

**Strengthening the Capacity and Multi-Sector Collaboration to
Improve Social Health Insurance in Mongolia**

ILO-WHO-GTZ-ADB

Final Report

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INTRODUCTION

1. WHO, GTZ, ADB and ILO have agreed following the request for a technical assistance to improve the consultation process of the Ministry of Social Welfare and Labor and other stakeholders of the social health insurance, to improve cooperation between the sectors and to develop a long term social health strategy document. The consortium was established under the purpose of supporting the Ministry of Social Welfare and Labor through implementation of measures to improve Cooperation and Capacity of Stakeholders of Social Health Insurance.

2. The partners fielded two missions comprising the social protection expert Mr. Axel Weber (ADB) and as local consultant Mrs. B.Otgonjargal. They have performed the following tasks within the project:

- **Assessment and review of the existing social health insurance system** with view to achieving its overall objectives.
- Development of a **national strategic plan** for social health insurance and related **consensus** among key stakeholders

3. During the assignment the consultants reviewed legal documents on social health insurance and met with Government officials, law enforcement organizations as well as international and local experts operating in Mongolia. This report consists of 6 parts:

- A description of the health system in Mongolia
- A historical description of the development of Social Health Insurance in the Last 10 Years, and Current situation of the health insurance system
- Existing problems and issues
- Strategy and Recommendations.
- Conclusion
- Annexes

4. The mission would like to express its gratitude to Ms S. Baigalmaa, the State Secretary of MSWL, Ms J. Altantuya, the State Secretary of MH, Mr S. Erdene, the Director General of SSIGO, Ms Ch. Oyun, Head of the Health Insurance Department, SSIGO, Ms. Erdenesuvd, the Specialist of MSWL, Bolor-Erdene and Chuluunbat, specialists of MF as well as others for their generous support for our work.

I. THE MONGOLIAN HEALTH SYSTEM¹

A. Background

5. Mongolia has a post-Semashko health care system with a mix of revenue sources, private sector service delivery and a plurality of actors. In the early 1990s, Mongolia embarked on the path of health care reforms, which has brought new policy initiatives and changes in priority areas allowing new actors and mechanisms in the health sector to emerge.

¹ The present overview is based on the paper „Health Systems In Transition” published by the WHO. 2007

6. Mongolia has a relatively small population of about 2.5 million people. Due to internal migration trends, 59% of its citizens now live in urban areas, while the other 41% live in remote rural areas, mostly working as nomadic livestock herders. The vast size of the country combined with low population density and nomadic tradition pose particular problems in the provision of health care services and, for rural nomadic populations, accessing health care.

7. Life expectancy at birth for males and females in 2004 was 61.6 and 67.8 years respectively. In 2005, the maternal mortality rate fell to its lowest level of 93.8 per 100 000 live births. Infant mortality has also decreased gradually and was 20.8 deaths per 1000 births in the same year. Mongolia is experiencing both a demographic transition as the birth rates fall and the population starts to age, and an epidemiological transition as the number of deaths from communicable diseases decreases and the number of deaths from noncommunicable diseases increases. The three main causes of mortality in Mongolia are currently cardiovascular diseases, neoplasms and external causes (injuries and poisonings). However, viral hepatitis, tuberculosis (TB) and sexually transmitted infections remain the most common infectious diseases.

8. Before 1991, Mongolia had a Semashko-style centralized and hierarchical health system where the Government, administratively and financially supported by the Soviet Union, fully financed and delivered health care services. While the Semashko system aimed to ensure equity and broad access to health services, it also had a strong orientation towards curative services. However, in the late 1980s to early 1990s, with the collapse of the Soviet Union and democratic changes in Mongolia, it became evident that free health care services with state financing alone were unsustainable in the new market economy. The introduction of informal user fees as a mechanism to supplement the underfunded health system led to access inequalities. To improve the system and find new ways of financing health care, in 1993 Mongolia started health care financing reform, which introduced social health insurance as part of a larger social security framework.

B. Organization of the Health System

9. The Ministry of Health (MoH) is the Government's central administrative body responsible for health policy formulation, planning and regulation. It also oversees the implementation of health-related policies and the meeting of standards by the appropriate institutions and agencies. Since the MoH continues to be heavily involved in the implementation of donor-funded projects and initiatives, it delegates some of its planning and policy-setting responsibilities to a number of agencies. Other ministries share responsibilities related to health care funding, provision of social and health insurance, and the improvement of professional training and health education. While international donor organizations play an important role in providing assistance and shaping health policies and programmes, the contribution from the growing nongovernmental organization community to strengthening health care system capacity remains relatively modest.

10. The health system is one statutory system organized according to administrative division: the capital city (Ulaanbaatar), and 21 regions (aimags), each of which is split into smaller districts (soums), which are further divided into three to four smaller units (baghs). Decentralization of the system occurred as part of a national development strategy in the mid-1990s and was a response to the reduction in government funding for health. Thus far, attempts to delegate to local governments planning, monitoring, financial and administrative functions within the health sector have not led to a meaningful increase in the level of primary stakeholder participation or to an improvement in the performance of health services. Health managers at both the central and local levels lack capacity, and there are no clear guidelines or procedures to implement decentralization systematically, even though the basic elements of the legal framework for decentralization and structural reform are in place. Lack of professionally trained staff, capacity limits of existing personnel, budgetary constraints and

inadequate information management system are among the major challenges that have hindered the success of decentralization efforts.

C. Health care financing

11. The state health budget allocated through the MoH covers the fixed costs of the health facilities based on the historical allocations and clinical capacities of organizations (the number of hospital beds, doctors, clinics, etc.), while health insurance funds are used to cover health service provision

12. According to the Health Act of 1998 all citizens have the right to receive certain medical care free of charge. As part of the essential package of services, free medical assistance covered medical emergency and ambulance services; treatment for certain illnesses such as TB, cancer, mental illness and some other diseases which require long-term care; disinfection and outbreak management of infectious diseases; and medical services for pregnant women. Other care, such as inpatient services and outpatient services and medicines on the Essential Drugs List, were covered by the health insurance system. However, since then certain population groups, such as students and the self-employed (including traditional herders) have had to pay their own insurance premiums, and health insurance coverage declined from 95.3% of the population in 1998 to 77.6% in 2005. To eliminate the potential effects of adverse selection in health insurance and to improve health care equality, the Health Act was amended in January 2006 so that primary health care (PHC) services could be provided to all citizens, regardless of their insurance status, and the essential services package is funded directly from the state budget. Today, the package of essential services includes public health components, adolescent health, social health programs and health education, as well as family group practices (FGPs). Extending the benefits of the essential services package to include FGPs has been seen as a progressive policy step towards providing financial and legislative guarantees for all Mongolian citizens to receive basic health care services fairly and equitably.

13. The state budget, for which revenues are raised through general taxation, covers the fixed costs of health facilities, capital investment, maternal and child care costs, some services in the essential services package and the minimum health insurance contribution for low-income and vulnerable groups. Health insurance, managed by the Health Insurance Fund (HIF), finances the complementary package of services through the monthly contributions from income-earning groups. Official out-of-pocket payments include direct payments to private health care facilities, official co-payments and user fees in public health facilities, and the direct costs of seeking medical services abroad. External sources of funds usually come from the international partners in the form of official development assistance grants (non-repayable development grants, technical assistance and other instruments) and as soft loans (repayable funds or assets).

14. Mongolia has two major pools of funds, the government health budget and the HIF, which together fund 70% of total health expenditure. Meanwhile, 84% of total health expenditure comes from prepaid sources pooled at the national level. The MoH acts as a third-party payer for health services funded from the central government budget. It allocates resources to city and regional governors, who are the purchasers of health services at the primary and secondary levels. The HIF, operated by the State Social Insurance General Office (SSIGO) under the Ministry of Social Welfare and Labour (MoSWL), is a single national fund with approximately 77% of the population insured. It uses its local branches to collect revenue and pay for insured care. Despite this high degree of pooling, a detailed study of Histate cross-subsidy between poor and non-poor or sick and healthy within the pool has never been conducted. Since 2002, it is likely that the number of people seeking health services abroad has increased, and so has out-of-pocket expenditure, exposing more people to financial risk. Consequently, an up-to-date, detailed and rigorous study of out-of-pocket expenditure and informal payments is needed.

D. Provider Payment

15. There are currently six main health provider payment mechanisms: line items in the state budget; provider based case payment from the HIF; capitation funds through the FGPs; patient co-payments; official user charges; and unofficial payments such as gifts and compensations. In 2006, significant changes to the health financing were made. First, FGPs and soum hospitals, as providers of primary care, will be funded only from the government budget to ensure that every person, irrespective of ability to pay, receives primary care services. Second, there will no longer be a division between fixed and variable costs by sources of funding. The government budget and HIF will be responsible for the full cost of their respective health services, and the MoH alone will set a payment fee and payment method for health services. The situation is still problematic with improving health service quality and efficiency. Despite the efforts to encourage output contracting, health service provision is still dominated by the public providers whose activities are controlled through a hierarchical management system. Purchasers do not practice selective contracting because insured patients are free to choose any selected private hospital for treatment and public hospitals are fully dependent on government funds. Because of the heavy reliance on line item budgeting, the output contracts fail to specify the cost, volume and quality indicators for each output. And despite a number of training schemes and capacity building efforts, the output costing process is still in its nascent stages. Although health care personnel at public hospitals receive state-provided salaries and benefits, they are allowed to engage in private practise and charge fees for services provided out of working hours.

16. Currently there are no regulations regarding private practice by public hospital-based doctors and no price regulation or guidelines in place to prevent perverse incentives. Similarly, there is no government regulation of how money should be allocated among doctors and nurses in FGPs, which are considered private profit-making cooperatives. Low salaries of doctors in public hospitals are seen as one of the major factors in high levels of informal payments in Mongolia. To resolve this issue, a number of options have been discussed and proposed, including an increase in the payment rate to hospitals from the HIF, an increase in official out-of-pocket payments and the privatization of public facilities (1).

E. Planning and regulation

17. The MoH is responsible for health policy setting, budgeting and monitoring its realization at the central, regional and capital city levels. It also develops, approves and oversees the implementation of rules, procedures and standards on health protection and promotion. The Ministry of Finance decides the total budget allocations to the health sector based on historical expenditure, norms and standards in the sector, as well as government resolutions and national health programmes related to the priority areas identified. The MoSWL is mainly responsible for the policies and programmes related to social welfare, social insurance, poverty reduction, employment and coordination of the labour market, among others. The MoH and MoSWL are involved in the purchasing of and resource allocation in health care. However, there is little coordination of the service purchasing policies between the health insurance scheme and the MoH. At the level of the health system (MoH) and the health insurance implementing agency (SSIGO), there is no systematic monitoring of the health system performance or the impact of health insurance scheme on quality, outcomes, access, efficiency or effectiveness. Currently, regulation of private insurance companies, as they are only just developing, is lacking and it is not yet clear which agency will be responsible for the regulation of the potential private health insurance market (1). The MoH at the national level and health departments at the local level are responsible for the regulation and governance of service providers. The Medical Licensing Board under the MoH has been managing the licensing system for health practitioners and the accreditation of health care organizations. However, the quality assurance system in the HIF is very basic and there is a need to build an assessment framework that would monitor and evaluate the effects of purchasing arrangements on services. Recently, both the MoH and

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SSIGO took a number of measures to check the quality of medical care and ensure its compliance with clinical guidelines. In terms of purchasing processes, the MoH and the Aimag Health Departments had virtually no involvement in the development and allocation of public budgets until 2003, when the Public Sector Management and Financing Law (PSMFL) was introduced, giving the MoH the opportunity to take control over health expenditure and to allocate funding according to the priorities set. While much has been accomplished over the past years in implementing the law, such as shifting from input to output accounting, there is still a need to change focus from centralized health care management towards building capacity at various levels, including all aspects of the mandated planning and budgetary system. The PSMFL introduced a totally new concept in planning, budgeting and managing public resources, but it has yet to be accepted by health care professionals and implemented in a uniform fashion. In Mongolia, neither health information systems nor new health technology assessment have been well managed or coordinated to meet the health needs of the population and the overall capacity of the health system. Standardization of existing and the introduction of new technologies including information technology have become one of the Government's priorities since 2002, when it started systematic collection of health status and health system's financial data. The role of health information has been recently expanding to become a tool for estimating the results of activities, rational planning and resource allocation. Currently, a number of projects on enhancing different aspects of the health information systems and data collection methods are being implemented to improve health sector performance and effectiveness. Many medical professionals are striving to become competent in English language and computer skills to enable access to online evidencebased information thus improving their clinical decision-making.

