Development of social health insurance in Mongolia: Successes, challenges and lessons

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This paper examines the process of developing social health insurance in Mongolia, and its successes, challenges and lessons. The government of Mongolia introduced social health insurance in 1994, which is compulsory for all public and private sector employees and low-income and vulnerable population groups. The scheme also provided voluntary insurance for unemployed people of working age. About 95 per cent of the population was covered by health insurance within the first two years thanks to a high level of government subsidy for vulnerable population groups. The insurance benefit initially covered nearly all inpatient services except the treatment of some specified chronic and infectious diseases, which were directly funded by the government. The scheme not only had many successes but also faced challenges in maintaining universal coverage. The new financing arrangement has provided little financial incentive for healthcare providers to contain health expenditure, contributing to rapid health cost inflation. In addition to reforming the payment system for providers, there has been an increasing need to expand benefits into ambulatory care. The development of compulsory health insurance in Mongolia shows that a prepaid health insurance mechanism based on risk sharing and fund pooling is feasible in low-income countries given political commitment and government financial support for vulnerable population groups.

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Mongolia is a landlocked country located in Central Asia. Its 2.5 million population is sparsely dispersed over a land area of 1.5 million km^2 (Tables 1 and 2). The country has 21 provinces called *aimak* and more than 300 rural districts called *sum.* Each *sum* is administratively divided into four to six *bag,* which is the lowest administrative unit in Mongolia. More than 50 per cent of the population are in urban areas and about 20 per cent are cattle breeders engaged in nomadic animal husbandry. Average population density in Mongolia is about 1.4 persons per square kilometre and is very low in rural areas, which creates difficulties in access to healthcare. Mongolia is a low-income developing country with an annual GDP per capita of US$ 450 (€350). Mongolia spends about 6 per cent of GDP on health, which can be roughly translated as US$ 25 (€20) per capita (WHO, 2003: statistical annex).

Before 1990, Mongolia followed the Soviet type of economic development where healthcare services were fully financed and delivered by the government. Under the centralized economic development model, the entire population were guaranteed free access to healthcare. The Mongolian health sector had been funded through central and local government budgets, and in the late 1980s, the country spent about 7 per cent of GDP and more than 10 per cent of the total government budget on health. From 1991, Mongolia went through the transformation from a centrally planned to a market economy. This transition took place in a difficult economic environment with the cessation of aid from the former Soviet Union, which had reached up to 30 per cent of Mongolian GDP (Nymadawa and Bayarsaikhan, 1995). It had the double effect of reducing the overall government budget and lowering the allocation of resources to the health sector. The level of health spending as a proportion of GDP dropped from 6.7 per cent in 1990 to 4 per cent in 1992 and the quality of health services declined owing to a shortage of funding resources (Ministry of Health, 1993). Under the new economic conditions, it became difficult to maintain free healthcare through government financing alone.

These difficulties resulted in a change to the constitutional provision of free health services. Healthcare became a shared responsibility between the government, individuals and organizations. Healthcare financing reform proposed by the Ministry of Health in this new socioeconomic environment focused not only on user fee policies for publicly provided health services and private health practices, but also on social protection and equitable access to healthcare. The option to set up a nationwide health insurance scheme was accepted, and the government made a commitment to support the low-income and vulnerable population's membership of the scheme. As a result, social health insurance was introduced in Mongolia in 1994. About

Table 1. *Socioeconomic indicators of Mongolia (2003)*

Total population	2,504,000
Population below age 15 as percentage of the total population	32.6
Population above age 65 as percentage of the total population	3.5
Urban population as percentage of total	58.5
Average life expectancy at birth (male/female)	63.51 (60.75/66.5)
Unemployment rate (%)	3.5
GDP growth in 2003 at 1995 prices	5.5

Source: Statistical year book, National Statistical Office of Mongolia, 2003.

