

**MONGOLIA SECOND HEALTH SECTOR  
DEVELOPMENT PROJECT**

**REPORT AND RECOMMENDATIONS FOR  
HEALTH SECTOR PUBLIC – PRIVATE  
PARTNERSHIPS**

**24 MAY 2002**

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**MONGOLIA HEALTH SECTOR  
PUBLIC – PRIVATE PARTNERSHIPS**

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**Executive Summary**

The aims and objectives of the Health Sector Public – Private Partnerships section of the Asian Development Bank consultancy were to:

1. Assess the characteristics of and constraints faced by the existing private health sector in Mongolia; and
2. Develop recommendations to facilitate public – private partnerships in the health sector, keeping in mind the needs of the poor.

The consultants inspected public and private hospitals in Ulaanbaatar, an Aimag Centre and a major Soum. Interviews were conducted with public and private Hospital Directors and Administrators, Government officials and members of Parliament, the World Health Organisation, the World Bank, the Health Insurance Fund, the National Centre for Health Development, the State Inspectorate for Health and a private medical university. The consultants participated in a 1.5 day workshop on outcomes of HSDP1 and the aims and objectives of HSDP 2. Valuable insights were collected from workshop participants.

Mongolian public hospitals and equipment have not been maintained for 10 years. Hospitals are inefficient, expensive to run, poorly designed and equipped, duplicate services provision (in Ulaanbaatar) and perform unnecessary levels of inpatient care due to a health insurance system, which encourages inpatient treatments rather than primary care. There appears to be a major imbalance between facilities provision in the capital city and rural areas. Resources (including human medical resources) require better/fairer allocation.

Government needs to be continually striving to find new ways of improving the quality of the services it provides. Ever rising public expectations, advances in technology and innovations in potential delivery mechanisms make clinging to the status quo no longer viable.

Unless Government is strongly encouraged (or forced) to immediately commence a comprehensive review of the health and health insurance systems with a view to implementing major structural reforms, **particularly the introduction of a “Single Purchaser”**, **no meaningful or lasting health sector reforms will be achieved**. Privatisation (public – private partnerships) by itself will not bring about structural reform, but the work required to identify and encourage private sector interest is complimentary to the work required to bring about meaningful and lasting reforms.

The existing health system is fragmented and lacks services integration. This situation can only be rectified if Ministry of Health becomes the sole health services purchaser for Mongolia and controls the development and allocation of the health budget.

Opportunities for the establishment of public – private partnerships in the health sector are plentiful, particularly in Ulaanbaatar; however, unless the current budgeting system is changed, budget savings achieved from public – private partnerships or restructuring activities, cannot be redistributed from urban to rural areas.

Pure privatisation has only limited application as withdrawal of budget support from hospital finances means that patient co-payments would have to rise on average 1900% to achieve the same income result. That is not feasible. The introduction of Performance Management Contracts for all public hospitals should be commenced immediately. These contracts can also be tendered to the private sector but budget support must be maintained in public hospitals (in full or in part). That is to say, the health budget should support the delivery of public patient health care outcomes but not treatments delivered to private patients.

Government should consider the establishment of collocated public and private facilities and enabling private practitioners to work under contract conditions in public hospitals. Private education institutions should be encouraged to assist Government in the design and delivery of suitable curricula for the continuing improvement and development of health professionals. Health professionals need to be educated in the use of contracting out techniques. Specialist medical, diagnostic and non- medical services should be outsourced.

Government should vigorously encourage the private sector to develop a “Super Hospital” to stem the flow of health revenues to foreign countries. Major ICT programs flowing from HSDP 2 should be delivered by public – private partnership. There are many successful global models that can be readily adapted to Mongolian conditions.

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**MONGOLIA HEALTH SECTOR  
PUBLIC – PRIVATE PARTNERSHIPS**

**24 MAY 2002**

**INTRODUCTION**

1. The Asian Development Bank commissioned consulting firm, HLSP Ltd. to develop a project proposal to further improve the Mongolian health services delivery system, particularly in rural areas and to ensure better health status for the population.
2. As part of the project proposal development, ADB highlighted for consideration within the consultancy, the following issues:
  - Facilitating health service delivery by the private sector for the better off so that public resources can be reallocated to address the needs of the poor.
  - Introducing payment mechanisms that guarantee free access to private health services for the poor.
  - Supporting medical auxiliaries (eg. Qualified and trained traditional healers) that particularly care for the poor.
3. The aims and objectives of the Health Sector Public – Private Partnerships section of this consultancy were to:
  - Assess the characteristics of and constraints faced by the existing private health sector in Mongolia; and
  - Develop recommendations to facilitate public – private partnerships in the health sector, keeping in mind the needs of the poor.