F. Physical and human resources

18. The amount of funds allocated for capital investment in Mongolia's health sector has been increasing and reached 2.6 billion Tugrik (approximately US\$ 2.3 million) in 2006. Capital investment in the public health sector is mostly funded by the Government out of the national budget or supported by international grant or loan aid. From 1999 to 2003, a rather small percentage of the state health budget was used for the procurement and maintenance of medical and other related equipment; of the 20.2 billion Tugrik (approximately US\$ 18.4 million) invested in medical and related equipment in this period, 96% came from international partner funds and only 4% from the state budget. To ensure the equitable distribution and gauge true levels of need for equipment at state-owned health facilities, the MoH has developed a list of essential medical equipment that sets the minimum and maximum numbers for medical equipment at each level in the health care delivery system. As Mongolia still has a large number of hospital beds, 730 per 100 000 population in 2004, the MoH has been implementing a policy to reduce them in health facilities. However, there has been little change because the payment for services in hospitals is based on the number of inpatient beds and their occupancy rate, rather than the services provided. Medical facilities, equipment and technology in Mongolia are often outdated and in a poor state of repair. The lack of a regular supply and maintenance system for medical equipment and laboratory technology weakens diagnostic capacity in the system, leading to failures in providing accurate diagnoses, which undermines patient trust in public health services. Because of the funding gaps, the construction of new health facilities and procurement of medical equipment are mostly financed by international partners.

19. Under the Semashko system, government policies to improve access to health services centred on increasing the number of service providers. Although there has been a decline in the number of all health workers from 217.9 per 10 000 population in 1990 to 130.5 in 2003, the current levels are still too high. As of 2004, there were some 33 478 professionals employed in the Mongolian health sector, with 2.7 doctors per 1000 population. However, the distribution of medical professionals across the country is not even. In Ulaanbaatar, there were 4.4 doctors per 1000 population, while there were on average only 1.7 doctors per 1000

population in the aimags. About 5.2% of the total of 323 soum and intersoum (serving populations of two or more soums) hospitals had no doctors as of 2005 (14). Financial incentives are currently insufficient to motivate enough doctors to move to rural hospitals. In order to increase the number of physicians working in the rural areas, amendments to the Health Act were made in 2006, requiring final-year undergraduates in medical schools to work under the supervision of soum and intersoum doctors for at least two years prior to completing their formal medical training and obtaining their diplomas.

20. Mongolia is also experiencing a shortage of nurses. In 2004, there were 7915 nurses working in Mongolia. While the doctor-to-nurse ratio is 1.16, it has been estimated that 2.5 times as many nurses are needed. This imbalance in skill distribution negatively affected areas of health care that require high numbers of nurses, such as reproductive health services. Today, medical staff training and education are not linked to factors such as population growth, the current and projected epidemiological profile of the population and the reform agendas of privatization, rationalization and modernization of health services. The supply side of human resources, such as medical schools, was traditionally controlled and funded by the Ministry of Education, Culture and Science (MECS). Amendments to the Health Act were made in 2005 to transfer the state medical schools from the authority of MECS to the MoH. These trends support current human resource policies which are aimed at improving quality and equal distribution

G. Provision of services

21. The health system in Mongolia still directs most of its financial resources to expensive hospital-based services, and preventive services remain underfunded unless supported by international aid. Despite official policy changes, it has proved difficult to reorient the health system away from curative to more cost-effective preventative services. Public hospital management is still a part of the bureaucratic hierarchy based on the Semashko model of centralized control. Hospital managers are not encouraged to produce budget savings and are not allowed to overspend. Meanwhile, services such as long-term care for elderly and disabled are still underdeveloped and rely on family care and support. Only recently palliative care has been officially integrated into the health care sector and medical education curricula. Despite the positive achievements in the development of palliative care, the government support for community and home care, and its implementation at primary and secondary levels, the provision of palliative care services is still insufficient. Although this is by no means unique to Mongolia, it does reflect policy shortcomings, in that the necessary structural adjustments to the system were not made at the same time as the policy directions were adopted.

22. Similar to other post-Semashko systems, Mongolia's public health system is primarily based on a network of sanitary-epidemiological stations, carrying out traditional roles such as monitoring hygiene standards, environmental health and epidemiological monitoring. However, since the 1990s, the Government and the MoH have made public health and preventive medicine a primary focus of the health sector. National programmes on communicable and noncommunicable disease control have been developed and are currently implemented at the national and local levels. Bagh feldshers (medically trained PHC workers in more remote rural regions) as well as soum and family doctors play an important role in providing immunization services. Most national health programmes also include components on health education and promotion targeted at different population groups. Informational and educational activities have been incorporated into primary care services, building a continuous and sustainable environment for delivering health education to the population. Health education has also been included in the school curriculum at all levels. However, initiatives and activities to promote health outside the health sector are still weak. The social determinants of health have not yet been included in the health priorities of the government action plan.

23. Primary health care services are delivered by FGPs, soum doctors and bagh feldshers, who are medically trained PHC workers in the smallest administrative units. In the Ulaanbaatar and the aimag centres there are district hospitals and FGPs. FGPs, which usually consist of three to six family doctors and one nurse per doctor, are required to deliver primary care for the listed population in their catchment area. On average, 6375 residents are registered with each FGP and one family doctor serves between 1200 and 1500 people. On a local level, feldshers report to soum hospitals through regular meetings and visits, and in case of emergencies refer patients to soum or intersoum (larger centres that render health services to the population of two or more soums) hospitals. Most of the soum hospitals have between 15 and 30 beds and provide antenatal and postnatal care, minor surgery, normal deliveries, referral to an aimag hospital, and health education and prevention activities. As of 2005, there were 31 intersoum and 287 soum hospitals (17). As a result of geographical circumstances, there are big differences between the patient pathways in urban and rural areas: FGPs provide primary care services for the people who live in the capital city and the aimag centres, while bagh feldshers or soum doctors provide a wider range of primary care services to the rural population. Understaffing in rural facilities make the access to and quality of primary

24. Specialized care in Mongolia is delivered by aimag and urban district hospitals, which cover all major clinical specialties and have an approximate capacity of between 200 and 300 beds for delivering inpatient services (1). The next level of specialized care is provided through the state clinical hospitals and specialized health centres, located mainly in Ulaanbaatar, but also through the three Regional Diagnostic and Treatment Centres, which provide specialized tertiary-level referral, diagnostic and treatment services to the catchment population outside the capital. Specialized care services are delivered by both publicly and privately funded hospitals. While the Government of Mongolia has been trying to reduce the number of state-owned hospital beds, the bed numbers in private hospitals have been expanding. A cultural belief, which equates better services with more specialized care, makes it hard to change the current hospital structure and contributes to the overcapacity of hospital beds at the secondary and tertiary levels. Hospital services are not appropriate for the corresponding level of care, and are still a major challenge for the whole health system in Mongolia.

H. Health care reforms

25. At the beginning of the 1990s, the abrupt end of assistance to the health sector from the Soviet Union brought about extreme difficulties in financing the health care system that was in place. Health sector reforms, introduced during this time, relied mainly on the strategy of mobilizing additional financial resources and reducing the government burden in order to tackle the sudden drastic decline in the health budget as a result of economic transition. The inherited Semashko system has evolved into a health system with a mix of revenue sources, private sector service delivery and a plurality of actors. Official user fees and social health insurance have been gradually introduced in order to plug the funding gap, along with significant contributions from international donors for health care delivery. Meanwhile, problems with access and quality have been exacerbated by the deteriorating socioeconomic situation and public funding shortfall for the health sector. In line with the Government's commitment to providing equitable and high-quality health services to all citizens, in the late 1990s the reform focus shifted towards systemic-level changes and promoting equity through institutional changes and improvements in quality and efficiency. From early 2000 onwards, the reform focus has brought in more programmatic and organizational changes promoting allocative and technical efficiency, equity and quality improvement based on the achievements and lessons learned from earlier reforms. However, appropriate responses to outstanding population health issues demand a stronger health system.

I. Conclusion

26. The vast size of Mongolia combined with low population density and nomadic tradition poses particular problems in the provision of health care services. The problems of inequitable coverage and access are compounded by the poor quality of rural and remote health care facilities, which are inadequately staffed and equipped to address changing health needs of the populations they serve. User fees, informal payments and costs of medicines have become a major barrier in access and utilization of health care by poorer sections of the Mongolian society. High costs of health care lead to failure in following health care advice or delay in seeking care, and promote further impoverishment among socially and economically disadvantaged groups. Although public health services and PHC are highlighted as most important for improving the overall health of the population, the majority of resources still actually go to curative secondary and tertiary care services. The budgeting system based on input line items and not on output classifications reinforces existing patterns of resource allocation and provides little incentive to improve technical efficiency. Mongolia has had notable success in reducing the infant and maternal mortality rates and vaccine-preventable diseases, although it is still challenged by the health disparities between various socioeconomic groups and the double burden of noncommunicable and communicable diseases. An appropriate response to these health issues demands a stronger health system focused on PHC and health promotion. Recent trends in long- and medium-term planning by the current Government demonstrate a willingness to ensure sustainable human development through equitable and improved health provision. Moreover, the implementation of public health programmes, supported by international organizations, has led to better health education of the population, greater intersectoral collaboration and the participation of local authorities in their realization.

II. HEALTH INSURANCE

A. History

27. Before 1990, under the centralized economic management system, a comparatively good health care infrastructure existed in Mongolia. Mongolia moved from a planned central economy to a market economy in the 1990s. One of many social and economic reforms which were undertaken during this transition period, was the establishment and development of a social health insurance system

28. Health care services for the population are offered through an extensive network of public health facilities at 4 levels, starting from bag feldshers posts to the tertiary hospitals.

29. Due to the attempts to ensure an equitable access to the health services even in the most remote areas, regardless their economic efficiency and sustainability with internal resource, there were practically universal coverage and accessibility to the primary health services.

30. The Law on Health Insurance for Citizens which was endorsed on July 6, 1993 and came into effect on January 1, 1994. It laid out the legislative basis for establishment of health insurance system in Mongolia.

31. With the introduction of the health insurance for citizens (HIC) new financing sources were created and the condition was put in place to strengthen the health responsibilities of individuals and stabilize the health financing. As a result, the total health share in domestic gross product (budget and insurance) has been on constant rise.

32. Health insurance for citizens, one of five types of social insurances in Mongolia has been developing according to the principles of social health insurance. Since the Law on Social Health Insurance was endorsed 10 years ago, the law was amended 5 times in the years of 1997, 1998, 2003, 2006 2007. The amendments were made to ensure thorough

coverage of health service, social guarantee, service and care for vulnerable groups. An amendment to separate the Social Insurance Health Fund from the central budget was made and took effect starting from January 2008. The Social Health Insurance Law was amended in January 30th, 2007. The amendments are:

- The contribution is capped to 4% of the wage or similar income.
- 50% of the contribution specified above is to be covered by legal entities and the rest is by individuals themselves”

33. The amended law was enforced starting from January 1st, 2008. This new amendment lowered the contributions. However, there is a need to evaluate the financial risks due to the reduction of the contribution income and the sustainability of the health insurance fund, the quality of health service and care.

34. Also ministers of health, social welfare and labor and finance jointly and individually issued total of 11 directives to regulate health service costs. See Annex 5.

B. Current Status of Health Insurance System

35. Since 2003, the obligatory social health insurance has been in place in order to improve the social protection by sharing the financial risks of the Mongolian population related to health costs. For foreigners and residents without Mongolian citizenship the voluntary health insurance is accessible.

36. The Ministry of Social Welfare and Labor and the Ministry of Health jointly define the social health insurance policy. General Principles of the Mongolian Social Health Insurance System are:

- Social health insurance is based on risk pooling of its members, in principle the entire population.
- The major contributors are the individuals/households, enterprises and government.
- These contributions serve to pay for health services, thereby giving access to its members, irrespective of income or social status.
- Individual/household contributions are based on ability to pay. Enterprise contributions are usually fixed as a percentage of wages and salaries. The level of government contributions is generally determined in such a way that they give access to health insurance to individuals/households that are unable to pay contributions.
- Membership of the Social Health Insurance Fund is compulsory for all population groups.

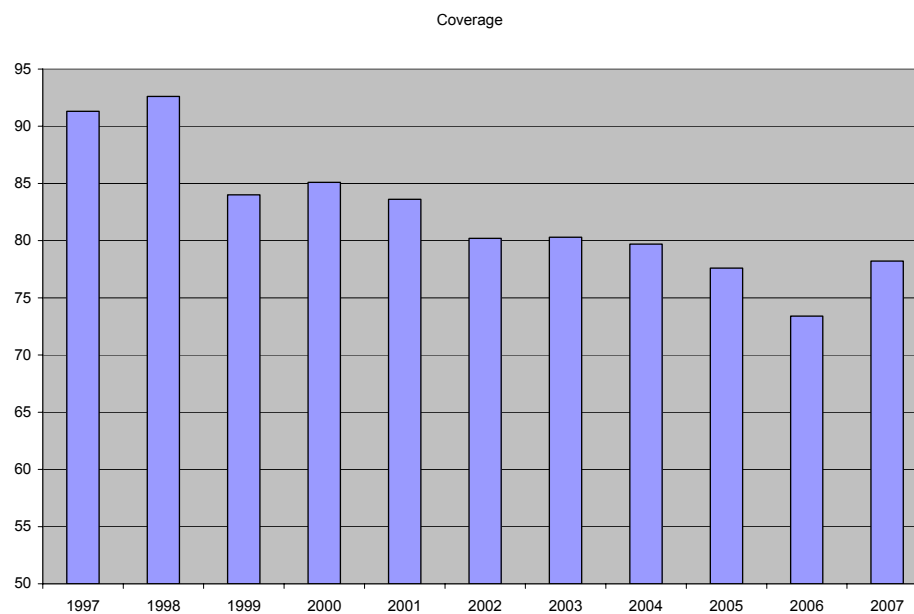
37. Though the coverage of the entire population is the goal, to date significantly less people are covered. The total coverage is 77.3% of the population. However, coverage varies significantly between certain population groups. The coverage rate of the specific groups is Shown in Table 1.