Table 2. *Health sector statistics of Mongolia (2002)*

Number of medical doctors per 10,000 population	26.7
Number of hospital beds per 10,000 population	73.2
Percentage of hospital beds in the public sector	90.3
Average length of stay, days	10.1
Average number of ambulatory visits a person a year	5.1

Source: Based on statistics of Ministry of Health, Mongolia, 2003.

half of all health sector funding began to be channelled through the health insurance fund and the other half through central and local government health budgets (Bayarsaikhan, 1995).

It was not easy to practise such a contributory scheme in the situation where the population had enjoyed free medical care for more than seven decades under the Soviet-influenced Communist legacy. There were several important factors contributing to the successful implementation of health insurance in Mongolia with near universal coverage. One of them was general awareness of the necessity of fundamental reform towards democracy and a market economy with adequate social protection. Political commitment and economic support, provided in the form of subsidy to the health insurance premiums of the low-income and vulnerable population, were other important success factors. The following sections explain the process of development of social health insurance in Mongolia, and its successes, challenges and lessons.

Successes

Introduction of social health insurance

Drastic cutbacks in public expenditure in the early 1990s affected dramatically the quality of and access to health services. The government lacked adequate resources to support the range of health services carried out in the past. It became clear that it needed additional funding resources to the government budget in order to maintain the previously attained levels of health service quality, access and coverage. It was a difficult task when health financing was heavily hampered by high inflation and depreciation of the national currency. The consumer price index reached its highest point in 1991-92, exceeding the prices of 1980 threefold. In such situations, public resources met only 60 to 70 per cent of the previous year's health budget in real terms. The gap had to be filled by alternative sources of revenue, including user fees. As a result, patients were routinely asked to pay for medicines, X-ray films, dressings and other medical goods that were still free in public health facilities. Moreover, the rural nomad population had an additional financial burden because they were charged for emergency calls and transportation by ambulances. Such informal payments played a certain role in sustaining healthcare as in many other countries of the former Soviet Union and central and eastern Europe (Lewis, 2002; Thompson and Witter, 2000). However, the purchasing power of the population continuously deteriorated because of high inflation, loss of income and unemployment due to the closing down of many state-owned enterprises and agricultural cooperatives.

The market-oriented reform process opened up various policy debates on financing health services in Mongolia. Privatization of public health facilities and extensive use of cost-recovery and cost-sharing mechanisms, including user fees for publicly provided services, were brought to the attention of policymakers as feasible options to introduce market elements into the health sector and reduce government's predominant role in the provision and financing of health services. However, the government was also concerned about undesirable social consequences of such radical changes in healthcare financing without adequate social safety net and financial protection mechanisms. The issues of how to mobilize additional resources to the health sector without imposing an excessive financial burden on individual households and how to protect low-income and vulnerable population groups became the main theme of policy debate in the introduction of a stable, equitable and sustainable health financing mechanism.

In these circumstances, social health insurance based on the concept of social solidarity through the risk sharing and fund pooling principles was quite attractive. But there were limited experiences in developing social health insurance in a low-income country like Mongolia (Chernichovsky, 1995). With technical input from the WHO, the potential of social health insurance based on a contributory prepayment mechanism was brought to the attention of policymakers. The Ministry of Health set up a task force consisting of representatives from related government agencies and public organizations, which was assigned to design the social health insurance framework to provide appropriate financial protection and risk pooling for the entire population. Through a series of discussions at various policy levels, a political consensus was reached on the feasibility of health insurance in Mongolia.

The Mongolian Citizen's Law on Health Insurance was adopted by the Parliament in 1993. Accordingly, all public and private sector employees and low-income and vulnerable population groups were compulsorily insured by the Law. The Law also provided voluntary insurance for unemployed people of working age with the ability to work. The Parliament approved the state commercial insurance company Mongol Daatgal[1] to carry out health insurance administrative functions including registration, collection of premiums, claim processing and payment to service providers. The implementation of the social health insurance Law began on 1 January 1994. Since the insurance company had secured initial financial reserves, the insured members had immediate access to health insurance benefits from the moment of premium payment. Within the first two years, almost 95 per cent of the population were covered by health insurance on a compulsory basis. The Health Insurance Council provided guidance on health insurance policy and managerial aspects. In 1996, when the government reorganized the social security system, the administrative functions of health insurance were transferred to the State Social Insurance General Office, operating under the Ministry of Labour and Social Welfare.

