ADB SUPPORT IN
THE HEALTH SECTOR REFORM IN MONGOLIA

SUPPORTING HEALTH-CARE FINANCING REFORM IN MONGOLIA

EXPERIENCES, LESSONS LEARNED, AND FUTURE DIRECTIONS

Altantuya Jigjidsuren and Bayar Oyun

NO. 55

December 2022

ADB EAST ASIA
WORKING PAPER SERIES

ASIAN DEVELOPMENT BANK

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ADB East Asia Working Paper Series

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Supporting Health-Care Financing Reform in Mongolia: Experiences, Lessons Learned, and Future Directions

Altantuya Jigjidsuren and Bayar Oyun

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Altantuya Jigjidsuren is senior social development officer of the Mongolia Resident Mission, East Asia Department, Asian Development Bank (ADB).

Bayar Oyun is health systems consultant at ADB's Mongolia Resident Mission.

ASIAN DEVELOPMENT BANK

6 ADB Avenue, Mandaluyong City, 1550 Metro Manila, Philippines
Tel +63 2 8632 4444; Fax +63 2 8636 2444
www.adb.org

Printed in the Philippines

Publication Stock No. WPS220609-3
DOI: http://dx.doi.org/10.22617/WPS220609-3

Notes:
In this publication, "$" refers to United States dollars and "MNT" refers to Mongolian togrog.

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CONTENTS

TABLE AND FIGURES

TABLE

FIGURES

ACKNOWLEDGMENTS

The authors would like to thank Bayarsaikhan Dorjsuren, senior health systems advisor, Department of Health Systems Governance and Financing, World Health Organization; and Claude Bodart, former principal health specialist, Asian Development Bank, for their peer review.

ABBREVIATIONS

ADB	Asian Development Bank
DRG	diagnostic-related group
GDP	gross domestic product
HIGO	Health Insurance General Office
MOF	Ministry of Finance
MOH	Ministry of Health
OOP	out-of-pocket
SSIGO	State Social Insurance General Office
THSDP	Third Health Sector Development Program
UHC	universal health coverage

CURRENCY EQUIVALENTS

(as of 15 December 2022)

Currency Unit – togrog (MNT)
MNT1.00 = $0.00029
$1.00 = MNT3,434.36

EXECUTIVE SUMMARY

Before the 1990s, the state took full responsibility for the funding and delivery of health-care services in Mongolia. There was no private sector, and the entire population was guaranteed free access to public health care. Exclusive tax-based financing—with resources coming from general taxation—funded health-care expenses. At the beginning of the 1990s, Mongolia started transitioning from a centrally planned to a market economy. Transition difficulties started when the withdrawal of Soviet assistance caused an economic collapse that significantly reduced the overall state budget and allocation of resources for public expenses. Under the new economic conditions, it became difficult to maintain free health care through state financing alone. The government needed additional funding resources for the state budget to keep the previously attained levels of health-care quality, access, and coverage. That necessitated the reform of the health system and its financing mechanisms. The Asian Development Bank (ADB) support for the reform of the health system in Mongolia started in 1994 when the Government of Mongolia requested ADB to assist in strengthening the newly introduced health insurance scheme. Since then, ADB-funded health sector development programs and technical assistance projects are continuously supporting the health system in Mongolia, including the health-care financing reform.

The reform of Mongolia's health-care financing system transitioned from an exclusively input-oriented financing model to the output-oriented model in use in 2022 that is better suited to the realities of a market economy. The shift to an output-oriented model has delivered several significant results including (i) the establishment of the mandatory national health insurance scheme as a major source of health-care financing; (ii) the introduction of more efficient payment mechanisms, such as capitation for primary health care and case-based payments for hospital services; (iii) the pooling of the main sources of health-care funding, such as the state budget and the health insurance fund; and (iv) the establishment of the single-purchaser system for health services.

There are still challenges that need to be addressed by the government to improve the overall efficiency and effectiveness of the health-care financing system such as (i) continued underfunding of health care, (ii) high out-of-pocket expenditure that exacerbates financial risks of households, and (iii) insufficient funding allocated for primary health care compared with the funding allocated for oversized and excessive hospital care.