Table 1: Coverage of population Groups

Group	Coverage rate
Employees	88.0
Children under 16	100.0
Citizens with no income except pension	100.0
Women taking care of children	100.0
Vulnerable people	100.0
People in military service	100.0
Full time students	24.6
Herders	56.4
Others	81.2
Total Population	77.3

38. Coverage has been constantly going down during the last decade (though there was a slight increase in 2007, see also figure 1).

Figure 1: Population Coverage Rates



39. Over the last ten years the insurance coverage decreased by 14 percentage points. This can be explained by poor quality of service and poor access to health insurance services, inadequate awareness, lack of advocacy and lack of enforcement/evasion.

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40. It can be sent that the main problems with membership subscription are related to the specific population groups like herders, self and unemployed people.

41. There are 2 types of contribution: salary related and flat rate. Contribution rate of employees is 4% of their salary and not less than 50% of the rate is to be paid by the employers. The contribution rate of employees is determined by the government annually. For the non salaried population groups there is a fixed flat contribution rate which is determined annually by the National Social Insurance Council. Contribution rate per month for self and unemployed, herders and students is 500 Tugriks. The following table gives an overview over the population groups and the the contribution payment.

42. An insured student and herdsmen shall pay his/her premium annually, others shall pay monthly if its not stated differently in the insurance contract. For the existing scheme principal Payment is in cash. In the early stage of implementation, among herders were practiced some kind of in kind contributions like leather, wool, meet etc. There are no population groups who are exempted from contribution payment.

43. The health care system knows two kind of benefits

- benefits financed by the central budget and
- benefits paid by the insurance.

44. Out and inpatient services related to communicable diseases, maternity, and late stages of some diseases (like cancer) which require long term care, are paid from the state budget.

Table 1: Contributions According to Population Groups

	Population Group	Contribution (Tugricks)	Payment
1.	Citizens for whom the Government pays	500	Monthly
2.	Self employed, herders and students	6,000	Annually
3.	Foreigners	1,800	Monthly
4.	Employees	4%, minimum salary 4,800	Monthly

45. Other services are paid by the insurance except cosmetic services and therapy, additional aids and services requested by the insured, additional diagnostic services for the medical examination result requested by the insured, vaccination for the citizen traveling abroad for private and official purpose, some types of orthopedics.

46. The Payment method is as follows:

- Family Group Practices - Capitation
- Hospitals (inpatient service) according to DRGs
- (out patient service) per insured (number of visits)

47. The current funding of the health sector of Mongolia is from central state budget (73%) and revenue from social health insurance contribution (27%).

48. According to 2007 record of State Social Insurance General Office, 84.6% of the health insurance comes from contributions paid by enterprises, 9.7% from contributions paid by the government and 5.7% from other sources.

49. 15.5% of the health insurance funds was spent on formal employees and 60.5% on citizens paid by the state. When the expenditures are broken down, 90.9% was spent on in-patient care and clinic services, 2.1% on drug/medicine price rebate and 7% on spa.

50. The Social Health Insurance Scheme is a part of a broad Social Security System and SSIGO is responsible for all fund management including the Health Insurance Fund. The Health Insurance Department of SSIGO is responsible for HIF management. There are 22 branches of SSIGO, and each branch is responsible for management of respective local funds. Local branches of SSIGO are paying service providers according to agreement and defined payment methods and tariffs. The Health Insurance Sub Council and its local branches are supervising the insurance funds utilization and spending. According to the Law, the central state administrative bodies in charge of health, finance, economy and social welfare shall set up the provider payment tariffs based on the comments of National Insurance Council. In other words, the scheme is under the joint control of the ministries of finance, health and social welfare.

III. EXISTING PROBLEMS AND ISSUES

A. Actuarial and Financial

51. During the last decade, the health insurance fund income always exceeded the expenditure, which led to huge reserves. According to 2008 income and expense projection of the Health Insurance Fund, however, HI expenditures are likely to reach 51 millions and income will be reach only 48 millions. The expenses seem to exceed the income and to negatively impact on reliable functioning of the insurance fund. This is related to reduced insurance coverage and lower contribution rates as well as higher costs. If this trend should continue, the reserves will be depleted within 6 years.

Figure 2: Income and Expenditure of the Health Insurance Fund 1997-2007

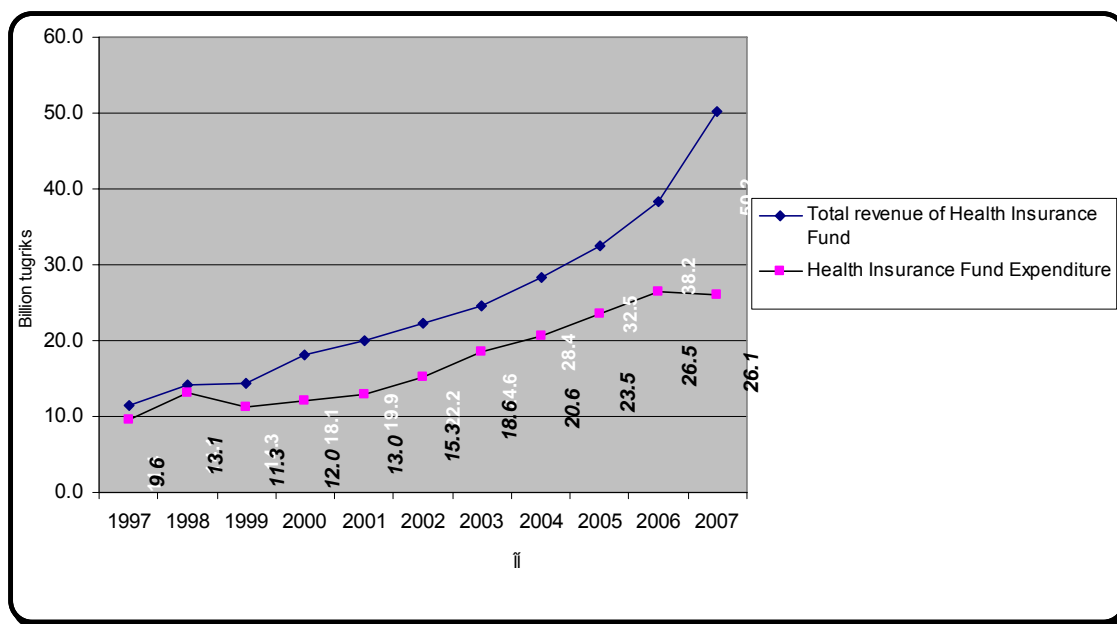


Table 2**Health Insurance Fund Statistics**

billions of tugriks	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Total revenue of Health Insurance Fund	11.4	14.1	14.3	18.1	19.9	22.2	24.6	28.4	32.5	38.2	50.2
Contribution revenue	7.5	8.1	9.5	13.3	14.9	17.2	19.5	23.2	27.4	32.8	44.6
State budget revenue	3.9	6.0	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.8
Fines, interest, etc				0.04	0.12	0.22	0.27	0.42	0.29	0.64	0.76
Health Insurance Fund Expenditure	9.6	13.1	11.3	12.0	13.0	15.3	18.6	20.6	23.5	26.5	26.1
State Clinics	9.1	12.5	10.6	11.1	11.7	13.3	15.1	16	18.5	22.2	22.6
Family Clinics							1.6	1.8	1.9	1.0	0
Drug price reduction	0.2	0.2	0.1	0.2	0.3	0.4	0.3	0.5	0.5	0.5	0.5
Sanatoriums	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.5	0.5	0.5
Private Clinics	0.08	0.2	0.4	0.5	0.8	1.3	1.3	2	2.1	2.3	2.5
Number of insured	2160.8	2217.4	1977.8	2030.2	2019.7	1963.7	1984.7	1990	1968	1903.9	2036.9
Coverage percentage	91.3	92.6	84.0	85.1	83.6	80.2	80.3	79.7	77.6	73.4	78.2
	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Total revenue of Health Insurance Fund	11.4	14.1	14.3	18.1	19.9	22.2	24.6	28.4	32.5	38.2	50.2
Health Insurance Fund Expenditure	9.6	13.1	11.3	12.0	13.0	15.3	18.6	20.6	23.5	26.5	26.1

52. Furthermore, Service type and expenses of the Health Insurance Fund have been adjusted by the decision of political parties and the government without any calculation, research and future plans. Policy and decision makers lack consolidated understanding about the issues which negatively affect service type, results and quality and could harm the sustainability of the scheme. We can see this from the 8 government decisions on health insurance in the last 10 years and an indefinite cost and payment mechanism approved by the joint order of the ministers of the relevant ministries.

53. Therefore, actuarial calculations based on the accurate data of fund revenue and expenditure have to be developed further, complying with the international health financing standards in order to create an optimal health service payment and expenditure mechanism and, ultimately, prevent the insured effectively from risks.

54. Table 2 shows the current statistics of the health insurance fund. It shows that the total revenue is substantially higher than the expenditure. It is evident that over a 10 years period a reserve of 84bn tugriks has been accumulated representing a surplus of 44% of the income over the expenditure. However, this time series has been reverted in 2008, as said above and the reserve will decrease. If the tendency continues like in the last months, it will be depleted by 2014. The number of insured has been relatively constant. But given the fact that the population of Mongolia is increasing rapidly, total coverage has decreased. Both can be seen from Table 2.

55. A look at the sub-categories of income and expenditure shows on the income side that revenue from state budget has remained constant in nominal terms whereas the revenue from contributions has increased dramatically. On the expenditure side, the expenditure for hospitals has increased steeply. Both together shows a relatively dramatic decrease of the state contribution to the cost recovery.

56. As a consequence it can be said that from an actuarial point of view the stability of the health insurance fund is at stake and measures to increase population coverage and financial stability are urgently needed.

B. Administrative

57. At present, the health insurance organization is institutionalized, but administratively it needs to be strengthened to be responsive to the rapidly changing needs and demand. Its current activities are mainly operational and focused on fund management issues rather than benefit assessment, member satisfaction and provision of quality of health care. There is no coordination of budget and health insurance policy in financing the health care system. Capacities of the health insurance organization are limited, its strategic goal and role have not yet been fully established.

58. Therefore, there is an urgent need to improve health insurance operations, administration and management to maintain and strengthen further the role of social health insurance in health and social sector developments in Mongolia. Further, there are still many unsolved social issues that challenge the government of Mongolia, which impact on social health insurance. They include poverty caused by slow progress in economic development. According World Bank almost 36% of the population live below the national poverty line and struggle with inequitable access to health care, excessive financial burden associated with ill health and poor quality of health care service.

C. Lack of Consensus

59. In recent years, a lack of coordination and collaboration among key stakeholders has been observed and created difficulties for the further development of social health insurance

in Mongolia. Poorly coordinated health and public sector management laws and regulations created barriers rather than promoting social health insurance development and led to

- Decreasing coverage of social health insurance
- Inadequately defined health insurance services
- Unmet needs and expectations of the insured regarding quality of health insurance services.
- Lacks in coordination of financing and operation

60. At the same time the size of the reserve funds of the HIF increased to nearly one year of public health expenditures.

61. In the final stages, policy and decisions related to Social Health Insurance are not made through a consultative mechanism and consultative process, which leads to backlogs and blocked decisions as well as non-optimal performance of the health insurance. This negatively impacts the implementation of the policy and decisions and the quality of health services to the public.

62. Given this situation, there is an increasing need for agreements on reforms. These will only be successful if they are carried forward by a broad consensus of stakeholders involved like the insured, trade unions, employers, health care providers, government and civil society. In order to achieve the consensus, it will be necessary to raise awareness on social health insurance and build capacity for improving social health insurance with a view to all stakeholders.

IV. STRATEGY AND RECOMMENDATIONS

A. Reform Proposals

63. Reform proposals that are on the table include:

- To increase the independence of the social Health Insurance Department of SSIGO, in order to strengthen the capacity as “purchaser”.
- To create incentives to improve quality of care through appropriate provider payment mechanisms, monitoring and strengthening patient’s rights.

64. Two strategic Documents have been elaborated:

- These are the Social Health Strategy and
- The Health Sector Financing Strategy developed with ADB technical assistance.