## **BACKGROUND**

### **Privatisation**

4. A pilot health sector privatisation program was launched in 1997 under Government resolutions No's 160 and 219. Within the pilot exercise, some District Hospitals and Soum level hospitals were to be managed either by the private sector or individuals on a contract basis. The Bayanzurkh District Hospital and 47 soum hospitals of 16 Aimags were covered by the pilot program. The aim of the program was to improve the quality and access to health services, increase efficiency and identify issues and principles that should be followed for further application of contracting out mechanisms in the health sector.
5. The scope of the program included the potential contracting out of some medical services, laboratories, diagnosis, cleaning, canteen services and management contracts for Soum, Aimag, District, Clinical Hospitals and Specialised Centres. Contracting out of health and associated services must comply with the Constitution of Mongolia, the Health Act 1998 (as amended), the Civil Code, the Health Insurance Act as well as other legal acts adopted in conformity with these laws. The MOH, MOF and SPC were responsible for the establishment of contracting out policy, guidelines and implementation.
6. Despite privatisation experiments not having not been carefully evaluated, the Bayanzurkh District Hospital appears to have been successful in improving the use of available resources, however, anecdotal evidence suggests that health services quality has not improved. Management contracts for Soum hospitals have since been cancelled because they were not successful for a multitude of reasons (for example, lack of proper management skill among contractors). Contracting out was not widely embraced by hospitals as it seems that an implementation plan was never developed.
7. In 1998, the Ministry of Health and Social Welfare and the Asian Development Bank implemented the Mongolia Health Sector Development Program. Its' objectives were the:
  - Promotion of the Primary Care Health Model
  - Encouragement of private health sector participation in health services delivery
  - Restructuring of health facilities
  - Rationalisation of health personnel
  - Improving health care financing and management
  - Protection of the poor and vulnerable groups

8. Under the Program, privately operated Family Group Practices (FGP's) were established in remote Soum areas, Aimags and some Ulaanbaatar districts to provide primary care health services. Doctors are contracted by way of performance contracts; the contract also specified the services to be provided to the registered population. Payment is effected through capitation payments made by local budgets. In 2003, the Health Insurance Fund will assume the payment regime obligations. Satisfaction surveys conducted in May 2000 and October – November 2000 using a self-completion questionnaire indicated that FGP's are generally working well, all family doctors reported that the work conditions were better than before, 65% estimated that clinical practices had improved and 85% of respondents replied that they get very active or active support from the local communities. The most often reported problems were related to financing, premises, equipment and drug supply.
9. On 25 January 2001, Privatisation Guidelines for 2001 – 2004 were approved by Mongolia's State Ih Hural (Parliament). These Guidelines serve as an official statement of the Government's privatisation policies and define enterprise and sector specific objectives and priorities.
10. The Mongolian Government's overall policy goal is to accelerate the privatisation process and increase private sector participation in the economy, thereby improving economic efficiency, generating economic growth and enhancing the welfare of the people. Based on the Guidelines, the Government will adopt annual action plans specifying the enterprises and assets to be privatized by the State property Committee during the year and the methods to be utilized. For each privatisation, the Government will choose the most appropriate method and structure of sale to achieve its objectives. The Government will prepare annual progress reports on the implementation of the privatisation policy for submission to and review by Parliament.
11. Whilst the Government's strategy for 2001- 2004 focuses largely on the privatisation of Mongolia's largest companies, through international tenders, the Guidelines also detail plans for social sector restructuring and privatisation. With respect to health, the following restructuring and privatisation measures are to be implemented under the Guidelines:
  - As deemed necessary by the Government, privatise some clinics and specialized hospitals in part, or whole, by attracting foreign and domestic investment and establishing joint ventures. Investors shall be selected through a competitive tender with specific terms and conditions;
  - As deemed necessary by the Government, the management functions of some rural and urban area hospitals will be executed under management contracts. Medical help and services, as well as non-medical auxiliary services, will be

- executed under performance contracts. Some hospital facilities, medical equipment and laboratories will operate under lease contracts;
- Contractors to perform the services will be selected through a competitive tender from among non-governmental professional organisations, domestic and foreign private legal entities and individuals. These contracts will not serve as the basis for transferring the property and property rights to private ownership;
  - The principal terms of a management contract will be to use revenues in excess of expenditures to invest in the hospital and improve and remunerate the hospital's management. The terms and amount of revenue allocation will be clearly stated in the management contract:
  - The principal terms of a performance contract will be the contractor's obligation to provide quality services according to the required standard. The employer will bear the responsibility for the ultimate results of a particular service;
  - Emiin Uildver, the pharmaceutical company, shall remain state-owned to support the national pharmaceutical industry and implement projects in this field;
  - Resorts and spas providing nationwide services, such as Hujirt and Shargaljuut, will be transformed into state-owned joint stock companies. A certain portion of shares will be privatized through a competitive tender to a foreign and domestic investor provided that the nature of the services remains unchanged, the property is used according to its purpose, investments for improving efficiency are made, and requirements in terms of professional and technological aspects are met.
- A Steering Committee comprising representatives from the MOH, MOF and SPC was formed to determine an implementation program and identify clinics and hospitals for potential privatisation.

## **Existing Mongolian Health System**

12. As in other former Soviet Bloc countries, the dominant aim of the health system has been to provide roughly equal access to medical and hospital services. This was achieved in Mongolia through the establishment of facilities at four levels, namely:
- Physician's assistance (Bag feldsher) posts in rural areas. These have since been augmented in part through the establishment of family doctor posts in provincial towns and cities.
  - First-level referral hospitals at the soum level. Staff are mainly doctors and midwives.
  - Second-level referral hospitals serving each aimag and located in the main town or aimag centre. These were general hospitals with approximately 200 beds in each aimag centre.
  - Third or national referral institutions. They comprised general and specialized medical and public health centres in Ulaanbaatar, the country's capital.

13. The Government instituted a decentralization policy in the early 1990's as part of the move away from central planning. Local Governments are now directly responsible for the provision of health and education services. Their responsibilities include budgeting, capital investment and expenditure control.
14. Health expenditures represented between 4% and 4.5% of GDP between 1990 and 1995. However, real expenditure in health has steadily declined due to inflation and an overall fall in per capita GDP. In 2000, 4.1% of GDP was spent in the health sector. Financial constraints have adversely affected operation and maintenance of physical infrastructure and equipment in the health sector. General hospitals and facilities are too large and badly designed, which has led to maintenance difficulties and extremely high running costs, in particular, heating costs.
15. Health services are now provided by both public and private providers under the Health Act 1998 (as amended).