Contribution, benefits, and payment methods

History shows that it takes many years for social health insurance to achieve universal coverage of populations (Carrin, 2002). On the other hand, consideration of a number of factors is necessary for the success of a social health insurance system. These include the current employment rate in the formal and informal sectors, costs of service delivery, health service infra-

1. Mongol Daatgal provides all types of private and commercial asset insurance services.

Table 3. *Contributions to health insurance, 1998-2003 (%)*

	1998	1999	2000	2001	2002	2003
Government subsidy to vulnerable population groups	37.9	33.6	26.8	24.5	21.9	19.9
Employees and employers	58.6	62.3	66.3	70.2	73.3	76.7
Others	3.5	4.3	6.9	5.3	4.8	3.4
Total	100.0	100.0	100.0	100.0	100.0	100.0

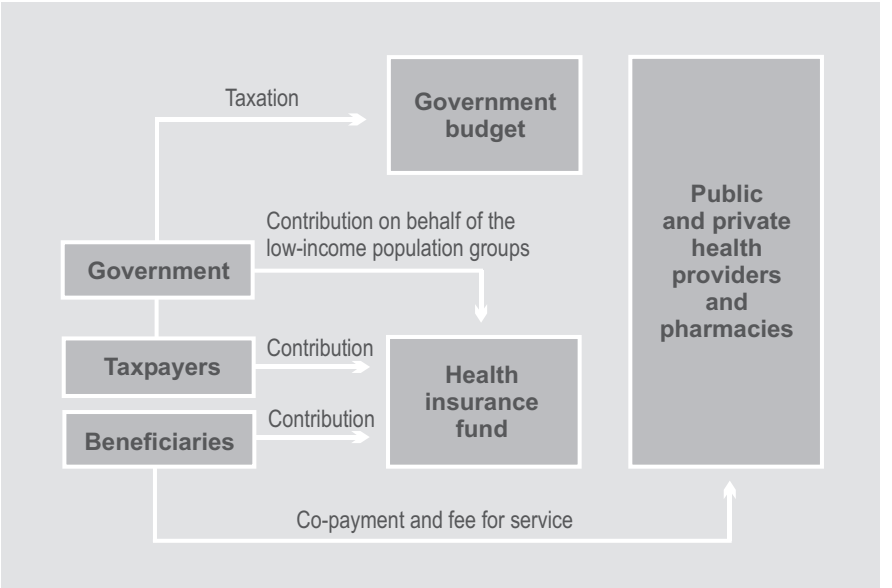
Source: Based on statistics of Ministry of Health, Mongolia, 2004.

structure, and level of contribution and its impact on labour cost and employment. A legal and regulatory framework reflecting firm political will and effective administrative capacity to run health insurance are also important factors (Kwon, 2002). Health insurance was a totally new concept for Mongolians, and the challenging issue was how to register and collect premiums from the self-employed nomad population.

There are two basic forms of insurance contribution. Children under 16, students, pensioners, mothers with newborn babies, persons on military service, herders and citizens covered by social assistance have been recognized as low-income and vulnerable population groups. For this population, the insurance contribution was established as a fixed amount of premium a person a month. The individuals in these categories accounted for nearly 70 per cent of the total population, and most of them were children under 16 years old. The current monthly health insurance premium for the low-income and vulnerable population is 500 Mongolian tugriks per head (Tug 1,000 = US$ 0.90 = €0.70 approx.), which is fully subsidized by the government. Another form of insurance contribution was established for employees of economic entities, institutions and organizations, and business owners and sole proprietors, at a rate of 6 per cent of the individual's salary or income. However, all types of employers are required to pay a minimum 50 per cent of their employees' premium (see Figure 1 for the flow of funds). The contribution share of employers and workers has been gradually increased over time, from 58.6 per cent in 1998 to 76.7 per cent in 2003 (Table 3).