65. These two related documents are targeted to improve health service policy and are joint work by a number of local and international consultants who worked together to determine medium and long term policy of the sector and health insurance. The documents have not been finalized yet due to disagreements among policy and decision makers and not finalized recommendations on policy and organizational structure.

66. The Consortium organized a consulting seminar on February 29th with participation of 25 delegacies from MSWL, MH, WHO, GTZ, WB and ADB to develop the main directions of the social health insurance strategy document based on the draft documents. 10 issues were thoroughly discussed with the purpose to identify the outline of the SHI strategy. The discussions drew a decision to establish professional working groups to work on each of the issues.

67. Afterwards, the working groups established at the directives of the ministers, and the Consortium had 4 seminars and trainings to draft Social Insurance Strategy Documents for 2009-2014. The draft is designed to have 4 parts as the document shall serve as the main

guideline for health insurance policy and strategy development, the main health insurance information database for people, and the facility to deal with financial sources. The parts are:

- Current constraints in Social Health Insurance
- Reform strategy
- Reform of cooperation for SHI development
- Monitoring and evaluation of strategy documents

68. The draft Health Insurance Strategy Document is at attachment 2.

69. A Stakeholder Conference held in April 2008 in Ulaanbaatar discussed the way forward and came to the conclusion that capacity building and effective consensus building are core.

70. By joint Ministerial Order 03/2008 of the three Ministries: Finance, Health and Labour a working group has been established to discuss a Strategy document to develop a social consensus mechanism on the reform of health insurance scheme and health insurance.

71. In addition to this, with help of the joint ILO/WHO/GTZ/ADB initiative a working group was set up on the development of a national social health insurance strategic process and social consensus building in policy development and decision making of social health insurance. So far the working group members agreed to address 4 main issues:

- strengthening health insurance fund
- improving the quality of health care
- Purchasing
- introducing an appropriate health care information system
- improving the structure of health insurance organization.

72. The working group divided into 4 subgroups of all members in order to discuss and work out each of the assigned issues separately. The plan is to submit the results to a stakeholder conference, which is to be held 28 – 29 April in Ulaanbaatar.

- A need to development of national goals, vision, strategic process and key elements for social health insurance reform should be discussed and agreed upon by the stakeholders working group. Also the ministerial working group will work in this direction and it would be important to establish a link between the ministerial working group and the stakeholder working group.
- During the conference, participants are expected to endorse a time frame and a strategic process in response to the identified needs and to come to the desired reform of the health insurance in Mongolia in the near future.

B. Recommendations for further actions

73. It is recommended to take a series of urgent measures, which include:

- Strengthen the capacity to do evaluation of amendments to health insurance regulations and analysis of financial and health service related risks following the amendments;
- Identify appropriate methods to calculate health insurance contributions and build the relevant capacity. Intensive trainings are needed to be provided for policy and decision makers to raise their awareness about types and features of health insurance contributions.
- To provide training on policy, operations and general principles of health insurance

- To provide training on single purchaser models and their advantages and disadvantages

74. There is an urgent need to organize trainings on main principles of social health insurance and future tendency of the fund for the members of the National Health Insurance Council. This will help to improve health service quality and to rationalize the fee amounts as well as to manage them with right attitude.

75. Trainings and seminars on how to organize open debates and public awareness activities about draft amendments to the health insurance regulations should be provided to primary level staffs. This will allow to broaden the frame of law enforcement.

76. WHO, ADB and ILO consultants have developed numerous recommendations and survey reports about social health insurance and health service. Unfortunately, these materials have not been delivered to relevant ministries and agencies. Thus, the recommendations and survey reports about health insurance and service should be translated into Mongolian language and delivered to researchers, policy and decision makers in a handout form. This will help to develop social health policy and programs.

77. For the reform of the health insurance the three-Ministries Working Group should develop a list of key steps needed, a list of reform issues based on the strategic plan and master plan that are on the table and a time frame for the reform. Possible strategic steps are:

- Introducing reforms on a pilot basis.
- To develop a data based costing framework for the actuarial calculation of provider payment mechanisms.
- To build capacity in core courses on issues of reforming Social Health Insurance
- Approving a list of key reform issues
- Agreeing on the ways to institutionalize the mechanism for social policy dialogues among all stakeholders on social health insurance development and reform process. This mechanism can be also used for other social sector issues.
- Discuss the following as necessary actions for policy dialogues among the stakeholders:
 - a. Agreeing on a background paper including studies that would form the basis of the reform and draft laws as well.
 - b. Elaborating draft laws and regulations through a collaborative process between the concerned ministries.
 - c. Having an extended national dialogue process, including government ministries, trade unions, employers, expert, and other civic group hearings.
 - d. To revise the law draft.
 - e. To pass the law draft to the Parliament and have it discussed and reviewed.
 - f. To approve the law draft.
 - g. To implement the law in cooperation with stakeholders based on strengthened capacity of administration and stakeholders.

78. These steps and their time frame should be discussed and approved in the course of the workshop planned. The existing working groups can also make a first step and develop a key issues paper with a time frame for discussion.

79. It is expected that the whole process including the establishment of stakeholders' social policy dialogues mechanism will take at least one year.

80. External partners will explore the possibility to provide support in establishing the social policy dialogue mechanism and actions to strengthen social health insurance development in Mongolia involving awareness raising and capacity building.

V. CONCLUSION

81. As a final conclusion, capacity building is an important step to establish a consensus building mechanism among the stakeholders of social health insurance. We drew this conclusion as inconsistent awareness among the stakeholders of social health sector about related issues may cause irrational decision and policy making.

82. Various steps have been taken to make progress in developing a strategic consensus including working groups and strategy proposals. External partners, especially the consortium are willing to continue their support.

Position Paper: Strengthening the Capacity and Multi-Sector Collaboration to Improve Social Health Insurance in Mongolia

ILO-WHO-GTZ-ADB

Draft Position Paper for Discussion

A. THE CHALLENGES IN THE MONGOILAN SOCIAL HEALTH INSURANCE

1. In Mongolia, social health insurance has been introduced in 1993, when the country was implementing fundamental socioeconomic reform measures to move from a centralized planned economy to a market economy. The main insurance policy aimed to mobilize additional financial resources for the health sector and provide financial protection for the low income and vulnerable population. Universal insurance coverage is attained with extensive public subsidy for specific population categories and the subsidy is gradually reduced as long as some population categories such as herdsmen have become economically self-sufficient.
2. In the past, social health insurance in Mongolia has played an important role in:
 - Ensuring continuity in financing health services
 - Providing access to health services for large parts of the population and
 - Protecting the insured from excessive financial burden and catastrophic health spending associated with ill health.
3. Focused analytical research and studies need to be encouraged to assess, for instance, out-of-pocket expenditures and catastrophic diseases, and possibly produce and document evidence on successes and challenges of social health insurance during Mongolia's economic transition period. This will provide important lessons to be learnt for future strengthening social health insurance in Mongolia. Mongolia experience will also add value on international work and social health insurance development efforts in other countries.
4. Available documents and sources show that health care providers and the population reacted differently under various incentives provided by the Mongolian social health insurance scheme (SSIGO). Accordingly, several amendments have been introduced into the health insurance Law (amendments of the law in 7 times and 12 joint ministries order in refer to implement the amendment of the law since 1994) to support rational behaviors both in terms of benefit provision and utilization. Some of these amendments were also introduced to pursue with the above stated policy objectives.
5. At present, the health insurance organization is institutionalized, but administratively it needs to be strengthened to be responsive to the rapidly changing needs and demand. Its current activities are mainly operational and focused on fund management issues rather than benefit assessment, member satisfaction and provision of quality of health care. There is no coordination of budget and health insurance policy in financing the health care system. Capacities of the health insurance organization are limited, its strategic goal and role have not yet been fully established.
6. Therefore, there is an urgent need to improve health insurance operations, administration and management to maintain and strengthen further the role of social health insurance in

health and social sector developments in Mongolia. Further, there are still many unsolved social issues that challenge the government of Mongolia, which impact on social health insurance. They include poverty caused by slow progress in economic development. According World Bank almost 36% of the population live below the national poverty line and struggle with inequitable access to health care, excessive financial burden associated with ill health and poor quality of health care service.

7. In recent years, a lack of coordination and collaboration among key stakeholders has been observed and created difficulties for the further development of social health insurance in Mongolia. Poorly coordinated health and public sector management laws and regulations created barriers rather than promoting social health insurance development and led to

- Decreasing coverage of social health insurance
- Inadequately defined health insurance services
- Unmet needs and expectations of the insured regarding quality of health insurance services.
- Lacks in coordination of financing and operation

8. At the same time the size of the reserve funds of the HIF increased to nearly one year of public health expenditures.

9. Reform proposals that are on the table include:

- To increase the independence of the social Health Insurance Department of SSIGO, in order to strengthen the capacity as “purchaser”.
- To create incentives to improve quality of care through appropriate provider payment mechanisms, monitoring and strengthening patient’s rights.

10. In the final stages, policy and decisions related to Social Health Insurance are not made through a consultative mechanism and consultative process, which leads to backlogs and blocked decisions as well as non-optimal performance of the health insurance. This negatively impacts the implementation of the policy and decisions and the quality of health services to the public.

11. Given this situation, there is an increasing need for agreements on reforms. These will only be successful if they are carried forward by a broad consensus of stakeholders involved like the insured, trade unions, employers, health care providers, government and civil society. In order to achieve the consensus, it will be necessary to raise awareness on social health insurance and build capacity for improving social health insurance with a view to all stakeholders.

B. THE WAY FORWARD

12. There are several issues to be addressed:

- To agree on a common vision and strategic directions for health insurance.
- To discuss and agree on the social health insurance development goals, vision and strategic development directions in order to:
 - o to maintain equity, access and financial protection
 - o to ensure that all people use quality health care when they need
 - o to provide protection against catastrophic health expenditures
- To develop a national framework for an effective consensus building mechanism based on participatory processes such as information sharing, negotiation and/or consultation in the policy and decision making processes to implement the goals and visions.

Strengthening the Capacity and Multi-Sector Collaboration to Improve Social Health Insurance in Mongolia

- There are two strategic papers on the table: the health insurance development strategy developed with ADB assistance and the Health Sector Master Plan that was approved by the Parliament. So it is an urgent task to develop and implement these in consensus among key stakeholders.
- To define the responsibilities and roles of the agencies dealing with health insurance issue such as role of ministry of social welfare and labour, health, and finance as well as state social insurance general office.
- To support administrative management and capacity building process at all levels of social health insurance operations.
- To develop a time frame for the above. .

C. KEY STEPS TO OVERCOME THE OBSTACLES

13. Several steps are proposed to bring the process forward and to overcome the backlog in decision making and reform:

- By joint Ministerial Order 03/2008 of the three Ministries: Finance, Health and Labour a working group has been established to discuss a Strategy document to develop a social consensus mechanism on the reform of health insurance scheme and health insurance.
- In addition to this, with help of the joint ILO/WHO/GTZ/ADB initiative a working group was set up on the development of a national social health insurance strategic process and social consensus building in policy development and decision making of social health insurance. So far the working group members agreed to address 4 main issues:
 - strengthening health insurance fund
 - improving the quality of health care
 - Purchasing
 - introducing an appropriate health care information system
 - improving the structure of health insurance organization.

14. The working group divided into 4 subgroups of all members in order to discuss and work out each of the assigned issues separately. The plan is to submit the results to a stakeholder conference, which is to be held 28 – 29 April in Ulaanbaatar.

- A need to development of national goals, vision, strategic process and key elements for social health insurance reform should be discussed and agreed upon by the stakeholders working group. Also the ministerial working group will work in this direction and it would be important to establish a link between the ministerial working group and the stakeholder working group.
- During the conference, participants are expected to endorse a time frame and a strategic process in response to the identified needs and to come to the desired reform of the health insurance in Mongolia in the near future.

C. PROPOSED PROCESS AND TIME FRAME

15. For the reform of the health insurance the three-Ministries Working Group should develop a list of key steps needed, a list of reform issues based on the strategic plan and master plan that are on the table and a time frame for the reform. Possible strategic steps are:

- Introducing reforms on a pilot basis.

- To develop a data based costing framework for the actuarial calculation of provider payment mechanisms.
- To build capacity in core courses on issues of reforming Social Health Insurance
- Approving a list of key reform issues
- Agreeing on the ways to institutionalize the mechanism for social policy dialogues among all stakeholders on social health insurance development and reform process. This mechanism can be also used for other social sector issues.
- Discuss the following as necessary actions for policy dialogues among the stakeholders:
 - h. Agreeing on a background paper including studies that would form the basis of the reform and draft laws as well.
 - i. Elaborating draft laws and regulations through a collaborative process between the concerned ministries.
 - j. Having an extended national dialogue process, including government ministries, trade unions, employers, expert, and other civic group hearings.
 - k. To revise the law draft.
 - l. To pass the law draft to the Parliament and have it discussed and reviewed.
 - m. To approve the law draft.
 - n. To implement the law in cooperation with stakeholders based on strengthened capacity of administration and stakeholders.