**(a) Private Health Providers**

16. A legal framework for licensing and accreditation has been developed. However, there is no evidence that the framework has been implemented. Legal procedures for establishing new private enterprises have been set and the number of private service providers has been increasing year by year.
17. The Ministry of Health (MOH) provides licenses for private medical practices and institutions. MOH statistics provides the following data for the year 2000.

<b>Type of service or institution</b>	<b>Number in all Mongolia</b>	<b>Number in Ulaanbaatar</b>
<b>Private Clinics</b>	<b>361</b>	<b>282</b>
<b>Private Hospitals (with beds)</b>	<b>122</b>	<b>83</b>
<b>Private Pharmacies</b>	<b>263</b>	<b>174</b>
<b>Drug wholesale agencies</b>	<b>42</b>	<b>42</b>
<b>Laboratories</b>	<b>14</b>	<b>14</b>
<b>Total private practices and institutions</b>	<b>828</b>	<b>618</b>

18. The above figures show that private health services are mainly in Ulaanbaatar (UB). Private hospitals had a total of only 826 beds in 1999 (MOHSW and HMIEC); the average size of these hospitals is therefore very small. In 1999, 7 Aimags had no private hospitals. MOH statistics also reveal that there are 3 private medical universities and 23 enterprises involved in pharmaceutical production. The total number of staff in private health services and enterprises in 2000 was 2219 – 996 were physicians. (WHO).
19. Government Resolution 181 established a Licensing and Accreditation Unit in September 1998 in the Health Management, Information and Education Centre (HMIEC), now known as the National Health Development Centre (NCHD). NCHD began reporting to the Minister for Health in March 1999 on both public and private hospitals.

### **Licensing**

20. National and local (aimag level) licensing committees have been set up. Standards for the licensing of health personnel have been approved. Licensing of health professionals has been completed, including nearly 7000 doctors and pharmacists and nearly 14,000 nurses and other professionals.
21. MO63 provided health facilities licensing commission and rules. The standards for licensing health facilities (relating to structure, function, layout etc.) have been completed. The standards for licensing FGP are being developed. Licensing of facilities has commenced but the checklists and criteria need to be more specific.

### **Accreditation**

22. Standards for accreditation of health facilities are being reviewed and better adapted to the Mongolian conditions however there does not appear to be an implementation plan or responsible Agency. It will be critical for the improvement of quality health services as to how the standards will be formulated and used. These standards are a potentially good tool for decreasing service delivery overcapacity.

### **Payment mechanisms**

23. The Health Insurance Fund (HIF) has covered hospital inpatient services since 1995. All licensed private hospitals, sanatoriums and pharmacies are eligible to bill the HIF and receive payment for the services, which are covered by health insurance. Health insurance and imbursements to the private hospitals follows the same principle of

prospective payments (since 1999) as in the public hospitals. Budget funding does not support private hospitals. However, private hospitals are free to set their patient fees.

24. Reimbursements from the Health Insurance Fund to the private hospitals have increased steadily in the last few years: 1997 85 million MNT, 1998 295 million MNT, 1999 472 million MNT, 2000 559 million MNT, and 2001, 807 million MNT. The percentage of HIF allocations to private hospitals increased from 2.2% in 1998 to 5.4% in 2001. Treated patients in private institutions rose from 3374 in 1997 to 27560 in 2001, or from 0.4% to 3.7% of total treated patients.

Source: SSIGO Financial Statements

**(b) Public Health Providers**

25. According to official statistics (Mongolian Statistical Yearbook 2000), the number of clinical and specialized hospitals in Mongolia was 47 in 1999 but 66 in 2000, and the total number of beds slightly increased from 1999 to 2000, to 17,974 beds (7.5 per 1000 population). Most of these hospitals are in UB.
26. In 2001 the number of beds per 10,000 was 94.6 in UB and on average 61.1 in the Aimags. There were 7506 public sector hospital beds in UB out of a total of 18090 countrywide.
27. The number of hospital admissions is in most disease categories much higher in UB than in the Aimags. UB citizens averaged 7 outpatient treatments in 2001 compared to 4 by Aimag residents. These great differences cannot be explained by different morbidity. The figures refute the Government principle of equal access to health services by maintaining high overcapacity in UB. It is probable that the threshold for hospital admission is much lower in UB than in the Aimags because of the oversupply of beds, which in turn increases demand for inpatient care. Hospitals want to use available bed capacity and the HIF seems to be supporting this without any critical analysis of hospital admission criteria or hospital utilisation.
28. In 2000, 64.9% of the health sector income was financed by the State and local budgets, 31.7% by the Health Insurance Fund and 3.4% paid by patients themselves as co-payments. 35.6% of the total health expenditure was related to employee salary and other contributions, 19.5% for food and drugs and 16.3% is spent on fixes costs.
29. As at May 2002, **only 2** public hospitals have gained accreditation from the NCHD, 1 Aimag Hospital and 1 Soum Hospital

**(c) Health Insurance Fund**

30. The Health Insurance Law was approved in 1993 and the HIF commenced operations in 1994. There have been four subsequent amendments to the Law.

There are two main types of insurance – obligatory and voluntary. No tax concessions are available.