The government health policy priorities, cost and utilization of health services, and estimated revenue from health insurance contributions were the basis for planning an initial benefit package. The benefit package of health insurance covered nearly all types of hospital care, except the treatment of certain specified chronic and infectious diseases such as diabetes,

Figure 1. *Flow of funds in the Mongolian healthcare system*



cancer, tuberculosis, brucellosis, HIV/AIDS and mental diseases. The government took the responsibility for providing treatment for these diseases free of charge in addition to a number of public health services such as immunization, sanitation, food safety, hygiene and those related to pregnancy and childbirth. Outpatient drug cost was fully reimbursed initially by the insurance fund if the drugs prescribed by the *bag* health worker or family physician were listed in the National Essential Drug list.

The last amendment in the health insurance Law approved by the Parliament in 2002 has expanded the health insurance benefit package to limited outpatient services and health services provided by the family group doctors' practices (FGPs) in urban districts and provincial centres. At the end of 2003, about 52 per cent of the total population were covered by 240 FGPs established in all districts of the capital city Ulaanbaatar and provincial centres. The health insurance agency has contracts with the FGPs on a capitation basis. The payment for outpatient services is established on the basis of a fee for service that currently ranges between 600 and 1000 tugriks per visit or test, depending on the level of health facilities. With the introduction of health insurance, all hospitals were grouped into several categories according to their referral locations and the range of services offered. Since health insurance covered only inpatients, hospitals were reimbursed according to

Table 4. *Types of public healthcare institutions*

Levels of medical care provided		Number of posts and hospitals
Level 1	*Bag* posts	875
Level 2	Primary sum hospitals	345
Level 3	Secondary *aimak* hospitals	33
Level 4	Tertiary national hospitals and centres	11

Source: Ministry of Health, 2001b.

the inpatient bed-day tariff for the particular group of hospitals. Along with hospitals, public pharmacies were reimbursed based on the price of essential drugs dispensed through doctors' prescriptions. Both payment methods were retrospective because the reimbursement is made to a service provider after the services have been delivered to a patient.

Challenges

Hospital financing and private sector growth

Healthcare in Mongolia is organized according to administrative division. Health services at the lowest administrative level are delivered by a *bag* health worker, called *bag feldsher* or assistant doctor. The next referral level is the *sum* hospital, with 10-20 beds. More than 300 *sum* hospitals and about 1,400 *bag* health workers carry the responsibility for the delivery of basic and primary healthcare services to the rural and nomad populations in Mongolia. Provincial central and urban district hospitals with 200-300-bed capacities deliver mostly secondary healthcare to the population. Tertiary care is provided by more than ten state clinical hospitals and specialized health centres located in the capital city (Table 4).

Healthcare costs in Mongolia are relatively high owing to the low population density and high dependency on imported pharmaceuticals, medical equipment and supplies. Non-service-related costs such as heating, electricity and building maintenance, especially during the cold winter season, absorb 23-25 per cent of the total national health budget. The introduction of health insurance improved hospital financing, which was the most expensive component of healthcare. The study conducted by the Ministry of Health in collaboration with UNICEF in 1994 showed that inpatient care accounted for 70-80 per cent of provincial and 60-75 per cent of rural district health expenditures (Ministry of Health and UNICEF, 1994).

Table 5. *Number of registered private health institutions*

	Years						
	1991	1993	1995	1997	1999	2001	2003
Private family doctor groups	—	—	—	—	99	178	231
Privately owned clinics	9	26	197	254	366	384	476
Private hospitals	—	6	41	64	82	96	135
Total	9	35	238	318	547	658	842

Source: Based on statistics of Ministry of Health, Mongolia, 2004.

The dual hospital funding sources — government budget and social health insurance — have required new skills in financial planning, budgeting and management of resources. Some decision-makers at decentralized administrative levels lacked knowledge and capacity to provide operative support to health insurance. Health insurance administrative units also had limited capacities in effective management of revenue collection and payments to providers. Hospital managers had difficulties in maintaining good-quality services when budgetary financing was underestimated, reduced or delayed, especially at provincial level. Provincial authorities often misinterpreted the new system as meaning that health insurance had been introduced to free up or replace budgetary financing rather than complementing local health budgets.

