family planning activities. They also distribute contraceptives, and at the bag level sell essential drugs.

Although many international and Mongolian non-government organisations exist, the *level of activity, especially among Mongolian NGOs, is low, and they have financial difficulties.* It is unrealistic to expect them to take over any major responsibilities on behalf of the public sector. Many of the activities organised by NGOs are reliant on the financial support of international organisations, political parties and big companies. Many of the NGOs focus on very poor, disadvantaged and marginalized groups, on women and street children. If such *NGOs could be encouraged and helped*, it would greatly assist the country to meet its policy objectives regarding vulnerable groups.

The concept of community participation is being introduced in particular test programmes. Since 1994, UNICEF has implemented the Bamako Initiative with the aim of providing essential drugs to 99 soums. Its aim is to shift the drug management system from the central level to the community level; improve the quality of care at the community level; reinforce the capacity of health managers in cost analysis and resource use in rural health services, and encourage community participation as a means of strengthening the local health delivery system.

The National Poverty Alleviation Programme also supports strengthening of community participation by bringing together local political and administrative personnel and citizens from the local communities to form committees for managing resources, administering projects and undertaking developmental activities. Support of government officials and sound financial resources have proved to be essential factors of successful community participation.

Emergency preparedness and emergency health services

The most common natural disasters that have affected the Mongolian population are snowstorms, forest fires, floods and outbreaks of some infectious diseases (plague, diphtheria). Potential human-made disasters are industrial accidents (mine explosions, chemical accidents), aviation accidents and winter energy crises.

Mongolia has a *law on Civil Defence (adopted in 1994), which legislates the management, role, and authority of civil defence organisation and emergency activities.* The structure of Civil Defence is decentralised so that local units can actually set up their systems for preparedness and response. The country has a Standing State Emergency Commission that is the focal point for the implementation of multi-sectoral emergency plans. The *health sector is not heavily involved in preparedness and recovery activities; Civil Defence plays a bigger role.* There are detailed plans defining

the role of MoH during earthquakes, chemical accidents and plague outbreaks. There is also good coordination between MoH and the UN agencies in emergency preparedness. The Ministry of Health also began to implement a project on emergency and disaster preparedness in1992 in cooperation with the WHO.

4.4 EVALUATION OF HEALTH SERVICES

Accessibility

The present health system tentatively provides free access to health services to everyone, but in reality it is not so. ***Poor financial resources have obstructed support to rural health services.*** **Physical access for the 28% of the population who live in the countryside** is, therefore, **limited by the lack of support** to feldshers, communications, and the availability of emergency transport.

Physical access for the 22% living in soum towns is good for some basic services, but for most of the complicated cases, some services may not suffice. This will mean either upgrading the soum services or providing increased access to aimag services by improved communications and transport. Physical access for the 50% of the population that live in urban areas is good.

Acceptability

Feldshers, staff of soum hospitals and the community are well integrated in the prevailing socio-economic and cultural context. The fact that health personnel are very often born and brought up where they are working increases acceptance on both sides. Also usage indicates a **high acceptability of services. However,** the **high rates of self-medication and the interest in traditional medicine** also indicate an increasing interest in alternatives to the formal medical system.

Utilisation of services

The use of ambulatory services was high in the beginning of 1990s, with nearly 5 contacts to physician per person per year, half of them being in preventive care. The number of visits has decreased in the 1990s by nearly one third.

Table 14. Trends in outpatient and inpatient services in the 1990s

	1990	1992	1994	1996	1997	change 90-97%
Ambulatory visits total	14581000	10537460	10344013	9661122	9788047	-33
Ambulatory visits/person	6.8	4.8	4.5	4.1	4.1	-39
Hospital discharges	512528	446045	481935	504456	472373	-8
Hospital days	6920600	4948536	5074064	6341613	5749374	-17
ALOS (days)	12.3	11.5	11.5	12.6	12.2	-1
Number of hospital beds	26427	24225	22939	23082	18436	-30

1 Hospital discharges in 1001. ALOS= average length of stay in hospital

Use and coverage of preventive services (e.g. antenatal care, immunisation and person-to-person health education) is good for all population groups. Population demand for and willingness to pay directly for such services is probably low, so these need to be indirectly financed and supported by the Government.