31. Obligatory insurance is levied at the rate of 6% of each employee’s salary, payable equally by the employee and the employer. Government pays for children under 16years, pensioners, students, herders, the unemployed, the disabled and soldiers. The payment rate is revised each year in line with economic conditions.

The maximum HIF pay out is USD400/year. This is supposedly equivalent to the shortfall between budget funding and the cost of a 20-day public hospital stay. Additional insurance cover can be taken where the cost is likely to exceed USD400/year.

32. Voluntary insurance is generally paid by expatriates with the lowest premium set at USD 0.8/month.

HIF payments are primarily for bed days (95%), drugs and some ambulatory services. The HIF collects approximately USD 19.6 million/year (USD 5.2 million Government contribution) and pays out around USD 14 million per annum. New amendments in 2003 include provision of capitation payments to FGP’s and coverage of outpatient preventative examinations.

**Coverage of the Health Insurance Fund for the year 2001**

<b>Vulnerable Group Premium paid by Government</b>	<b>Group paid by</b>	<b>Employees of Economic Entities Premium</b>	<b>Voluntary Contributions</b>		
USDm	%	USDm	%	USDm	%
5.2	26	13.9	71	0.5	2

Source: Health Insurance Fund

**(d) Medical Staff**

33. There is one state medical school – Mongolian Medical University (MMU), three private medical schools and four nursing colleges. MMU receives Government funding for electricity and heating costs; all other costs have to be met through student fees. MMU therefore has a strong incentive to increase student numbers. MOH has no say in the number of students to be accepted. So long as the three private medical schools meet the Ministry of Education’s minimum criteria, the private institutions are free to do as they please.

This situation has led to a surplus of doctors and the trend appears to be continuing. There does not appear to be any official estimates of the need for physicians or the costs of too many doctors (training costs and costs to the service/reimbursement system).

## ISSUES

34. At the time of writing this report, it should be noted that Government is/was considering the Fourth Draft of the Health Sector Privatisation Program as part of the Social Sector Privatisation Program 2002 -2004, submitted for it's consideration by a Steering Committee comprising members of Parliament and representatives from relevant Government Departments, including MOH. In addition, Government was also considering the Soum Hospital Plan 2002 – 2008. The authors have not been made privy to this information.
35. It is therefore likely, that some of the issues discussed and conclusions reached in this report may differ from the Steering Committee's recommendations and Government's final decision; further, some recommendations contained in this report may be enacted by Government prior to the commencement of HSDP 2.

## Soum Hospitals

36. Soum Hospital infrastructure and equipment has not been adequately maintained or replaced for the last 10 years. Hospitals are inefficient, expensive to run, poorly designed and equipped, devoid of ongoing medical training and appear to perform unnecessary levels of inpatient care due to a health insurance system that encourages inpatient treatments rather than primary care. The introduction of FGP's in some Soums appears to have reduced the number of patients presenting at Soum Hospitals, however, referral protocols do not yet seem to be strong enough to change consumer attitude/practice.
37. Patient co-payments at Soum Hospitals are very small reflecting the populations' ability to pay. At the Inter - Soum Hospital visited by the authors, the level of co-payments was equal to 0.92% of 2001 turnover. If Soum Hospitals were to undergo full privatisation ie. treat patients as private patients, Soum Hospitals would loose their greatest source of income, namely the local budget. As previously mentioned, in 2000, 64.9% of health sector income was provided by State and local budgets. It would be impossible for Soum Hospitals to operate on such a reduced budget.
38. Government previously considered establishing Soum Hospitals under Management Contracts and a pilot program was introduced. This experiment failed for many reasons, tyranny of distance etc., but the **three most apparent important reasons** are the fact in many Soums, local budget support was withdrawn from the hospitals as

Local Governments failed to understand that the hospitals were still only providing public patient treatments and not private patient care, that the majority of the Management Contracts were awarded to the incumbent management, or to doctors who lived and worked outside the Soums. In the second example, without the provision of proper hospital administration and business training, it is most unlikely that incumbent operators will be able to operate the hospitals in a more efficient manner. Similarly that is true for doctors who reside outside the Soum as well as those doctors not having a “hands on” management role, let alone adequate reporting systems from which to make management decisions. Management contracts did not provide for or create the ability to access ongoing post graduate medical training. Health services delivery outcomes did not improve.

39. Soum Hospitals offer a critical service to rural Mongolians. They are in urgent need of refurbishment, new and additional equipment, more trained staff and access to ongoing medical and hospital administration training. Performance Management Contracts can and should be introduced at Soum Hospital level (see later reference), however they should not be privatised. The poor and vulnerable should continue to be treated free of charge. Soum Hospitals may seek to contract out some services and also collocate private doctors within surplus facilities capacity or enter into contracts with private doctors for the use of facilities and equipment so long a services are not duplicated and public patients receive priority treatment. (see Collocations reference).
40. Soum Hospitals may also consider establishing a private ward in surplus space within their existing facility, however care needs to be taken to ensure that services are not duplicated, patients are protected from unscrupulous practice and that payments to the hospital come only from the Health Insurance Fund and patient co-payments.