It soon became clear that the budgetary financing mechanism and retroactive payment mechanism to providers under health insurance did not provide incentives to control cost. For example, local governors were interested in expanding their hospital service capacity to be eligible for health insurance funding and reduce budgetary financing. To restrict such incentives and control hospital costs, fixed and variable cost components of public hospitals were separated in 1997, and the health insurance fund became responsible for only healthcare-related variable costs. The fixed-cost component of hospitals was linked to budgetary financing, and therefore any expansion of services had a certain impact on local budgets. The share of health insurance funding in total healthcare financing decreased from 47 per cent in 1994 to 32 per cent in 2001 owing to the shift of fixed hospital costs from health insurance to local government budgets.

Such efforts had positive effects on cost containment in public hospitals, which account for more than 90 per cent of total hospital beds. But this reform did not have a significant impact on the rapidly growing private

Table 6. *Expenditure on health insurance benefits, 1995-2002 (millions of tugriks)*

Benefits provided	1995	1996	1997	1998	1999	2000	2001	2002
Inpatient care	6,089.5	9,377.2	9,279.5	12,789.4	11,047.5	11,543.1	12,430.8	14,630.6
	94.7%	95.1%	95.7%	97.5%	97.2%	96.0%	95.2%	95.5%
Pharmaceuticals	205.7	217.5	194.0	118.1	136.4	252.5	378.7	413.6
	3.2%	2.2%	2.0%	0.9%	1.2%	2.1%	2.9%	2.7%
Rehabilitative care	135.1	266.2	222.9	209.8	181.8	228.5	248.1	275.8
	2.1%	2.7%	2.3%	1.6%	1.6%	1.9%	1.9%	1.8%
Total benefits	6,430.3	9,860.9	9,696.4	13,117.3	11,365.7	12,024.1	13,057.6	15,320.0
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: Based on statistics of Ministry of Health, Mongolia, 2003.

sector. All newly established private healthcare institutions have a strong financial interest to have access to the health insurance fund for their operation. By 2003, there were about 840 private health facilities registered (Table 5).

This is a very significant but uncontrolled growth, which happened without proper planning or accreditation of service providers by the health insurance agency. This makes private sector growth a challenging issue for the health insurance system in Mongolia. It has affected both demand and supply of health services (Mills et al., 2002). Newly established private practices and institutions have widened the choice for patients in seeking care but contributed to the increase in overall health expenditure. The problems become more serious because of the absence of proper cost containment measures. Accordingly, a heavy burden fell on health insurance, which had modest revenue growth and a limited contributory basis to fund the newly emerging private for-profit hospitals along with the extensive public hospital network. As shown in Table 6, inpatient care benefits provided in public and private hospitals are very high, absorbing more than 95 per cent of health insurance revenue.

Healthcare cost inflation

The health insurance scheme in Mongolia has become the second major source of hospital financing next to the government budget. The new financing arrangement soon illustrated how hospital behaviour and perfor-

Table 7. *Trends in health expenditure (millions of tugriks)*

Years	Total government expenditure		Total health expenditure		Share of government expenditure (%)	Per capita health expenditure (tugriks)
	Amount	Annual increase (%)	Amount	Annual increase (%)		
1988	6,741.7		521.3		7.7	261
1989	7,062.3	4.76	551.6	5.81	7.8	270
1990	6,812.3	–3.54	578.9	4.95	8.5	276
1991	8,929.3	31.08	1,097.0	89.5	12.3	510
1992	11,741.3	31.49	1,690.9	54.14	14.4	878
1993	46,047.9	392.18	4,342.9	256.84	9.4	2,813
1994	101,333.6	120.1	11,754.7	170.7	11.6	5,092
1995	149,249.9	47.4	16,930.8	44.0	11.3	6,939
1996	211,813.0	41.4	26,053.0	53.8	12.3	9,150
1997	293,866.3	38.7	26,154.1	0.4	8.9	11,627
1998	296,516.5	0.9	32,320.3	23.6	10.9	13,736
1999	363,860.2	22.7	35,658.3	10.3	9.8	15,116
2000	429,653.1	18.1	45,951.6	28.9	10.7	18,234
2001	489,730.5	13.9	53,096.1	15.5	10.8	20,909
2002	548,629.2	12.02	57,963.5	9.2	10.6	23,148