Efficiency and effectiveness of the service system

The goal of the health system is the improvement of the health status of the population. However, *services have not been sufficiently oriented to outcome and quality.* The Mongolian health system has *focused too much on inputs and not enough on outputs and results.* One reason limiting *efficiency* is the sparse population and long distances between centres, increasing requirements for health resources.

Providing *an abundant supply of resources is no substitute for improving productivity and cost-effectiveness in health care or for implementing policies that promote good health.* Motivation comes from the need to control costs, but also reflects an awareness that more resources for health services do not equate to better health status in the populations. The experience of many countries affirms the conclusion that Mongolia's supply and utilisation of health resources is excessive and inefficient.

Effectiveness of the health sector is *low* as reflected in low health outcomes (for example, relatively high maternal and child mortality) compared to other countries, which use as much or less on health expenditure. **Overstaffing** and **over-specialisation** have contributed significantly to low effectiveness. Since the end of Soviet transfer payments in the early 1990s, *the Mongolian health system has become increasingly financially unsustainable.* Policy measures are aiming at achieving more appropriate use of hospital services.

The cost-effectiveness of the Mongolian health system can be improved in many ways to achieve better results by the same-or even fewer- resources. *Five main areas of*

inefficiency are often reported.

1. *Over-utilisation of hospital in-patient services by patients to get free drugs and food.* The present hospital financing system, which is based on hospital days, provides the *wrong incentive for the hospital administration to increase the number of hospital days.* Therefore, the bed-occupancy rate is high, and the average length of stay in hospitals is very long. The present reimbursement system may also lead to inappropriate admissions to hospital. The existing system of hospitals is not economically sustainable, and many interventions can be provided through cost-effective PHC services.
2. *Over-specialisation of health services,* especially at the soum levels, and excessive use of referral services.
3. *Over-staffing and poor-quality of the service system.* Also, the clinical and case management skills of the medical workforce need to be improved through changes in training. There should also be a redistribution of family doctors and other health personnel to rural areas.
4. *Over-prescription of drugs (and over-utilisation of over-the-counter drugs) and in some cases traditional treatment practices (often with too-long hospitalisation).*
5. The health system has focused too much on inputs instead of outputs and outcome (changes in health status). Before the 1990s, *the main indicators of health-care development were the number of beds and number of medical personnel.* This was initially a policy strength resulting in better access, but later became a policy weakness, resulting in excess beds and high utilisation rates, duplication of services, and low cost-effectiveness.

Length of stay in hospitals is longer than in most developed countries, and better organisation of services would probably improve efficiency. The average length of hospital stay (ALOS) in soum hospitals is 9 days, and the occupancy rate is 80%. The corresponding figures for aimag general hospitals are 13 days and 71%, and for Ulaan Baatar hospitals, 15 days and 76%.

Quality of care

Mongolia *has relied on structural standards as the main mechanism for ensuring quality.* These have included educational requirements, specified ratios between numbers of physicians and nurses, equipment standards, and treatment protocols. Many of these earlier standards need to be updated because they do not respond to present conditions or are of questionable efficacy.

A major issue that Mongolia faces is that of clinical quality. This goes hand in hand with the overstaffing, as clinicians do not see sufficient clinical material to maintain their clinical skills. Also, increased awareness and *application of western practice guidelines is necessary.* There is a world-wide trend towards evidence-based medicine and evidence-based health-service systems. This means that both the clinical activities and development of health-service systems should be based on sound scientific evidence that indicates that the resources are used effectively and that they really have a positive impact on health status. *Quality assurance programmes and research-based medicine are at the core of assuring the quality of care.*