16. These steps and their time frame should be discussed and approved in the course of the workshop planned. The existing working groups can also make a first step and develop a key issues paper with a time frame for discussion.

17. It is expected that the whole process including the establishment of stakeholders' social policy dialogues mechanism will take at least one year.

18. External partners will explore the possibility to provide support in establishing the social policy dialogue mechanism and actions to strengthen social health insurance development in Mongolia involving awareness raising and capacity building.

Attachment 2:

STRATEGIC DOCUMENT FOR DEVELOPMENT OF HEALTH SECTOR IN MONGOLIA (2009-2014)

***Ulaanbaatar
2008***

I. INTRODUCTION

1. The requirement duly arises to summarise the achievements and problems from introduction and implementation of health insurance in Mongolia over the last decade and define the mid term policy framework (5 year) of health insurance development in line with economic growth and poverty reduction strategy of the country.

2. Accordingly, a strategic document for development of health insurance has been developed in correspondence with the global trend and the national development and health financing policies of Mongolia.

3. The purpose of this document is to determine the perspective of ensuring the quality, access and equality of health services through increased health responsibilities of state, organizations and individuals and established optimal economic, financial and health services.

4. The document presents the general development guideline for mid term development(5 year) of health insurance and serves the foundation for short and mid term cooperative actions and activities by MSWL, MoH and other related organizations. In this context the strategic document for health insurance development is (SDHSD) :

- Main guideline for policy development and strategic planning for health insurance of citizens
- Key data base for users and managers on health insurance of citizens
- Means to mobilize fund resources

II. CURENT SITUATION AND CHALLENGES OF HEALTH INSURANCE SCHEME

A. Current situaion of health insurance, Mongolia

1. Management and institutional set up

5. Mongolia moved from a planned economy to a market economy in the 1990s. One of many social and economic reforms which were undertaken during this transition period is establishment and development of health insurance system for citizens.

- Law on Health Insurance for Citizens which was endorsed on July 6, 1993 and came into effect on January 1, 1994 laid out the legislative basis for establishment of health insurance system in Mongolia.
- With the introduction of health insurance for citizens(HIC) new financing sources were created and the condition was put in place to raise the health responsibilities of

individuals and stabilize the health financing. As a result, the total health share in domestic gross product (budget and insurance) has been on constant rise.

6. Health insurance for citizens, one of five types of social insurances in Mongolia has been developing according to the principles of social health insurance.

7. Since 2003 the obligatory social health insurance has been in place in order to improve the social protection by sharing the financial risks of all Mongolian population related to their diseases. As for foreigners and residents without Mongolian citizenship the voluntary health insurance is accessible.

8. The Ministry of Social Welfare and Labour and the Ministry of Health define the social health insurance policy.

9. Parliament establishes a national council for social insurance(NCSI) with part time membership represented by the insured and employers on equal ratio. Chairman and members of the council are appointed by Parliament for six year tenure based on proposals of involved parties. The membership composition is as follows:

- One member each from state central administration in charge of justice and labour on behalf of the government
- Three members from trade union representing the rights and legal interests of majority of workers on behalf of the insured
- Three members representing employers.

10. National Council for Social Insurance reports to Parliament every year and has a mandate to propose on improvement of social insurance system and legislation, approve the revenue and expenditure of social insurance fund including health insurance fund and place a control over them.

11. Sub council of health insurance functioning at NCSI is represented by members of government, the insured and employers. It has a mandate to control the expenditure of health insurance fund and make proposal on health insurance issues as such as improvement of the legislation.

12. There is formal representation of members of involved parties in NCSI and SCHI. However, the intersectoral cooperation and negotiation is inadequate at policy and decision making levels.

13. State Social Insurance General Office which is an implementing organization has around 100 inspectors in charge of health insurance working in 31 divisions in aimags and capital city. A total of 1065 staff is employed at this department(at soum and bag level). There are 365 soums. Social insurance officer is responsible for activities of five funds.

14. The current financing of the health sector of Mongolia is comprised of state budget and revenue of health insurance fees. Of them 73% comes from state budget and 27% from HIF.

2. Revenue of health insurance fund

15. Health Insurance Fund (HIF) is constituted from revenue fees of employers, the insured, self employed and citizens whose insurance is paid by the state.

16. The health insurance fees are varying. Employees of enterprises and organizations pay the fee equaling to 4% of their monthly wages and income, herders, students and unemployed- 500 MNT and citizens whose fees are paid by the state- 500MNT.

17. According to 2007 record of State Social Insurance General Office, 84.6% of the health insurance fund is made from revenues of health insurance fees paid by formal enterprises, 9.7% from fees paid by the state for citizens and 5.7% from other sources.

18. Over the last ten years the insurance coverage reduced by 14 percentage point. By 2007, out of the total population 77.3% were covered by health insurance. This low coverage is explained by poor quality and poor access of health insurance services and inadequate awareness and advocacy of the insurance.

3. Expenditure of health insurance fund

19. The health insurance fund finances the costs of inpatient services and essential drug prices.

20. According to Order 279 issued by Health Minister in 2006 financing additional health service package by groups of similar cost diagnose was introduced. As of now, in-hospitalization services are paid by base tariff as per groups and by coefficient of similar 22 groups while clinic services are paid by surgery and non surgery disease groups.

21. Financing the health insurance services by payment of similar group cost diagnose is based on similar diagnose groups rather than on service costs. Because health organizations are unable to pay floating costs the formal and informal fees are rising and the social security of people are weakening.

22. The expenditure of health insurance fund by the insured who received the services shows that 15.5% was spent on formal employees and 60.5% on citizens paid by the state. When the expenditures are broken down, 90.9% was spent on in-hospitalization and clinic services, 2.1% on drug/medicine price rebate and 7% on spa. Provision of contract based health services by health organizations stimulates to increase economic relations between the service providers, the insured and insurance organizations.

23. According to expected performance of 2008 revenue and expenditure of health insurance fund are likely to reach... The expenditure seems to exceed the revenue to negatively impact on reliable functioning of the insurance fund. This is related to reduced insurance coverage and lower share of fees and higher floating costs.

24. The accredited chemistries' sell essential medicines with discounted prices based on recipes by soum, bag and family doctors. The budget for this expenditure has been increasing over the years.

25. The capacity of software is limited at SSID to compile and process the data of the insured.

B. Challenges

1. The reliable status of social health insurance fund is disrupt.
 - The synergy in policies of health and insurance organizations is inadequate and health financing and insurance policy is vague.
 - The insurance coverage is gradually declining.
 - Functions to fix fees are not optimal and have sharply reduced the fees.
 - Human resource and technical capacity is weak to expand the insurance coverage.
 - Informal sector has low insurance coverage.
 - The expenditure of health insurance tends to drastically increase due to the high inflation and high cost of goods as well as new payment method of health services.
 - Health and insurance policy and decision making is highly politicized.

2. Activities to purchase health insurance services are not sufficient.
 - The capacity to control and monitor the quality and access of services of insurance organizations is weak.
 - The health financing method fails to be an effective means to improve quality and access of services.
3. Types of services are inadequate and the quality is poor.
 - Committed policy and economic means are missing to improve the performance and types of services.
 - Mechanisms and coverage are not rational in relation to medicine price rebate for the insured.
 - High cost in-hospitalization services are more preferred and supported.
4. Information and management system of insurance organizations cannot adequately cater to needs of users.

III. GOAL AND OBJECTIVES OF REFORM

A. Long term goal:

26. To extend coverage of social insurance through provision of efficient technical services to the insured, to create favorable conditions from them to be entitled to ensuring the high quality, full access and equity of health services.

B. Principles

1. covering all the population
2. pursuance to solidarity and through understanding and support
3. ensuring high quality, full access and results of services

C. Mid term health insurance policy of Mongolia

27. Mid term health insurance policy is defined in alignment with the Mongolian legislation, MDG, National Development Policy, Health Targets in Economic Growth and Poverty Reduction Strategy, Social Security Sector Strategy and Master Plan for Health Sector:

- An affordable, viable and independent health insurance system will be established.
- Health insurance fund will turn into optimal means to distribute resources and implement a policy on health services.
- Financing source will be reliable and affordable to share the health risks of the insured.
- The quality and effects of insurance services will be improved and made friendly to the insured.

- Payment method of health insurance fees will be improved to translate into policy means to achieve the sectoral objective for upgrading the quality and effects of health services.
- Performance based remuneration system will be established to advance the quality, effects and access of health services.
- The capacity will be enhanced and experts will be trained in order to implement a long term health insurance policy.
- Public awareness raising and advocacy of insurance services will undergo improvement.

D. Objective of reform

28. Reforming HI relations presents one condition to solve HI challenges and increase the quality and access of services to people. The reform will be undertaken in the following directions:

- Ensuring the reliability of health insurance fund in line with market oriented economy,
- Improving the buying functions of health services
- Optimizing the types and coverage of insurance
- Setting up a proper information system on health services

Objective 1: Ensuring the reliability of health insurance fund

Target 1.1: to achieve the equal ratio in HI fees

- The fees of herders, self employed, students, unemployed and citizens whose fees are paid by the state will gradually increase.
- Fees of employees of enterprises and organizations will remain stable at fixed level.
- Revenues will increase and the share of HI in health services will rise.

Target 1.2: to expand the HI coverage

- Optimal activities will be taken to cover every citizen especially informal employees and poor people in insurance.
- The coverage of citizens whose fee is paid by state will be rationalized.
- Technical and human resource capacity will be enhanced.
- A means will be used to expand HI coverage for people.
- Direct and indirect remuneration mechanisms will be created to expand insurance coverage.

Target 1.3: on protection of HIF from risks

- Health insurance fund will have resources for potential risks.
- Risk resource will be used to finance during the inflation, rise in consumption costs and tax, natural disasters and spread of diseases.

- Optimal mechanism will be established to protect health insurance fund from financial risks.

Target 1.4: to develop private and voluntary insurances

- Private and voluntary insurances will be developed in the framework of public health system.
- Those who have been covered by obligatory social insurance will also be covered by voluntary insurance.
- Dual insurance will be developed within public health system (high cost diagnosis, joint payment etc.)
- State will provide support for development of private health insurance during the particular time.

Objective 2: Improving the buying functions of health insurance services

Targets:

- Institutional structure will be established to buy the health insurance services and its capacity will be enhanced.
- Service providers will be selected through competition and contracted on the result based principle.
- Payment mechanism will improve to buy health services which are in contract and in compliance with quality and activity standard.
- Civic society and NGOs will be increasingly involved in quality monitoring of health insurance services.

Expected results:

- Effective system to facilitate the buying of health insurance services will be created.

Objective 3: Optimizing the types and coverage of insurance services

Targets:

- Health service packages will be optimized.
- Rehabilitative and spa activities will be supported.
- Buying home and day health service will be gradually introduced.
- Inquiry service on insurance and hospitals will be introduced.
- Additional service will be provided for necessary health assistance to the insured who are vulnerable, bed ridden and in remote areas /transport etc./
- Possibility to share the cost of rebated health services will be studied and implemented.
- Support will be given to organizations which are having high customer satisfaction and better quality of services.
- Additional health services will be provided as incentive to organizations with reducing percentage of loss of work capability) and individuals.

Expected results:

Strengthening the Capacity and Multi-Sector Collaboration to Improve Social Health Insurance in Mongolia

- Types and quality of services for the insured will improve and insurance coverage will expand.

IV. ESTABLISHMENT OF MANAGEMENT INFORMATION SYSTEM OF HEALTH INSURANCE

29. General health insurance data base will be set up and management information system will be introduced with the support of efficient information technology and in compliance with the health management information system.

A. Establishment of management information system for health insurance

- Current status and future requirements of management information system for health insurance will be defined.
- Management and institutional set up of management information system for will be rationalized.
- Human resource capacity of parties involved in information system will be enhanced.

Expected results:

- Management structure will be created for implementation of sound information system for health services.

B. Introduction of optimal management information technology of health insurance

- Comprehensive software on information system will be developed, tested and introduced.
- The issue regarding the exchange of information among hospitals, MoH and social insurance organizations and common reporting system will be jointly treated and solved.
- Data on the insured will be fully automated and transferred into electronic file.
- A system will be established to research, monitor and feedback on quality of health services and activity standard in context of requirements.

Expected results:

- Hospitals, MoH and social insurance organizations will have common information exchange network and the data on the insured will be fully automated and transferred in electronic file.

V. COOPERATION REFORM FOR HEALTH INSURANCE DEVELOPMENT

Reform direction:

- MoH, MSWL, MoF, employers, trade unions and organizations working for interest of the insured will collaborate in decision making for policy development on health insurance.
- MoH, MSWL and MoF will be in charge of providing management methods and coordinating the service buying functions.
- Current arrangement of SSId will improve and its capacity to buy will be enhanced.
- State Inspectorate, National Auditing and other organizations will jointly make external control over the expenditure of health insurance fund.