Source: Ministry of Finance, *Statistical Year Book of Mongolia*, 2001, 2002, 2003.

mance are sensitive to financing modes and payment methods, as in other countries (Duckett, 1995; Gauri, 2001; Kwon, 2003a). Prior to health insurance, the utilization and quality of services began to suffer seriously because of the lack of resources caused by the economic crises in 1991-93. The average rate of hospital bed utilization nationwide decreased from 83.0 per cent in 1990 to 57.2 per cent in 1993. On the other hand, after social health insurance was implanted, the bed occupancy rate reached 80 per cent according to the statistics of the Ministry of Health. The total number of hospital admissions increased from 376,330 in 1993 to 504,490 in 1996, and the number of hospital beds from 21,500 to 23,082 during the same period (Ministry of Health, 2001a). This was not due to changes in morbidity but because the number of hospital beds and their utilization determined the hospital revenue funded by the health insurance fund. The Minister's order not to apply

to insured persons any kind of user fees in public facilities not only eased the financial burden on individuals but also created incentives for hospitalization.

As a result of the sharp increase in inpatient service utilization, the financial sustainability of the health insurance scheme has become critical. Since the introduction of social health insurance, health expenditure has increased very rapidly (Table 7).[2] Consequently, the new amendments in 1997 and 2002 introduced 5-15 per cent co-payment for inpatient services and up to 50 per cent cost share for outpatient essential drugs prescribed by *bag* health workers and family physicians. The hospital payment method also changed to prospective payment based on per capita resource need and the cost per admission. Under the new payment arrangement, the total amount of health insurance funding is agreed with each provincial administrator and public hospital manager, based on the average cost per hospital admission and expected inpatient care utilization rate. Then the health insurance fund provides prospective funds to public hospitals on a monthly basis, and health insurance inspectors monitor the quality of healthcare.

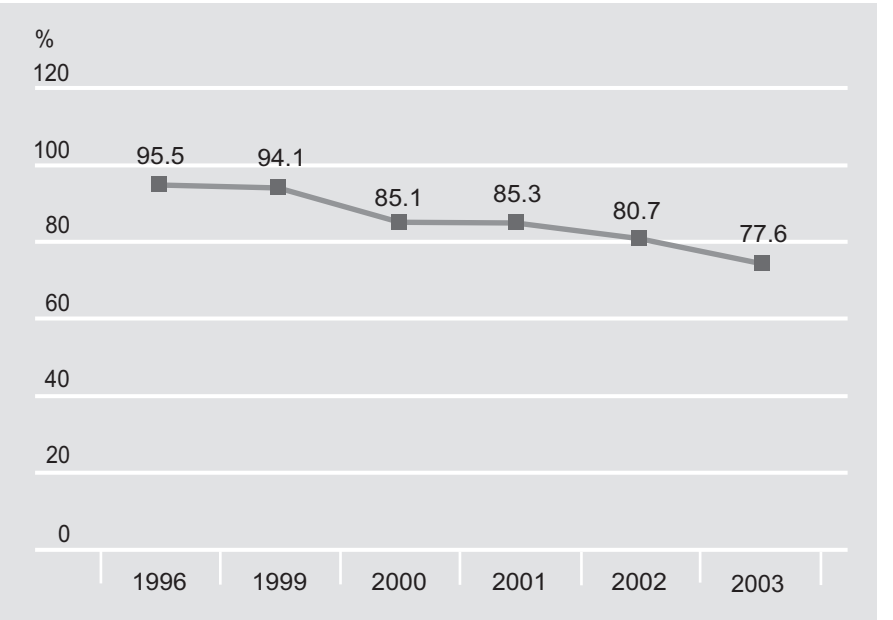
Such changes provided improved incentives and flexibility for more efficient resource management because the agreed amount is fully funded regardless of the actual utilization and expenses. Soon after, positive changes occurred in hospital service indicators. The statistical reports of the Ministry of Health show that the annual average number of hospital visits per capita decreased from 4.62 in 1995 to 3.78 in 1998. This change also led to a decrease in bed occupancy and average length of stay in hospitals. The peak in bed occupancy was reached at 98.5 per cent in 1998; in following years the rate decreased gradually and reached 89.5 per cent in 2000. Similarly, during 1996-2000, the average length of stay in hospitals declined nationwide from 12.6 to 11.2 days.