### **Aimags Hospitals/Regional Referral Centres**

41. As with Soum Hospitals, Aimag Hospitals have not been adequately maintained or refurbished over the last 10 years, although they do possess far more and better equipment (as you would expect in a secondary level hospital). Equipment maintenance however, remains a problem with many pieces of equipment lying idle due to lack of spare parts or qualified maintenance providers. The establishment of Regional Diagnostic Centres however has increased the quality and complexity of diagnostic equipment available to rural communities but rigorous equipment maintenance programs need to be established to ensure that this sophisticated equipment can be maintained in a state that will enable an improvement in diagnostic outcomes and a reduction in referrals to UB.
42. The Aimag Hospitals are also inefficient, expensive to run, poorly designed and equipped, devoid of ongoing medical training and appear to perform unnecessary levels of inpatient care due to a health insurance system that encourages inpatient treatments rather than primary care. The introduction of FGP’s in Aimag centres appears to be operating better than in Soums in reducing the number of patients

presenting at Aimag Hospitals, however, referral protocols could be further strengthened to discourage unwarranted hospital presentations.

43. Aimag Hospitals operate in a far more populous area than Soum Hospitals and are complimented by FGP's and private hospitals and clinics. Scope exists at Aimag Hospital level for contracting out of some clinical services, non – clinical services, collocation with private hospitals/clinics, contracting with private doctors for sessional clinical work of a specialist nature and/or establishing private wards/beds within any existing surplus facility capacity under terms and conditions previously mentioned.
44. Full privatisation of Aimag Hospitals would remove their largest income source, the local budget. Aimag Hospitals could not operate as private hospitals and provide the level and complexity of services without budget support. Patients do not have the financial capacity to make co-payments equal to the budget reduction. Performance Management Contracts can and should be introduced at Aimag Hospitals. (see later reference). The poor and vulnerable should still continue to be treated free of charge.

### **Contracting Out**

45. As mentioned in the Background Section of the report, Government established a Contracting Out Program in the late 1990's. This Program also produced a very broad (non detailed) set of policies, guidelines and expectations, and very broadly, detailed the responsibilities of MOH, MOF, SPC and Governors of Aimag Capital Cities, Soums and Districts. It even contained four (4) post – program evaluation indicators. There is great uncertainty as to whether this Program was ever really implemented apart from the pilot program for Soum Hospitals and the Bayanzurkh District Hospital in UB. A few Aimag Hospitals may have undertaken some contracting out of non – clinical services but the evidence is anecdotal. Certainly, some UB District Hospitals have outsourced kitchen, cleaning and laundry services, but rural areas appear not to have embraced the concept.
46. There appears to have been no training of Hospital Administrators and Directors regarding principles, applications, benefits, risks, contract design and execution for contracting out activities. A satisfactory (easily understood) set of policies and guidelines was never developed and promulgated nor a practitioner's guide provided to assist hospitals implement the policy when/wherever appropriate.
47. Opportunities for contracting out exist at both Soum and Aimag levels, however, Aimag with their larger population bases and greater services complexity, are more likely to be able to provide viable business opportunities for the private sector in both clinical and non – clinical areas. It is essential however that adequate policy /guideline development be undertaken, a practitioner's guide developed and adequate training be provided before Government encourages further services outsourcing. Contracting out must provide value – for – money and satisfy and protect the public

interest. Hospital Administrators and Directors must be taught how to develop business cases for contracting out opportunities.

48. Local Governments must allow hospitals to retain savings made from outsourcing activities and not reduce subsequent budgets, as has been the practice to date. Management must be encouraged to look for innovative and value – for – money ways of delivering health services.

**Hospitals must be funded to a level that ensures contracts can be honoured on a timely basis if contracting out activities are to be pursued. (see newspaper clipping attachment).**

*Potential Contracting Out Opportunities for Soum and Aimag Hospitals.*

- a. Food Provision.
- b. Laundry.
- c. Cleaning.
- d. Maintenance of Building and Engineering Services.
- e. Maintenance of Medical Equipment.
- f. Diagnostic Laboratories. (Aimags only)
- g. Medical Imaging. (Aimags only)
- h. Introduction of ongoing training.
- i. Performance Management Contracts. (see later reference)
- j. Leasing of equipment from suppliers. (Aimags only)

**Collocations**

49. Private hospital participation in other countries' hospital industries includes the establishment of private hospitals that are collocated with a public facility to form a joint medical facility or precinct. While there may be some 'sharing' of facilities, the private hospital is not usually involved in the delivery of any public hospital services. Moreover, collocated public and private hospitals operate at arm's length.
50. Collocations were rare a decade ago, but have gained popularity since the mid 1990s, particularly in Australia and South Africa. The growth in collocations reflects complementarities and economies of scope in the provision of public and private hospital services. The predominant collocation model involves a separate private

hospital on the same campus as a public hospital. Other models include a private hospital occupying a ward of a public hospital, and a private hospital adjacent to a public hospital.

51. The advantages of collocation for a private hospital are:

- lower operating costs due to shared facilities such as pathology, radiology, laundry, catering and parking;
- an increased customer base through patients admitted via the public hospital accident and emergency ward;
- greater access to doctors;
- greater access to research and development, new equipment and new techniques; and
- greater opportunities to provide private services in rural locations which may be unable to support a separately sited private hospital, but may sustain a collocated private hospital.

52. The advantages of collocation for a public hospital are:

- decreased operating costs by sharing facilities; -greater access to doctors; and
- better utilisation of equipment.

53. The disadvantages of collocation for both public and private hospitals are:

- loss of total management control due to contractual obligations to the co-located hospital; and
- increased dependency on the operator of the co-located hospital to jointly manage risks.