VI. MONITORING AND EVALUATION OF STRATEGIC IMPLEMENTATION

A. Strategic guidance for health insurance development

30. MSWL and MoH will be responsible for strategic guidance for health insurance development(development, approval, amendment)and ensuring its implementation. They will be accountable to Government of Mongolia. SSID will be in charge of implementation and day to day management.

31. This guidance will comprise the following parts:

- development of document and its improvement
- monitoring and evaluation of implementation and ensure the problems and errors corrected,
- evaluation of reform results and take actions to improve strategy parts.

32. The implementation progress will be monitored and evaluated every 2 years. Monitoring and evaluation will be made by Monitoring and Evaluation Department of MSWL, Subcouncil of Health Insurance and SSID. When required research organizations, inspectorate and auditors will be involved. Social partners, private sector, research organizations and media and press will participate in development and implementation of health insurance development strategy.

- Social partners and society- participate in development of strategy by sharing the comments on improvement of strategy and enhancement of its implementation, monitoring and consultation
- Private sector-participate in strategy implementation and provide comments and recommendations
- Research organizations-evaluate and assees the implementation progress and its results
- Media and press- inform and advocate to the public about the strategy reform, its implementation and results
- International organizations- technical and financial support to implementation activities, advise to management and others.

33. MSWL and subcouncil of social insurance will report to the public on implementation of strategy document for health sector development.

B. Implementation stage

- I. Preparatory stage (2009-2010)
- II. Transition stage (2011-2012)
- III. Implementation stage (2012-2014)

C. Financing effect of reform

34. With implementation of reform strategy total costs of health services will be rationally planned and monitored and resource mobilization and use will be made better. Some duplications in activities will reduce and inefficient costs will reduce. With established voluntary health insurance there will be additional financing sources for high cost and expensive health services.

35. In order to create the condition to reach the level whereby buying functions are in place, some additional funds are needed for activities to advance the management and institutional set up of general fund, enhance expertise and capacity and improve information and monitoring system. It is impossible to estimate the real cost needs, this will be possible only during the pilot projects. Needed costs can be solved by long term loans and assistance.

D. Risks of reform:

- With increased fee payable by the state the fund to be allocated from the state budget will rise.
- With drastic increase of fees by herders and self employed the number of insured will fall down.
- With weakened state control over additional insurance insurance companies will go in financial risks to harm the insured.
- The capacity and experience will be inadequate for full buying functioning.
- In case of slower process of standard and guideline development fixing standard tariffs for services and financing them might be impeded.
- Unexpected financial consequences might arrive to cause the disrupt in quality, equality and access of services.
- Quality and result monitoring system and remuneration mechanism are in place.
- Cooperation by involved parties might be insufficient in health services.
- Funds will be inadequate for establishment of sound information infrastructure.
- Political instability will slow the implementation.

E. Performance criteria of reform

- Legislation and rules will be finalized in relation to implementation of reform actions.
- Proper ratio between state budget and health insurance fund will have been created.

- Public participation in monitoring will increase and quality of services and fund expenditure will improve.
- Payment method will have become an economic means to support the health sector policy and advance the access, quality and efficiency of services.
- The liason between hospitals, MoH and social insurance organizations will improve and proper information share will be in place.
- The capacity of management and information system of health services will be built.

Attachment 4:

THE JOINT ORDER OF MINISTERS OF
HEALTH, SOCIAL WELFARE AND LABOUR AND FINANCE

2008 .03

Ulaanbaatar city

Concerning to establish a work group

Based on article 21.4 of law on Government, for Development of Health Insurance system of Mongolia, to It is hereby ORDERED to:

1. Approve members of Work group aimed at developing a cooperation of Health Insurance branches by Annex,

2. Assume a duty to chief (O.Bayar) of Information, Monitoring and Evaluation department of Ministry of Health, (Mrs.Natsagdolgor) Population Development and Social Welfare Policy and Coordination Department, Ministry of Social Welfare and Labour,

3. Assume to the head of work group (O.Baigalmaa) a duty to process a Strategy document to develop social consensus mechanism of health insurance scheme and health insurance, to discuss on board conference of Ministers of Health, Social Welfare and Labour.

Minister of Health

Minister of Social Welfare
and Labour

Minister of Finance

B.Batsereedene

D.Demberel

Ch.Ulaan

Attachment 5

The Amendments of Citizen's health insurance law, Mongolia

Amendments of 1994, 1997, 1998

Law has been adopted in 2002 and observing from the 1 January 2003.

The content has been reflected an amendments of 2006.

Chapter 1

Article 1

The purpose of the law

The purpose of this law is to determine the requirements and procedures for providing free medical aid to the citizens of Mongolia, to introduce health insurance and to regulate relations between the state, individuals, economic units, organizations, insurance and health institutions in respect to implementation.

Chapter 1

Article 1

The purpose of the law

The purpose of this law is to determine the scope and form of health insurance, to regulate relations in respect to insure on health insurance and to pay a contribution, to complete, allocate and spend the Health Insurance Fund between the insurance and health institutions, state, individuals, legal entity.

Chapter 1

Article 1

No amendment for this Article

Article 2

The legislation on health insurance

The health insurance legislation consists of the Constitution, Social insurance law, this law and other legislative acts enacted in conformity with them.

Article 2

The legislation on health insurance

Has been added Social welfare law, Health law.

Article 2

The legislation on health insurance

No amendment for this Article

Article 3 was newly added

The provisions for explanation of the legal appellation.

Article 3

No amendment for this Article

Chapter 2

Article 3

The Provisions for free medical aid

The special provisions for free medical aid was deleted in new law.

Chapter 3

Article 4

Health insurance, its forms

1. Health insurance is a socioeconomic measure that includes the payment of insurance premiums by citizens, government, economic units, and organizations to set up an insurance Fund, and to pay out the costs of treatment and services of the insured

Chapter 2

Article 4

Health insurance, its forms

4.1. Citizen's health insurance (hereafter referred to as "insurance") is a socioeconomic measure that includes the payment of insurance premiums by government, citizens, legal entity to set up an insurance Fund, and to pay out the costs of

Chapter 2

Article 4

4.1. Citizen's health insurance (hereafter referred to as "insurance") is a socioeconomic measure that includes the payment of insurance premiums by government, citizens, legal entity to set up an insurance Fund, and to pay out the costs of

from the Fund according to the appropriate procedure.
2. Health insurance (hereafter referred to as "insurance") shall have compulsory or voluntary coverage.

Article 5
Insurance Council

1. Non staff Health Insurance Council (hereafter referred to as "Insurance Council") shall be set up attached to the Social Insurance National Council.
2. The Insurance Council shall exercise the following powers:
1) to supervise the utilization and spending of the Insurance Fund;
2) to make proposals and conclusions on issues related to the insurance and submit them to appropriate organizations for

Article 5
Insurance Council

dispensary and inpatient aid and services of the insured from the Fund according to the procedure stipulated in the law.
4.2 The Government and legal entity shall liable to pay some rate of insurance contribution according to the grounds and procedure specified in Law.
4.3 Health insurance shall have compulsory or voluntary coverage.
4.4 Citizens may reinsure with purpose to compensate a damage which may occur to health.
4.5 Compulsory health insurance for civilians shall be handled by the Social Insurance Organization (hereafter referred to as "Insurance organization").
4.6 Various ownership insurance organization shall handle a voluntary insurance and reinsurance.
5.1. Non staff Health Insurance Council (hereafter referred to as "Insurance Council") shall be set up attached to the Social Insurance National Council.
5.2. The Insurance Council shall exercise the following powers:
5.2.1 to supervise the utilization and spending of the Health Insurance Fund;
5.2.2 to determine the maximum rate of drug price on Essential Drug List to fund from Health Insurance Fund;

Article 5
Insurance Council

health insurance aid and services of the insured from the Fund according to the procedure stipulated in the law.

resolutions;
3) to work out recommendations on insurance issues;
4) to approve the sample forms of insurance policy and certificate;
3. The Insurance council shall include an equal number of representatives from each of the following organizations:
1) insurer, organizations representing its interests;
2) insured, organizations representing their interests;
3) health organizations(hospitals);
4) State central administrative Bodies (handling budget, finance, legal, health and social welfare matters);
4. The Insurance council shall have non staff branch councils attached to the aimag and capital city Governors' offices.

5.2.3 to make proposals and conclusions on issues related to the legislation of Health insurance, the insurance activity and submit them to appropriate organizations for resolutions;
5.2.4 to establish a work group, to work out recommendations and decrees on health insurance issues;
5.2.5 to approve the sample forms of insurance policy and certificate of the health insurance;
5.3 The Insurance council shall include an following equal number of representatives from the Government, insured and insurer:
5.3.1 1 person from each of State central administrative Bodies handling health , finance and social welfare matters;
5.3.2 3 persons, representing the insured persons;
5.3.3 3 persons, representing the employers;
5.3.4 The National Social Insurance Council shall approve a procedure for work and members of Insurance Council based on proposal of parties;
5.5 The Insurance council shall have non staff branch councils to the aimag and capital city. The Insurance Council shall approve a procedure for work and members of branch

5.3 The Insurance Council shall have a following members representing its:

councils.

Article 5¹

The functions of unit liable health insurance matter has been newly added

5¹.1 The Insurance Organization stated in Paragraph 5, Section 4, Article 4 of this Law may have an unit liable a compulsory health insurance activity and shall implement a following functions:
5¹.1.1 to organize and advertise an implementation of legislation on health insurance, to provide a insured person with necessary information;
5¹.1.2. to collect the Health Insurance Fund, to perform a execution of income and outcome, to introduce a activity to the Insurance Council.
5¹.1.3 to conclude a contract with the health insurance aid and service provider, to supervise an implementation of contract;
5¹.1.4. to supervise a quality of health aid and services for insured person under treatment and diagnostic directive of Disease;
5¹.1.5. to finance a health insurance aid and services;
5¹.1.6. to make proposals on issues related to the aid and services to finance from the Insurance Fund and submit them to appropriate the State Administrative Body;
5¹.2 The unit stated Section 1, Article 5¹ may shall have a health insurance inspectors to implement a its function and that shall

exercise a right and response a liability stated in Article 26 of Social insurance law..

Article 6
Insurance organizations

1. Compulsory health insurance for civilians shall be handled by the Social Insurance Organization.
2. The organization handling insurance shall have State Health insurance inspectors and it may have an accreditation agency and insurance hospital.
3. The regulations on health insurance inspection shall be approved by the Government.

The provision for insurance organization moved to Paragraph 5, Section 4, Article 4 of this chapter. The provisions for state inspectors and regulations on inspection moved to Article 14 of chapter 3 and the provision for insurance hospital has deleted according to the amendment of the Law.

Article 7
Scope of coverage

1. The citizens of Mongolia shall be compulsorily insured by health insurance:
1) employees of business units and organizations, herders involved in cattle-breeding on the basis of a contract concluded with a business unit, organizations and individual;
2) self-employed sole proprietors and owners of economic units;
3) children under 16 years old (18, in case of general secondary educational school children);
4) students of professional schools;
5) individuals without any cash income except pension;
6) mothers (fathers) caring for their children to age 2 (3, if twins);

Article 6
Scope of coverage

6.1 The following citizens of Mongolia shall be compulsorily insured by health insurance:
6.1.1 employees of economic units and organizations;
6.1.2 owners of economic units and self-employed sole proprietors;
6.1.3 children under 16 years old (18, in case of general secondary educational school children);
6.1.4 students of the university, college, professional training and industrial centre;
6.1.5 individuals without any cash income except pension;
6.1.6 mothers (fathers) caring for their children to age 2 (3, if twins);

7) individuals of 1st and 2nd category disability;
 8) persons on regulatory military services;
 9) self-employed herders;
 10) individuals covered by social assistance according to the legislation on social assistance;
 2. Citizens of Mongolia, other than stated in Section 1 of this Article, foreigners and stateless persons shall be insured on a voluntary basis (Mongolian citizens, foreigners and stateless persons covered by insurance further referred to as "insured person").
 3. If an insured person stated in Section 1 of this article wishes, he/she may be reinsured on a voluntary basis.

6.1.7 persons on regulatory military services;
 6.1.8 herders;
 6.1.9 individuals covered by Article 12 of the legislation on social assistance;
 6. 1.10 Prisoners are serving a centence;
 6.1.11 Citizens other than stated in Paragraph 1-10, Section 1 of this Article;
 6.2 foreigners and stateless persons shall be insured on a voluntary basis.
 6.3 Insurance of insured person stated in Paragraph 1, 2, 8, 11, Section 1, Article 6 of this Law shall may cover the children under 16 years old (18, in case of general secondary educational school children).
 6.4 The National Social Insurance Council shall pass a rule to cover a member of family to the insurance stated in Section 3, Article 6 of this Law based on proposal of State central administrative Bodies handling social welfare and Insurance Council.
 7.1 Dispensary and inpatient aid and services shall be provided to the insured.
 7.2 The dispensary and inpatient aid and services shall be provided to the insured by licensed various ownership accredited hospitals according to the Law.
 7.3 The State Central

Article 7
 Medical aid and services for insured person

The medical aid and services shall be provided to the insured by fully licensed State and mixed ownership public and private hospitals according to the referral classification system. The classification list shall be approved by the State Central Administrative Body handling health matter.