Quality management strategies are not evident in most hospitals. Quality management in the health field covers *professional and technical aspects, management aspects, and consumer relationship* issues. All three areas have been neglected. There is a *lack of articulated standards, no committees or staff designated for quality assurance, little or no peer review or clinical audit, little attempt to collect systematic feedback from patients, and little emphasis on quality improvement as part of staff management.*

There are many activities ongoing for continuous quality development in Mongolia. *Accreditation is being developed for defining the standards for health inputs (staff qualifications, size of rooms, etc) and for processes. Quality assurance methods* are being developed for the family-practice system. Until now, there has been little activity for the development of outcome measurement and outcome indicators. Improved licensing of individual health professionals and provider institutions is being followed up as part of the strategy to raise standards of quality.

Low quality curative services at soum level combined with weak and underdeveloped preventive and promotive services mean that access to effective services, particularly for the poor, has already dropped.

Re-training of physicians and continuing education is required to improve the quality of care. Better **transport** facilities and an improved supply of essential equipment and drugs are urgently needed to ensure the efficient running of rural health institutions.

Equity in health and health care

The obvious emphasis in the past to **ensure equity of access to services** in Mongolia to

even the most remote nomads is impressive, as is the attempt to ensure an infrastructure of hospitals across the whole country. Mongolia was a relatively egalitarian country at the beginning of 1990s. Despite growing inequities during transition, Mongolia still enjoys income equality comparable to its neighbours.

There is an **emphasis on equity by providing financial assistance in old age, for the disabled, childbirth and child care. Primary health services continue to be subsidised,** as only a certain percentage (depending on the drug) is charged for essential drugs; and emergency care services are free. A package of free medical aid that fulfilled the constitutional right of citizens is identified and legalised by the health insurance law.

The nation-wide health insurance scheme allows access to health services for all, in principle. People unable to afford health insurance and who qualify for social welfare are able to access health services without paying insurance premiums. However, all users are charged a basic fee for use of services and for the purchase of medication. The World Bank Poverty Assessment 1995 found that *the burden of health care as a result of fees was proportionately higher for the poorest 40 per cent of the population* and that this was among the most important reasons for the lowest quintile of the population do not consult a health facility when in need.

Health, illness and use of health services are unequally distributed. Several factors contribute to the extra vulnerability of poor people to illness and death, e.g., malnutrition, poor hygiene, substandard housing, few clothes and inadequate heating and water supply. Infant mortality varies much throughout the country and also between social groups. The variations are determined mostly by level of maternal education, housing conditions and water supply. There is also remarkable variation between aimags in maternal mortality and life expectancy at birth.

Parental education levels and place of residence are also important factors affecting child health and growth patterns. Children whose mothers and fathers are uneducated are 50-60 per cent more likely to be stunted. *Malnutrition is more common among children living in gers* (traditional dwellings) as compared to children living in apartments.

According to a study conducted by the World Bank in 1996, the *health service utilisation pattern shows sharp differences between income groups.* The wealthy tend

to utilise aimag hospitals, special hospitals and private clinics, while the poor utilise soum hospitals. Private health facilities are becoming a popular option for those who are financially better off. Among the poorest quintile of the population, the most important reasons for not consulting a health care facility are distance, expenses, and lack of quality care. It will be important to monitor the impact of health sector reform on the access to and use of health services among the vulnerable groups.

4.5 Formulation of a Health Master Plan:

Following the approval of the ToR and authorisation to begin the Health Master Plan Exercise, the task force appointed by the Minister for the development of the ToR reviews the ToR and discusses the management structure that will be required to carry out the two phases of the exercise namely the feasibility study and the actual development of the HMP. This would be done in consultation with JICWELS technical adviser.