**Collocations offer opportunities for Soum, Aimag, District, Clinical and Specialised Hospitals to better utilise surplus capacity, attract and retain doctors and improve the quality of health services provision.**

### **Sessional Work**

54. A further development of the collocation theme can be the introduction of sessional work. Sessional work involves private practitioners operating in public facilities on a contract basis. Such practitioners are generally highly skilled from whom public doctors are able to learn new techniques whilst assisting with diagnosis, surgery and

patient recuperation. The private practitioners benefit from being able to use the best available equipment and facilities.

55. Mongolian private practitioners are currently precluded from working in public hospitals with the exception of a special class of doctor known as a “General Consultants”. One of the great dangers of adhering to current policy is a “brain drain” as the very best doctors leave the public sector to develop private practices and hospitals. Doctors with good reputations attract clients and will be financially successful. The public system will continue to stagnate if the best minds are not able to assist in ongoing professional development of public sector staff.
56. Whilst the focus of this consultancy is essentially centred on making recommendations for improving rural health outcomes through the introduction of appropriate public – private partnerships, the major key to success is the ability to provide increased financial resources to rural areas to improve facilities, equipment, staff training, attraction and retention and the development of an integrated health system to replace the fragmented and confusing system that exists today.
57. Accordingly, it would seem appropriate to review what improvements could be undertaken on a “whole of Government” basis and also in Ulaanbaatar where there is large scope for improvement and resource reallocation.

### ***Current Health System Structure***

58. The Ministry of Finance, Local Government Offices and the HIF currently control financial resource allocation. The Ministry for Health is responsible for Health Policy development, planning and promulgation. The NCHD is responsible for the development and implementation of licensing and accreditation standards, although there does appear to be some confusion as to whether or not they are fully responsible for implementation. The SIH is responsible amongst other things for the policing of licensing and accreditation standards. It has the ability to impose financial penalties on doctors and hospitals that seriously contravene licensing and accreditation standards.
59. Whilst the MOH is responsible for Health Policy development, planning and promulgation, it has very little control over actual policy implementation. This responsibility by default resides with Local Governments; it appears that implementation policy/methodology differs from district to district resulting in inconsistent application of Government Policy and indiscriminate financial resource allocation. MOH does not have the financial levers necessary to influence consistent policy implementation. This has resulted in a fragmented system with little or no services integration.
60. Government should be strongly encouraged to immediately commence a comprehensive review of the health and health insurance systems with a view to

implementing structural reforms, part of which maybe private provision of public health services. Privatisation by itself will not bring about structural reform, but the work required to identify and encourage private sector interest is complimentary to the work required to bring about meaningful and lasting reforms.

61. The major impediment to the development of an integrated health system is the lack of a **single health services purchaser**. MOH should become the sole health services purchaser. Budgets can still be developed at Soum, Aimag Hospital levels and consolidated at Aimag Regional Centres. UB District Hospitals can do the same but the consolidated budgets should be submitted to MOH for final approval before submission to Government. Once approved, MOH can release the budgets to districts in accordance with approved policies. Should districts fail to implement approved programs and divert moneys to other uses (particularly outside of health), then MOH has the ability to withhold payments until remedial action has been undertaken.
62. The public system will not improve significantly unless the Purchaser/Provider model is adopted. The issues discussed in relation to public - private partnerships in UB and resultant savings are useless unless Government reverts to a single purchaser that can redistribute budget savings. Otherwise, budget savings remain with the Local Government and cannot be used to improve health care outcomes in rural Mongolia.

### *Performance Management Contracts*

63. Performance Management Contracts should be developed and implemented in all public hospitals by MOH to ensure consistency of approach. Hospital management should be trained in performance management techniques and MOH or some other associated agency, should be trained in performance reporting and monitoring. The proposed contracts would reward excellence and penalise poor performance. This is the first step in preparing hospitals for partial or full management privatisation and would encourage improved performance amongst public hospitals, particularly if they were able to grow their business by attracting clients from other districts (UB only) due to their good performance. It would enable Government to clearly identify poor performing hospitals and rationalise bed and facilities allocation.

### *Health Insurance Fund*

64. The HIF currently contracts with individual private hospitals and negotiates rebates with those hospitals on the basis of the quality and complexity of procedure delivered. The average rebate achieved by private hospitals is currently approximately 57% of the public hospital rebate level. Whilst it is acknowledged that a lot of private hospitals are really only clinics, for the few established private hospitals offering comprehensive inpatient services, it is difficult to believe that their service quality is not equal to or better than some public facilities. This must be the case as only 2

public hospitals are accredited and none are subject to performance outcome standards.

65. HIF should agree to reimburse private hospitals that provide services equal in quality and complexity to public hospitals at the public hospital rebate rate. Further, HIF should be encouraged to review its' payment regime for ambulatory outpatients. Ambulatory outpatients seek treatment from FGP's, but because of inadequate/inconsistent referral protocols and the public's failure/unwillingness to change, large numbers of clients still present at public outpatient clinics. This behaviour wastes limited financial resources.
66. HIF should review its inpatient reimbursement strategies with a view to developing incentives for hospital managers to reduce ALOS. This would enable Government to further rationalize bed and facilities allocations and perhaps close some older and more inefficient hospitals. **Financial savings could be redistributed to rural areas.**

### *Collocations*

67. As previously mentioned, collocations offer substantial benefits to both Government and the private sector. Immense scope exists within UB to develop a variety of collocation models, particularly if the HIF were successful in influencing a major reduction in ALOS and Government facilities (part or whole) became surplus to requirements.