Decrease in population coverage

Despite many important policy reforms, the Mongolian health insurance scheme has faced critical challenges in maintaining universal coverage and effective monitoring of benefit provisions in terms of content, volume and quality of services. The satisfaction and compliance of the insured population declined, because the insured members did not benefit much from the scheme unless they were hospitalized. The annual report of the State Social

2. In the context of extremely adverse economic conditions compounded by hyperinflation, health sector financing experienced a sharp increase in budget in nominal terms during 1991-94, as shown in Table 7. But the health budget in real terms was much lower than needed to maintain and provide previously accessible health services with assured quality.

Figure 2. *Trend in population coverage of health insurance in Mongolia*



Source: Based on statistics of Ministry of Health, Mongolia, 2004.

Insurance General Office for 2001 showed that only 18 per cent of insured members received inpatient benefits, 20 per cent received benefits other than hospitalization and the large majority, 62 per cent of continuously contributing members, did not receive any benefits in that year. The gradual exclusion of students and nomads from the government subsidy interrupted their contribution payment, and a significant number of students and nomadic cattle breeders dropped out. As a result, the health insurance coverage rate among the total population declined from almost 96 per cent in 1996 to 78 per cent in 2003 (Figure 2). By the year 2002, about 50 per cent of the population, compared with 70 per cent in 1994, remained under the government subsidy. Among the individuals still subsidized, about 80 per cent were children under 16 years old, 14 per cent were pensioners without any supplementary income, and the remaining 6 per cent were people with disabilities and poor people, who come under the social assistance programme.

Limited capacities of the insurance administrative office to process information on the persons insured, lack of client-oriented arrangements for the collection of premiums, inability or unwillingness to pay their premiums on the part of certain population groups, high internal migration and lack of

appreciation of the importance of being insured have contributed to the lowered coverage (Samyshkin, 2004). The decrease in population coverage has seriously limited the role of health insurance in the era of steadily increasing healthcare costs and an expanding healthcare providers' network with newly established private practices. Social health insurance members, particularly employed members, reportedly do not feel that they get sufficient value for their contributions (Knowles, 2004). Healthcare providers have complained about the basis for setting payment tariffs, which may not match the true costs of services and therefore are likely to lead to lowered service quality and standard. Unofficial payments and charges also began to be practised in major hospitals in the capital city and provincial centres.

Currently, the Health Insurance Council and administration are failing to adequately address these critical challenges. The gap exists in terms of technical capacity and capability. During the transition, the technical skills and capacity, including trained human resources, were not fully transferred to the state social insurance agency, owing to the differences in personnel career opportunities, salary and fringe benefits between commercial and public companies. Existing administrative staff of social health insurance in many districts and provinces seriously lack sound knowledge, expertise and incentives to take active measures to maintain or increase population coverage and revenue collection. Rather, more time and effort are expended in the distribution of scarce revenue among public and registered private providers. Limited funding has been a barrier to expanding benefit packages and maintaining regular training programmes for health insurance staff.

Lessons

The Mongolian healthcare system is determinedly surmounting the economic hardship caused by the fundamental socioeconomic reforms. Low income, low population density, the existence of a large informal economy including nomads, a high dependency ratio and newly emerging social problems such as unemployment and poverty led to multidimensional needs in healthcare financing and delivery. Health sector reform in Mongolia has mainly been guided by the broader public sector reform process, which was characterized by decentralization, privatization and cost recovery initiatives.