Since the development of the Health Master Plan will be looking at a long-term time frame of 15 years or so and will require intense collaboration with a variety of stakeholders, both national and international including the main donors (multilateral and bilateral), the management organisation should be based on the following key principles:

- That an interdisciplinary team be set up that may be derived from the initial task force constituted for the development of the ToR including the JICWELS Senior Technical Advisor and the Japanese study team members.
- That the team that will be working on the HMP should and have the seniority and authority to work directly with the international donors and other stakeholders in the government outside of the MoH to ensure close collaboration and effective coordination. Such a level could be in the office of the Vice Minister.
- That the team should have clearly defined linkages with the main departments in the MoH and be able to with due permission review and examine documentation, plans, reports, project proposals and other instrument pertaining to operations and implementations including guidelines, checklist, budgets, indicators and situation analysis and needs assessments that have be developed.
- That the team be assigned a basic budget and office space to work in

partnership with the Japanese study team.

- That through proper government channels all the agencies and organisations within the health sector, other government sectors, international community of donors, health related NGOs and other national and local stakeholders be notified of the ToR for the HMP development exercise.
- That the activities of the HMP team and the counterpart Japanese study team be guided by the tasks for developing a master health plan listed in section 5.3 of the ToR.
- That the team report to the Vice Minister and through regular presentation at MoH staff meeting and at the meetings of the management team at the MoH level and where necessary to the Minister's Council or equivalent body.
- That intersectoral steering committee be set up with representation of all the donors involved in health that would meet to review and approve the management structure to initiate the feasibility study. The committee would review and approve the Inception Report and to review the draft HMP for submission to the Minister for approval. The final draft of the HMP would be submitted to the government and the international donors for adoption and implementation
- That the MoH and the Japanese Study Team have the right to review and re-examine the management structure and the plan of action for the HMP exercise whenever this may become necessary

4.6 Feasibility Study

During this period the study team will engage in a review of the ToR and analysis of the current situation in terms of the existing planning frameworks and donor coordination mechanisms, review objectives vis-à-vis the current situation, develop activities for the implementation of the objectives and draft a plan of action with resource requirements in the form of an Inception report to guide the implementation of the Development Study for Developing the Health Master Plan.

The overall goal is realizing a Healthier Mongolian Population

The strategic objective is the Elaboration of Health Master Plan for the development of the health sector over the long term – at least 15 years.

Specific Objectives:

Drafting of an Inception report for elaborating a Health Master Plan that would include the following

1. To describe the Current Situation
2. To determine the Relevant Project Context
3. To review the current legal framework for strategic planning and donor coordination including policy review and development.
4. To describe the Situation of the MoH and other stakeholders in the health sector
5. Identify problems and constraints affecting strategic planning, policy review and development and donor coordination
6. Identity and list the target groups of the project
7. Review and reconfirm Commitment of counterpart agency
8. Describe and clarify relationship to other projects

5 Scope of the Study

5.1 Study Area

The study will be carried out nation wide.

5.2 Collection of General Data

Collection of general data will be done through documents review and observation, report, surveys, interviews and etc.

References to be used: National Health Plan, National Planning Guidelines, National Development Plan, UN/WB Sectoral Reviews, UNICEF/UNFPA Situation Analysis, UNICEF Master Plan of Operations, other reviews by bilateral donors and NGOs, National Policy Documents:
National Statistical Report; MOH Annual reports over last five years: National Health Plan, Morbidity and Mortality data: OPD and Inpatient data:
Manpower status and Civil Service Procedures, Manpower Development Plan, Establishment List of approved post, those filled and those not filled. Geographical distribution of manpower and by facility and by cadre or post.

5.3 Tasks for developing Health Master Plan

- **Technical requirements**
  - Assignment of qualified personnel from the MoH and the donor supported projects,

    The Task Force established by the Minister's Decree of 08 January, 2001 will be continuously responsible for development of the Master Health Plan. The Strategic Management and Planning Division of the Ministry of Health will be

assigned to coordinate meeting with donors and ensure consistency of the plan with currently ongoing health policy development activities and programs.

- Access to relevant documents and reports.

  The main constraints is that a systematic database of documents is not developed, therefore searching of relevant information will be time consuming. Thus, the Monitoring and Evaluation department of the Ministry of Health or project team must identify a list of currently available documents for appropriate filing immediately.

- Provision of required health, management and financial data,

  Relevant facilities and institutions will be asked by the Task Force or the Ministry to provide information when it is necessary.