### *Foreign Exchange Loss*

68. It is estimated that somewhere between 30 – 35,000 Mongolians went to Inner Mongolia in 2001 for medical procedures. Other Mongolians are known to have traveled to Beijing, Seoul and Tokyo for major surgery and cancer treatment. If we assume a cost of USD 1,000 per trip, then a substantial amount of foreign exchange is being lost despite some of the services being available within Mongolia. For those services that are available within Mongolia, there appears to be client distrust/uncertainty or lack of knowledge as to the alternatives to traveling abroad.
69. An alternative that should be considered is the establishment of a “Hospital of Excellence” within UB. This hospital could be delivered under a BOO model – Built, Owned and Operated by the private sector. Government should encourage the local private health sector to consider developing such a model. The International Finance Corporation (IFC) may consider contributing debt and or equity to such a project. The hospital could provide specialist inpatient treatments for private patients; Government could also consider purchasing selected services under a contract arrangement, subject to quality outcomes. The hospital could perhaps provide MRI and CT Scan

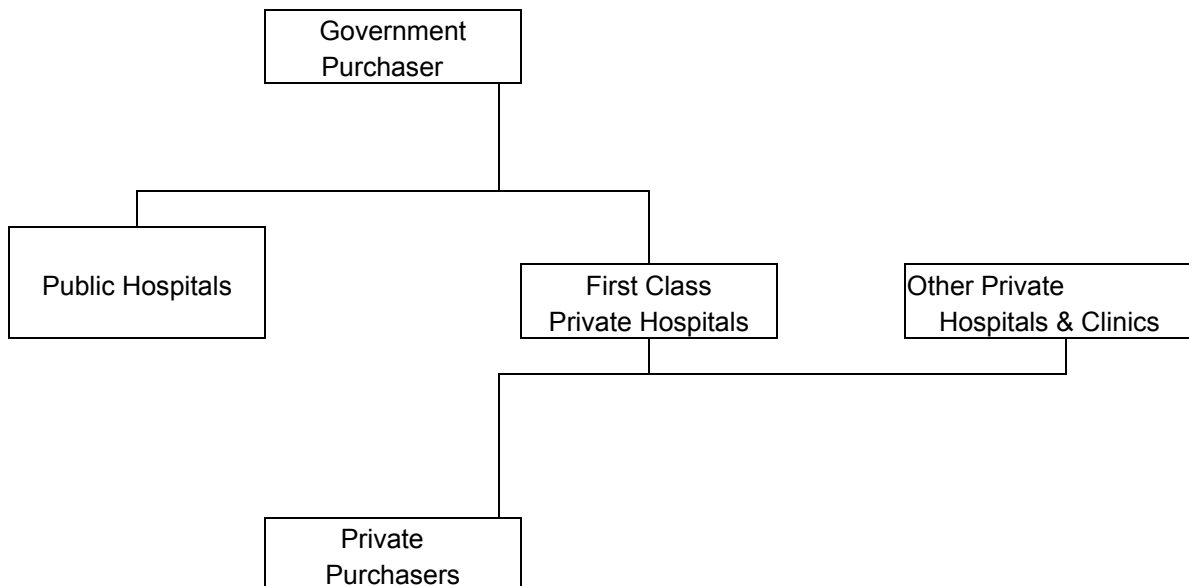
services. It could be further strengthened by visits from internationally renowned physicians. The majority of income generated would remain in Mongolia.

### ***Hospital Accreditation Standards***

70. Hospital Accreditation Standards have been developed for both public and private hospitals but to date have only been implemented in 2 public hospitals. Hospital Accreditation Standards should be reviewed with a view to developing two classes of private hospitals:

- one where Government would be prepared to purchase specified inpatient services from a private hospital; and
- another which would cover the operations of all other private hospitals.

71. A strengthening of private hospital standards would also assist industry rationalisation and improve consumer confidence. Perhaps it maybe worthwhile developing minimal acceptable standards for private health clinics. SIH has a role in assessing the suitability of premises and ensuring licensing of doctors but here do not appear to be any minimum equipment regulations or obligations for doctors to provide health education/prevention functions.



### ***Contracting Out (UB)***

72. As previously mentioned, some UB District Hospitals have already contracted out kitchen, cleaning and laundry services. Hospital 1 purchases some diagnostic tests from a private provider. UB offers many and varied opportunities for contracting out activities, such as:

- a. Food Provision.
- b. Laundry.
- c. Cleaning.
- d. Maintenance of Building and Engineering Services.
- e. Maintenance of Medical Equipment.
- f. Diagnostic Laboratories. There is no reason why a central, privately owned and operated diagnostic laboratory could not be established within UB to provide services to all UB public and private hospitals. A fleet of small cars would deliver the results.
- g. Medical Imaging. Same as the diagnostic laboratory.
- h. Central Blood Bank.
- i. Specialist medical services.
- j. Professional development/training – medical and administration.
- k. Information, communication, telecommunications – to be provided by a private provider/s under performance contract. Costs could be shared with other Government Departments if a Mongolia wide service was developed.
- l. Performance Management Contracts.
- m. Partial or full privatisation of selected hospitals – see Performance Management Contracts.
- n. Leasing of equipment.