Article 7
 Medical aid and services for insured person

Article 7
 Medical aid and services for insured person

7.1 The following health aid and services shall be referred to the Health insurance aid and services:
 7.1.1. the disease of intestines;
 7.1.2. the disease of nerve system;
 7.1.3. the disease of eye, ear, skin, bone, beef and to join tissue;
 7.1.4. Non urgent breakage,

Administrative Body handling health shall approve the list of aid and services stated in Section 1, 2, Article 7 of this Law and its provider hospitals based in proposal of Insurance Council.

the disease of operation;.

7.2 The health aid and services shall be provided to the insured by Health Organization has licensed under the Law. When the aid and services, was lacked a capacity of State ownership health organization or need a high technology, shall be perform by private ownership health organization.

7.3 The Government shall approve a regulation to choose a medical organization provide aid and services stated in Section 1, Article 7 of this Law based on proposal of State Administrative Central Body handling health matter

7.4 The member of Government handling a health matter shall determine the list and payment method to finance of aid and services stated in Section 1, Article 7 of this Law.

7.5 In case of Insured person is served to the district complex hospitals, shall be serve without dependant;

7.6 If an insured person who registered to the hospitals of family, soum and bag purchase from a pharmacy a drug included in the Essential Drug List according to prescription of a family, soum and bag doctor, shall be provided a price reduction.

Article 8
Rate of insurance premiums
and collection procedure

1. The premiums payable by the insured shall be calculated as below:
1) The premiums payable by the insured states in Paragraphs 1 and 2, Section 1, Article 7 of this law shall be annually determined by the Government at the rate not exceeding 6 percent of insured person's wages or other similar earnings;
2) The insurable earnings and the rate of premiums payable by sole proprietors and owners of economic units specified in Paragraph 2, Section 1, Article 7 of this Law shall be determined annually, based on their earnings declared to the taxation Office;
3) The students of professional institutions and self-employed herdsmen specified in Paragraph 4 and 9, Section 1, Article 7 of this Law shall pay the

Article 8
Rate of insurance premiums
and payment procedure

8.1 The rate of premiums payable by the insured shall be determine as below:
8.1.1 The rate of premiums payable by the insured stated in Paragraphs 1, Section 1, Article 8 of this law shall be annually determined by the Government at the rate not exceeding 6 percent of insured person's wages or other similar earnings;
8.1.2 The rate of insurable earnings of insured stated in Paragraph 2, Section 1, Article 6 shall be determined annually, based on their earnings declared to the taxation Office;
8.1.3 The rate of premiums payable of insured persons other than stated in Paragraph 1, 2, Section 1, article 6 of this Law shall be determined annually by the National Social Insurance Council based on proposal of Insurance Council in

Article 8
Rate of insurance premiums
and payment procedure

7.7 If non insured person was provided health aid and services by health organization, shall pay cost is calculated under real value of aid and service stated in Paragraph 1, Section 7, Article 7 of this Law.
7.8 The Insured person didn't receive a health aid and service for continuously 3 years, shall be reward by full medical examination and its regulation shall be approve by the National Social Insurance Council.
8.1 The rate of premiums payable by the insured shall be determine based on proposal of the Insurance Council as below:

8.1.3 The rate of premiums payable of insured persons other than stated in Paragraph 1, 2, Section 1, article 6 of this Law shall be determined annually by the Government based on proposal of Insurance Council in relation to the minimum wage.

insurance premiums on their own;

2. The rate of premiums payable of by the insured stated in Paragraph 3-10, Section 1, Article 7 of this Law and prisoners who are in detention shall be annually determined by the Government based on the recommendation of the insurance Council in relation to the minimum wage.

3. Business unit and organizations shall pay not less than 50 percent premiums of the insured person indicated in Paragraph 1, Section 1, Article 7 of this law, and the rest shall be paid by the insured persons themselves.

4. The insurance premiums payable by business unit and organizations on behalf of their employees shall be exonerated from taxable income.

5. The amount equal to not less than 50 percent of the budgetary organizations' employees total premiums shall be included annually in the budget of relevant organizations.

6. The state shall be liable for the insurance premiums payable by the insured indicated in Paragraphs 3, 5-8, Section1, Article 7 of this Law. The insurance premiums shall be transferred to the insurer by the governors from the state

relation to the minimum wage;

8.2 The Insured persons shall pay a insurance premium according to regulation as below:

8.2.1 Business unit and organizations shall pay not less than 50 percent contributions of the insured person stated in Paragraph 1, Section 1, Article 6 of this law, and the rest shall be paid by the insured persons themselves;

8.2.2 The administration of school shall be responsible for payment of insurance contribution of insured person stated in Paragraph 4, Section 1, Article 6 of this Law according to contract with insurer;

8.2.3 The Governer of bag, khoroo shall be responsible for payment of insurance contribution of insured person stated in Paragraph 8, Section 1, Article 6 and other than stated in Paragraph 1, 2, Section 1, Article 6 of this Law according to contract with insurer;

8.2.4 The insurance contributions of insured person stated in Paragraph 3, 5, 6, 7, 9, Section 1, Article 6 of this Law shall be paid from a central budget and administrator of budget in concerned level shall transfer within the month;

8.2.5 The insurance contributions of prisoners shall be paid by penitentiary

8.2.3 The Governer of bag, khoroo shall be responsible for payment of insurance contribution of insured person stated in Paragraph 8, 11, Section 1, Article 6 this Law according to contract with insurer.

central and local budgets within the first 5 days of every month.

7. The insurance premiums of prisoners shall be paid by penitentiary institutions.

8. Voluntary contributors shall pay the insurance premiums as stipulated in the policy concluded with the insurer.

9. Collection of health insurance premiums from employees and herdsmen and settlement of payments with the insurer shall be arranged by the administrators of business units, organizations and bag governors on the basis of policy concluded.

10. The citizens for whom State has taken the liability to pay their premiums on their behalf may fully pay the premiums from their own assets on wish.

Article 9
Insurance Fund

1. Insurance Fund shall consist of premiums and other sources.
2. The Insurance Fund shall finance the costs involved in treatment and services (hereafter referred as "treatment") received by the insured and the operations of the Insurance Organization relating to implementation.

Article 9
Insurance Fund

institutions;

8.3 The rate of payable contributions of insured person stated in Paragraph 11, Section 1 and 2, Article 6 of this Law shall be regulate by contract.

8.4 Unless otherwise provided in contract, the insurance contribution shall be paid by insured person stated in Paragraph 4, 8, 11, Section 1, Article 6 of this Law annually and, insured person stated in Paragraph 1, 2, 3, 5, 6, 7, 9, 10, Section 1, Article 6 of this Law monthly.

8.5 When the insured person stated in Paragraph 4, 8, 11, Section 1, Article 6 of this Law has paid 12 mounth insurance contributions continuously, shall exercise the right to be paid from the insurance fund for recieved treatment and services.

9.1. the income of Insurance Fund shall consist of following sources:

9.1.1 the health insurance contribution has been paid by insured person;

9.1.2 the health insurance contribution has been paid by employer;

9.1.3 The contribution of citizens who state pays a their contributions has been paid from the budget;

9.1.4 The interest of saving of financial free balance in bank;

9.1.5 the penalty has been fell for delay a time to pay a

Article 9
Insurance Fund

			<p>health insurance contribution; .</p> <p>9.1.6 Other source;</p> <p>9.2 The Insurance Fund shall finance the following costs:</p> <p>9.2.1 The cost of dispensary and inpatient aid and services for insured person;</p> <p>9.2.2 The cost of price reduction of drugs stated in Section 9, Article 12 of this Law;</p> <p>9.2.3 The cost of health insurance activity;</p>		<p>9.2.1 The cost of health aid and services for insured person;</p> <p>9.2.4 The cost stated in Section 4 of Article 5, Section 8 of Article 7, Section 3, 4 of Article 9, Section 14 of Article 12 of this Law;</p> <p>9.3 The capital as 10 percent of Health insurance Fund may be remain to the probable risk resource and regulation to spend it shall be approved by the National Social Insurance Council;</p> <p>9.4 The saved remainder of the Health Insurance Fund shall be spend for to improve a quality of aid and service for population, to increase a endowment and coverage based on decision of the National Social Insurance Council.</p>
<p>Article 10 Insurance policy</p>	<p>1. The insurer shall conclude a policy with the insured, hospitals and pharmacies. The policy shall include the rate of insurance premiums, payment schedule, types and quantity of health care services supplied to the insured, the maximum of treatment cost payment from the insurance Fund, duties and liabilities of the</p>	<p>Article 10 Insurance policy</p>	<p>10.1 The insurance policy shall include the rate of insurance contribution, payment schedule, types, quantity, result index of health aid and services supplied to the insured, the maximum of treatment cost payment from the insurance Fund, duties and liabilities of the involved parties and policy conditions each in detail.</p>	<p>Article 10 Insurance policy</p>	<p>10.1 The builder of Insurance Organization shall conclude a insurance policy with health aid and service provider.</p> <p>10.2 The insurance policy shall include the rate of insurance contribution, payment schedule, types, quantity, result index of health care services supplied to the insured, the</p>

and districts, according to the Contract, having calculated on the basis of standard cost per an insured person receiving medical care. However, the regular costs and additional resources required following the decision on increase of salaries for civil servants shall be funded from central and local budgets.

2. Different payment tariffs shall be used in inter-hospital payments where an insured person has to be transferred from the hospitals of one referral level to another or from a private to a State owned or mixed ownership hospital on medical instructions.

3. If the insured persons stated in Paragraph 1 and 2 of the Section 1 of the Article 7 of this Law and students of professional training institutions, self-employed herdsmen or voluntary contributors are hospitalized, they shall pay 10 percent of the variable costs of treatment per night (excluding the cost for heating, electricity and water supply).

4. The standard costs of treatment stated in Section 1, 2, 3 of this Article and the rate of payments shall be fixed differently for each referral system level of medical care and services by the public Administrative Central Body responsible for health matter on a basis

persons to fund from Health Insurance Fund based in proposal of the National Social Insurance Council.

12.2 Variable cost of dispensary and inpatient aid and services shall pre-pay to the hospitals under month schedule and shall calculate under performance.

12.3 The aid and services of family general practitioner shall be finance based on cost of 1 insured.

12.4 Different payment tariffs shall be used in inter-hospital payments where an insured person has to be transferred from the hospitals of one referral level to another or from a private to a State owned or State participated ownership hospital on medical instructions.

12.5 If the compulsory insured persons other than stated in Paragraph 3, 5, 6, 7, 9, Section 1 of the Article 6 of this Law and voluntary insured persons are hospitalized, they shall pay 5 percent to the hospitals at primary level, 10 percent to the hospitals of aimag and district and Regional Treatment Diagnostic Centre, 15 percent to the tertiary hospitals at the national level.

12.6 The cost payment of following treatment and services shall be met by the insured person himself:

12.6.1 cosmetic service and

Insurance Fund based in proposal of the National Social Insurance Council.

12.2 Variable cost of aid and services shall pre-pay to the hospitals under month schedule and shall calculate under performance within 25 of next month.

12.3 This article has been voided.

12.4 This article has been voided.

12.5 If the compulsory insured persons other than stated in Paragraph 3, 5, 6, 7, 9, Section 1 of the Article 6 of this Law and voluntary insured persons are hospitalized, they shall pay 5 percent to the hospitals at primary level, 10 percent to the hospitals of aimag and district and Regional

of recommendation of the Insurance Council.

5. If an insured person purchase from a pharmacy a drug included in the Essential Drug List at the prescription of a family (community, soum, bag) doctor, a certain percentage of its price shall be reimburse to him by the Insurance Fund. The State Central Administrative Body in charge of health matters shall approve the Essential Drugs List and inform of it the public regularly.

6. The cost payment of following treatment and drugs received by an insured person stated in Section 1, Article 7 of this Law shall not be made from the Insurance Fund and shall be met by the insured person himself.

- 1) cosmetic service and therapy ,
- 2) all kind of orthopedics (glasses, hearing, device, artificial teeth etc),
- 3) the additional treatment and service requested by an insured person, drugs purchased from pharmacies (a certain percentage of price of the drug listed in essential drugs shall be reimbursed by the insurer. The rate of reimbursement from the Insurance Fund shall be determined by the Insurance Council at a given time),

The following diagnosis and services provided by the

therapy;

12.6.2 additional treatment and service requested by an insured person;

12.6.3 diagnosis and services necessary for health conclusion;

12.6.4 preventive injections for those going abroad as a tourist, privately, or on business;

12.6.5 the price of some kind of orthopedics;

12.6.6 Where the individuals choose a hospital providing nationwide services by passing over the referral system of medical aid and services in cases other than need to provide urgent aid and services, dangerous to life incidences;

12.6.7 The medical ambulance service for to delivery from airport and trainstation of Ulaanbaatar city and aimag centre at home by the Requesting of insured person;

12.7 The State Central Administrative Body handling health shall approve the list of orthopedic stated in Paragraph 5, Section 6 of the Article 12 of this Law, the disease stated in Paragraph 6, Section 6 of the Article 12 of this Law that dangerous to life incidences and need an urgent aid and services.