- Access to meeting within and outside of the MoH relating to health sector development and planning with particular reference to donor supported project activities and reviews.

  Meetings could be arranged with prior appointment with local and international organizations through International Cooperation Department of the Ministry. All planning and staff meeting will be open for attendance by the HMP team leader and Senior Technical Advisor.

- Review of the existing survey data and conducting of survey where necessary.

  Survey data and reports are open to all, and joint survey with the Ministry's team can be conducted when it is necessary.

- **Management Task – organization**

  Strategic planning and structure of the Ministry of Health

  Current situation:

  In 2000 the Government has issued a decree on the operational strategy and organizational structure of the Ministry of Health. This decree states mission, strategic and operational objectives, business strategy and model for organizational structure for the Ministry of Health. The main message of the strategy is in line with the Plan of Action of the Government and the ruling party in the Parliament.

On the other side, the Ministry developed Outlines for Action for the next 4 years based on the Government Plan of Action. Officers of the Ministry of Health developed an initial draft and submitted it to the Cabinet for approval. Working with other stakeholders in the formulation of plans of action and programs for particular areas of health such as adolescent health, nutrition and immunization etc. are currently being undertaken. Upon the initiative of President of Mongolia, a working group has been established for formulation of Public Health Policy.

At the same time many international organizations are starting their new strategy formulation and development of plans of action for the next 2-4 years, during this year. The situation is advantageous as it permits both the Government and international organizations to synchronize their planning and policy development activities. This augurs well for improving the coordination of the donor supported projects and activities. However this may not happen as the Ministry lacks skills, know-how and instruments and tools to carry out such coordination.

Gaps:

1. Limited involvement of the stakeholders including civil servants in the strategy formulation. In this regard, ownership of the strategy may be questionable. Its value is dominated by ruling party's one as opposite to corporate strategy building process. Higher degree of involvement of officers of the Ministry is needed in the formulation of the plans of action at the various levels.
2. Application of SWOT analysis in the strategy formulation process was not clear.
3. Time limits and other factors did not allow the synchronization of the strategy and policy formulation process.
4. Mechanisms and resources for consultative meetings for consensus building and facilitating participation of the various stakeholders in the health and other related sectors for policy and strategy formulation need to be further developed and institutionalized.
5. Mechanisms for coordinating donor participation in the strategic planning process still need to be improved that would promote more ownership and commitment.

- Financial – Resource Envelope
    - Sources of financing for health,

      The sources for the financing health are mainly from the government and from the external donors. The National Health Insurance derives a large part of the its funding from the premiums allocated by the central government for the vulnerable groups. The business entities are required to pay for the health insurance, but collection rate in poor as priority is given to the other funds such as pensions, unemployment, and occupational health. Donor funding is erratic and focused on donor priorities and is still focused in capital investment and service projects rather than on developing and sustaining the health care delivery system.
    - Budgeting mechanisms

      The separation of the budgeting process (assigned to the MoFE through the local government finance offices) from the technical and administrative processes, (assigned to the MoH HQ) has created a situation where the MoH can exercise only a very limited control over the budgetary process. Each national health facility and the health facilities in the local government areas develop their budgets based on a line item budget using established budget norms provided by the MoFE within ceilings provided. These budgets are submitted to the MoFE and are summarized and forwarded to the MoH. The MoH HQ collates these budgets and adds to it its own and those for other central programmes. It then submits this along with the plan of action as the formal budget for the health sector using the same line-item norm based approach.
    - Synchronization of the planning and budgeting cycles

      The planning and budget cycles are not synchronised especially at the facility level and planning is seen as drafting the budget proposal with a preamble that summarizes the main priorities for the current year derived from the government plan of action and the main policies of the MoH for the health sector. Planning of programmes and activities is seen as distinct from planning for the development of the budget proposal and the line-item approach using the MoFE frameworks do not lend themselves to planning and budgeting as a synchronised consolidated exercise. Current guidelines are inadequate to guide and