### ***Training***

73. The number of physicians continues to increase – 6,498 in 2000. This means one physician per 368 of population in Mongolia and one per 210 of population in UB. It should be realised that:

- (a) every licensed physician is increasing the total cost of health services, working either in the public or private sectors,
  - (b) the quality of health services does not have positive correlation with the number of physicians if there are no resources to train and equip them well, and
  - (c) MOH should have control over the intake of medical students. As the Government is committed to support both public and private services, this means support to an increasing number of private hospitals and practitioners without proper quality standards.
74. Why not target a lower number of physicians and hospitals with a focus on better training, better facilities and equipment and more funds for recurrent operating costs? Put quality before quantity. Such rationalisation could only be achieved with the co-operation of the private medical schools.
75. Mongolia lacks qualified Hospital Administrators, Health Planners and Health Economists. Why not consider a temporary embargo (in collaboration with private sector educational facilities) on the number of medical school admissions and concentrate on developing management skills in the health sector to improve performance outcomes.
76. As is the case with Soum and Aimag Hospitals, there does not appear to be any provision of ongoing post - graduate training. Private medical schools in conjunction with the MMU could develop appropriate courses and be contracted to conduct them by MOH, again assuming the sole purchaser model.
77. Health prevention/awareness could be improved through compulsory private hospital and private practitioner involvement. “**Twinning**” with foreign universities and medical institutions would provide the basis for knowledge swaps, further training, exchange students and practitioners. Installation of telemedicine facilities in rural and urban areas would allow the benefits of such a program to be maximised.

### ***Legislation***

78. Legislative changes would be required to facilitate many of the aforementioned public – private partnerships.

### ***Conclusions***

79. Opportunities for the establishment of public – private partnerships for the benefit and well-being of all Mongolians exist within the current Mongolian Health System; however, they will not produce meaningful and long-lasting results unless Government has a firm conviction to embrace major systemic reforms.

## RECOMMENDATIONS

1. The poor continue to be provided with free health services from public health facilities.
2. Performance Management Contracts be introduced in all public hospitals.
3. Soum Hospitals remain under Government ownership and direct control.
4. The Contracting Out Policy and Guidelines be updated, a Practitioner's Guide or Manual be produced and that adequate training in its' use be made available to all Hospital Directors and Administrators.
5. Public Hospitals should be encouraged to seek contracting out opportunities.
6. Government allow public hospitals to pursue collocation concepts where cost, education, quality, staff retention benefits can be gained and demonstrated to Government.
7. Government to permit sessional work by private practitioners in public hospitals under strict contractual arrangements, which shall include performance outcome measures.
8. Government undertake a comprehensive review of health sector financing and adopt a single purchaser model with the Ministry of Health becoming the single health services purchaser for the whole of Mongolia.
9. Review the Health Insurance Fund rebate scheme and agree to pay private hospitals that provide health services equal to or of greater quality and complexity than public hospitals, the same rebate as is attributable to the public hospital system.
10. Government should work with the private sector in the development of a "Super Hospital" to attract and retain patients who currently travel abroad for treatments.
11. Government should review the accreditation system for private hospitals and establish a two – tier system where the higher classified private hospitals would be accredited to provide a range of public hospital services. Government could purchase such services on a needs basis.
12. The public and private hospital accreditation standards need to be implemented and monitored promptly.

13. Government should use private educational facilities (on and offshore) to develop training courses for public health facilities and also to design courses that will produce Hospital Administrators, Health Planners and Health Economists to improve the Mongolian Health System.

## **Abbreviations and Acronyms**

ALOS	Average Length of Stay
FGP	Family Group Practice
GDP	Gross Domestic Product
HIF	Health Insurance Fund
HMIEC	Health Management Information and Education Centre
HSDP	Health Sector Development Plan
MMU	Mongolian Medical University
MNT	Mongolian Tugrig
MO	Minister's Order
MOH	Ministry of Health
MOHSW	Ministry of Health and Social Welfare
NCHD	National Centre for Health Development (until 2000 HMIEC)
SIH	State Inspectorate for Health
UB	Ulaanbaatar
USD	United States Dollars
WHO	World Health Organisation

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## **List of Visits/Contacts**

Dr. G Tsulbuur, General Director, The Emergency Medical Services Center  
Dash-Yandag Buddorj, General Director, "MHM" Co Ltd Bayanzurkh Hospital  
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J. Jargalsaikahan, Director, Economic Policy and Planning, MOF  
Dr. S. Dulamsuren, Director, National Centre for Health Development  
Dr. Dolgor, President, Association of Private Health Organisations

Mr. Bailikhuu, Senior Adviser, State Property Committee  
Mr. Michael O'Rourke, HSDP 1  
Dr. Bishendei, SSIGO, Head of Health Insurance Health  
Mr. W. Hagan, Director, World Health Organisation, Mongolia  
Mr. R. Stevens, Consultant, World Health Organisation, Mongolia  
Mr. S. Meyanathan, Country Manager, World Bank Mongolia  
Dr. A. Jigidsuren, Director, Chingeltei District Health Center  
Dr. Zina, Officer, MOH  
Visits to 2 Chingeltei District Family Group Practices  
Visit to 1 Bayanzurkh District Family Group Practices  
Dr. G. Buyan-Ulzii, General Director, Yonsei Friendship Hospital  
Dr. Dakisureen, Director, Private Health Centre  
Mrs. Erdenechimeg, Head of Policy Planning and Coordination Department. MOH  
Dr. N. Udval, Vice Minister for Health  
Mr. Sodnompil, State Secretary of the MOH  
Dr. S. Oyunchimeg, Head, State Inspectorate for Health  
Visit to Dr. Dulamsuren, Chief Doctor, Uvurkhougou Aimag Regional Diagnostic Centre  
Visit to Dr. Tsetsegsuren, Uvurkhougou Aimag Private Hospital  
Visit to Khar Khorum Inter - Soum Hospital, Uvurkhougou  
Dr. Dagvadorj, Manager and Chief, "Eleg" Private Hospital  
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