During the economic transition, social services and the living conditions of the population deteriorated sharply, and the government recognized compulsory social health insurance as a policy instrument to provide social safety nets. The specific goals of health insurance were to increase the level

of personal responsibility for health and to protect the entire population from catastrophic medical expenses caused by illness. The establishment of stable and equitable funding arrangements with a social health insurance system has also allowed shifts in government budget allocation towards public health services as another important policy objective. The Ministry of Health, moreover, considered health insurance a tool to implement its newly introduced policy on essential drugs and family doctor practices.

The development of social health insurance in Mongolia has experienced both successes and challenges. Appropriate policy measures taken systematically by the government played a critical role in the establishment of social health insurance as a new funding source in Mongolia. High government commitment and targeted subsidies ensured near-universal coverage in a very short period. Currently, no specific evidence is available about the effectiveness of government subsidizing of the premiums of vulnerable groups as compared with direct provision of public healthcare to the poor. But the universality of population coverage can contribute to the poor and low-income population gaining the same access to the same service benefit as the better-off have, resulting in a reduction in stigma. Health insurance in Mongolia has provided the insured population with protection against a high financial burden related to medical care costs during the difficult economic transition process. Although co-payments and user fees were introduced, their effect is low compared with that in many low-income countries in similar economic transition. The newly constructed Mongolia National Health Accounts estimate that out-of-pocket health expenditure is less than 30 per cent of the total.

However, there is a need to improve the efficiency of funding both from government and from health insurance sources. Health insurance still pays a high price for the universality associated with individual-based rather than family-based insurance coverage, substantial government subsidy, and hospital-based (inpatient) benefit. At the same time, adverse economic incentives under the new financing arrangements, including retrospective payment used for hospital reimbursement and the poorly regulated private sector, have demanded more resources from the restricted contribution base. The government's attempt to reduce targeted subsidies after the first years resulted in high drop-out rates from insurance membership. Future policy actions, such as a shift of the health insurance unit from the current individual level to family coverage, the widening of health insurance benefits to ambulatory services, the extension of prospective payment to providers, and building the capacity of health insurance administration by training health insurance staff at central and provincial agencies, can reduce many of the challenges faced by the Mongolian health insurance scheme, as

in other developing countries (Ron, Abel-Smith and Tamburi, 1994; Ron and Scheil-Adlung, 2001).

Analysis of the achievements and challenges of social health insurance in Mongolia can contribute to the discussion on many important aspects of the development of social health insurance in developing countries. The Mongolian experience shows that universal coverage can be achieved through a single national scheme that covers both the formal and informal sectors from the very beginning. An alternative would have been to start with the formal salaried sector, followed by a slow extension of coverage to the informal economy, or the development of separate schemes for these two population groups (Kwon, 2003b). Obviously, the decision to cover the entire population was crucial for equity and access for the majority of the population. In retrospect, this was a very positive development, although administrative capacity lagged behind. The development of compulsory health insurance in Mongolia demonstrates that social health insurance with its universality through a contributory prepayment method is feasible in low-income countries given high political commitment and financial support for the low-income and vulnerable population groups.

The recent challenges in maintaining universal coverage and supplying an effective response to the needs of the insured population are likely to require more innovative approaches and actions that would lead to gradual extension of health insurance benefits to ambulatory care, and acceptance of family coverage including legal dependants. In addition to the potential of preventing some diseases from developing into serious cases, outpatient benefits have a strategic value in reducing drop-outs, because they provide an opportunity for a larger number of insured people to experience the benefits of health insurance. It should also be noted that healthcare delivery is closely interrelated with healthcare financing, and inefficient delivery together with failure to contain healthcare expenditure threatens the financial sustainability of the social health insurance system. The Mongolian experience shows the importance of providing financial incentives to healthcare providers to hold down health cost inflation. Reforming the payment system for healthcare providers though an effective prospective (not retrospective) payment scheme will be vital in enhancing the efficiency of healthcare delivery and improving the financial sustainability of social health insurance.

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