12.8 If an insured person purchase from a pharmacy

Treatment Diagnostic Centre, 15 percent to the tertiary hospitals at the national level.

12.6 The Insured person shall pay the cost payment of aid and service other than stated in Section 1, Article 7 of this Law and in referral legislation to be pay a payment by the State.

12.7 This article has been voided.

public polyclinics and dispensaries:

- a) all type of diagnosis made at the hospitals providing nationwide services,
- b) diagnosis and services necessary for health conclusion,
- c) preventive injections for those going abroad as a tourist, privately, or on business;

6) The following emergency aid services provided in Ulaanbaatar and aimag centre:

- a) to deliver a bid-stricken patient to the airport, train station or home at request,
- b) to provide transportation of dead body;

7) Where an individual chooses a hospital providing nationwide services by passing over the referral system of medical care and services in cases other than urgent and dangerous to life incidences.

8) Other paid services specified by the Government

7. Where an insured person stated mentioned in Paragraph 1 and 2, Section 1, Article 7 of this Law, becomes unemployed, the insurer shall pay his treatment cost in proportion

a drug included in the Essential Drug List and the price reduction at the prescription of a family doctor, a certain percentage of its price shall be reimburse to him from the Insurance Fund.

12.9 The Insurance council shall approve the Drugs List stated in Section 8, Article 12 of this Law and the percentage of this drug price to finance from Insurance Fund and shall inform of it the public regularly.

12.10 Where an insured person stated in Paragraph 1 and 2, Section 1, Article 6 of this Law, becomes unemployed, the insurer shall pay his treatment cost in proportion to 25 percent of his total insured service.

12.11 The maximum limit to the medical dispensary and inpatient aid and services cost of the insured stated in Section 1, Article 6 of this Law to finance from Insurance Fund shall be established by the Insurance Council annually.

12.12 The insured person may cover a reinsurance for compensation of a payment stated in Section 5, 6 of the Article 12 of this Law and shall pay itself.

12.13 If the insured person was provided the aid and services by hospitals operating on the territory of Mongolia, the cost of aid and services shall be paid

12.8 This article has been voided.

12.9 The Insurance council shall approve the Drugs List stated in Section 6, Article 7 of this Law and the percentage of this drug price to finance from Insurance Fund and shall inform of it the public regularly.

12.10 This article has been voided.

to 25 percent of his total insured service.

8. The maximum limit to the medical care cost of the insured stated in Section 1, Article 7 of this Law shall established by the Government annually. The amount exceeding the maximum limit shall be paid by the insured person or can be recovered through additional voluntary insurance.

9. The procedure stated in Section 8 of this Article shall not be applicable for the voluntary contributors.

10. The non insured person's treatment cost shall be paid as below:

1) If a person is not covered by health insurance, he shall be required to pay the actual cost of treatment received by him on provision of medical aid necessary for him,
2) Voluntary contribution shall be entitled to the treatment cost payment from the insurance Fund, provided he has paid premiums for not less than 12 consecutive months.

11. The list of diagnosis and services stated in Paragraph 5, 6, Section 6 of this Article shall be approved by the State Central Administrative Organization responsible for health matters.

12. The cost of treatment provided to a person covered by health insurance

out from the Insurance Fund.

12.11 The maximum limit to the health insurance aid and services cost of the insured to finance from Insurance Fund shall established by the Insurance Council annually.

12.14 The rate of assignment may be increase to the accredited health organization overseing quality and result of aid and service and its regulation shall be approve by the National Social Insurance Council.

shall be paid out from the Insurance Fund, if the medical aid and services were provided on the territory of Mongolia according to this Law.

Article 13
Recovery of the expenses incurred by the Insurance Fund

The expenses incurred by the Insurance Fund shall repaid by the following persons:
1. The treatment cost of an insured person suffering from health loss due to a crime or offence shall be paid by the guilty person;
2. The treatment cost of an insured person whose health was effected due to violation of labor protection and safety rules and dangerous conditions prevailing in environment (injury, toxicity, occupational disease etc) shall be paid by the relevant economic unit or organization.

Article 13
Recovery of the expenses incurred by the Insurance Fund

13.1 The expenses incurred by the Insurance Fund shall repaid by the following persons:
13.1.1 The treatment cost of an insured person suffering from health loss due to a crime or offence shall be paid by the guilty person;
13.1.2 If next aggravation of treatment and injection was occurred wherefore wrongul action of medical specialist and health organization, shall be payid by concerned organization;

Article 14
Professional Inspection on insurance activity

14.1 The insurance State inspector shall supervise an implementation of this Law, quality and result of aid and services of organizations are financed from the insurance. 14.2 The Professional Inspection Agency and the State

Article 14
Professional Inspection on insurance activity

14.1 The insurance State inspector shall supervise a implementation of this Law, quality and result of aid and services of medical organizations was financed from the insurance, insurance activity.

Article 14
Imposing liabilities on
offenders of Insurance
Legislation

1. If economic units, organizations and budget managers fail to transfer the premiums in time as prescribed in this Law or Policy, they have to recover the outstanding premiums and pay 0.3 percent penalty equal to the premium dues per each day of delay. If there is a case of deliberate reduction or concealment of insurable payroll or similar thereto earnings, the premium arrears resulting from the concealed or reduced amount of earnings shall be recovered, as well as a penalty equal to this amount shall be imposed.

2. If an insured person fails to pay insurance premiums in time stipulated in the Insurance policy he shall assume the liabilities stated in the policy.

3. In case of avoidance from paying the treatment cost and recovery payment stated indicated in Section 10, article 12 and 13 of this Law, the issue of recovering the loss shall be resolved by court.

4. If the insurer delays payments to hospitals, the insurer shall recover the outstanding payments to relevant hospitals and pay

Article 15
Imposing liabilities on
offenders of Insurance
Legislation

inspectors shall control an insurance activity.
14.3 The Government shall approve a regulation of Health Inspection.

15.1 If economic units, organizations and budget managers fail to transfer the contribution in time as prescribed in this Law or Policy, they have to recover the outstanding contributions and pay 0.3 percent penalty equal to the contribution dues per each day of delay. If there is a case of deliberate reduction or concealment of insurable payroll or similar thereto earnings, the guilty person shall recover premium arrears resulting from the concealed or reduced amount of earnings, as well as a penalty equal to this amount shall be imposed.

15.2 If an voluntary insured person fails to pay insurance premiums in time stipulated in the Insurance policy he shall assume the liabilities stated in the policy.

15.3. In case of guilty person avoided from paying the aid and services cost and recovery payment indicated in article 13 of this Law, the issue of recovering the loss shall be resolved by court.

15.4 If the insurer delays payments to hospitals, the insurer shall recover the

Article 15
Imposing liabilities on
offenders of Insurance
Legislation

them 0.3 percent penalty equal to the outstanding amount of payments per each day of delay.

5. The complaints and disputes relating to the implementation of provisions stated in Section 1, 2 and 4 of this Article shall be settled by the court.

6. An officer who was faulted in the delay of insurance premium payments and accounts or confusion of records and accounts shall assume the liabilities stated in the Legislation of Mongolia.

outstanding payments to relevant hospitals and pay them 0.1 percent penalty equal to the outstanding amount of payments per each day of delay.

15.5 The complaints and disputes relating to the implementation of provisions designated in Section 1, 2 and 4, Article 15 of this Law shall be settled by the court.

15.4 If the insurer delays payments to hospitals more than 14 day, the insurer shall recover the outstanding payments to relevant hospitals and pay them 0.1 percent penalty equal to the outstanding amount of payments per each day of delay.

15.6 If the obligation stated in Paragraph 2, 3, 5, Section 2, Article 8 wasn't executed, the health insurance inspector in Section 2, Article 5¹ of this Law shall be re-paid a premium and shall sentence an officer In fine 10000-50000 tugrig, a business unit in fine 100000-250000 tugrig.

15.7 The citizen has violated the obligation stated in Section 4, Article 8 of this law shall re-pay a premium for delay a time.

Attachment 6

**Orders and decrees related to payment
from the Health Insurance Fund for the
Patient's hospital treatment costs**

No	Name of the Resolution	Year of release	Description	Unit	Hospital type	Payment amount	From the Health Insurance Fund	From the patient	Treatment limit
1	Decree A 161/226 of Minister of Health, Minister of Finance	1995.11.30	Amount of reimbursement for inpatient care for the patients with health insurance	One bed night	- General hospital	2400	2400		350 000 in 1996 by decree of the government of Mongolia
					- Mid soum hospital	1500	1500		
					- Soum hospital	1400	1400		
					- doctor, nurse	1000	1000		
					Ambulatory care				
					-day stationary	700	700		
					-home stationary	600	600		
2	Decree A 104/91 of Minister of Health, Social Welfare and Labour, Minister of Finance	1997.03.18	Tariff for the cost covered by the insured himself and cost covered from the Health insurance fund	One bed night	- General hospital - Soum hospital - doctor, nurse	3000 1900 1300	2700 1710 1170	300 190 130	
3	Decree A 358/359 of Minister of Health, Social Welfare and Labour, Minister of Finance	1998.12.08	Tariff for the variable cost covered by the patient himself, and cost covered by the central and local health insurance fund	One patient	- General hospital - Mid Soum hospital - Soum hospital - Doctor, nurse	40300 20250 19500 11520	36270 18225 17550 10370	4030 2025 1950 1150	
4	Decree 28/59 of Minister of Health, Social Welfare and Labour, Minister of Finance	2000.02.28	Tariff for the variable cost covered by the patient himself, and cost covered from the central and local health insurance fund	One patient	- General hospital - Mis soum hospital - Soum hospital - Doctor, soum	45000 25000 22000 12700	40500 22500 19800 11430		
				Ambulatory care (complete treatment)	- Dental care for children under age 18 - Ambulatory clinics	500-4500 3500	500-4500 3500		

No	Name of the Resolution	Year of release	Description	Unit	Hospital type	Payment amount	From the Health Insurance Fund	From the patient	Treatment limit
5	Decree 35/47/14 of Minister of Finance and Economy, Minister of Health, Minister of Social Welfare and Labour	2002.02.04	Tariff for the variable cost covered by the patient himself, and cost covered by the central and local health insurance fund	One patient	- General hospital - Mid soum hospital - Soum hospital - Military hospital	49000 30000 26000 13000	44100 27000 23400 11700	4900 3000 2600 1300	
				Ambulatory care (complete treatment)	ᠭᠦᠰᠢᠳᠤᠶᠡᠭᠦᠨ	6400	6400		
6	Decree 57/35/23 of MOFE, MOH, MOSWL	2003.02.21	Amount of variable cost to be funded for inpatient treatment and services	One inpatient	- General hospital - Mid soum hospital - Soum hospital - Military hospitals	49000 30000 26000 13000	44100 28500 24700 12350	4900 1500 1300 650	
7	Decree 103/125/53 of MOH, MOF, MOSWL	2005.05.05	Amount of variable cost to be funded for inpatient treatment and services for one patient	One inpatient	- General hospital - Mid soum hospital - Soum hospital -Military hospitals	51000 800 35000 32000 14000	45900 800 31500 30400 13300	5100 3500 1600 700	
8	Decree 306/300/92 of MOH, MOF, MOSWL	2006.09.25	Amount of cost to be funded for inpatient treatment and services for one patient	One patient	-General hospital - Mid soum hospital -Soum hospital -Military hospitals	80000 2400 14000	72000 2400 13300	8000 - 700	
9	Decree 436/457/127 of MOH, MOF, MOSWL	2006.12.29	Procedure to finance hospitals through health aid service package method from the Health insurance fund	One patient	State General hospitals Stationary Day care Ambulatory Mid soum hospital	Basic 60000 39000 2500 35000	54000 35100 2500 35000	6000 3900	
10	Decree 436/457/127 of MOH, MOF, MoSWL	2006.12.29	Procedure to finance hospitals through health aid service package method from the Health insurance fund	One Patient	State General hospitals Stationary Day care Ambulatory Mid soum hospital	Basic 60000 39000 2500 35000	54000 35100 2500 35000	6000 3900	
11	Decree 193/194/77 Of MOH, MOF, MoSWL	2007.07.04	Procedure to finance hospitals through health aid service package method from the Health insurance fund	One Patient	State General Hospitals Stationary Day care Ambulatory Mid soum hospital	Basic 60000 39000 2500 35000	54000 35100 2500 35000	6000 3900	600.000 tugrics by decree of the government of Mongolia