This paper describes the health-care financing system in Mongolia and associated reforms that started in the early 1990s. ADB's assistance for the reform of health-care financing in Mongolia offers lessons that could be useful in providing support to other countries across the region. Particularly noteworthy are the needs to (i) ensure the allocation of time and resources, (ii) continuously strive to implement systemic changes, and (iii) factor in issues about the consistency of policies and plans and their timely implementation.

I. THE NEED FOR HEALTH-CARE FINANCING REFORM

A. Health Care in Mongolia before the 1990s

Mongolia introduced modern health care in the early 1920s, substituting traditional oriental medicine that for centuries was the only available medical practice. Up until the beginning of the 1990s, the health-care system was based on strong central planning with the state being responsible for its financing and delivery.[1] This centrally planned health sector model was notable for its provision of free and universal access to health care and the control of communicable diseases. This model had weaknesses, which included low efficiency, low quality, and a lack of responsiveness to patient needs despite the high number of hospital beds and medical staff.[2] The success of the health-care system was measured by the number of doctors, nurses, and hospital beds per population or, in other words, was predicated on an "input-based" health-care model that did not readily translate into improvements of key population health indicators. To understand the context and basis of the input-based health-care financing model, it is important to examine the health-care system in Mongolia during the socialist period.[3]

During the socialist period, primary health care in rural areas was delivered through *soum* (subprovince administrative unit) hospitals[4] and *bagh* (sub*soum* administrative unit) feldsher posts that served people in remote areas.[5] *Soum* hospitals had good service coverage and were well suited to the needs of the rural population, primarily nomadic herders who were sparsely dispersed over a massive territory of 1.5 million square kilometers. Immunization programs were well organized and implemented. Overall, curative services dominated over preventive public health approaches. *Aimag* (provincial) general hospitals[6] serviced the entire population within their *aimags* and received referrals from all *soum* hospitals, deploying emergency care teams to remote areas when necessary.[7]

The situation in the capital—Ulaanbaatar—was significantly more complicated. Polyclinics provided outpatient services for a catchment population within a defined geographic area and delivered primary health care in urban areas (the capital and provincial centers).[8] District hospitals (with 100–200 beds) were designed to provide inpatient medical services that were limited to internal medicine and pediatrics. Maternity hospitals operated as separate facilities for obstetric services only. Tertiary-level state general hospitals—concentrated in Ulaanbaatar—provided services not available at the *aimag* and district levels,

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[1] Described as the Semashko model, which existed in the former Soviet Union (I. Sheiman. 2013. Rocky Road from the Semashko to a New Health Model. *World Health Organization Bulletin*. Geneva: World Health Organization).

[2] A. Jigjidsuren, B. Oyun, and N. Habib. 2021. Supporting Primary Health Care in Mongolia: Experiences, Lessons Learned, and Future Directions. *ADB East Asia Working Paper Series*. No. 35. Manila: Asian Development Bank (ADB).

[3] The socialist state of the Mongolian People's Republic existed from 1924 to 1992.

[4] Every *soum* had a 15–30-bed *soum* hospital that provided outpatient and inpatient services for patients with noncomplicated medical conditions. *Soum* hospitals also provided antenatal and postnatal care, and minor surgery; operated maternity rest homes for mothers from remote areas; and managed uncomplicated deliveries. Ambulance services for people from remote areas and home visits within *soum* centers were part of the routine duties of *soum* hospitals (footnote 2).

[5] A feldsher is a primary health-care worker with 2 years of medical training assigned to work at a remote post in a *bagh* under the supervision of a medical doctor from the *soum* hospital (footnote 2).

[6] Each *aimag* general hospital had, on average, 200–250 beds for provision of inpatient services in internal medicine, general surgery and trauma, pediatrics, obstetrics, neurology, infectious diseases including tuberculosis, and emergency care.

[7] There are 21 *aimags* in Mongolia. As of 2021, the smallest *aimag* has a population of 18,150, while the biggest *aimag* has a population of 136,794 (National Statistical Office of Mongolia. Population of Mongolia, by *Aimag*, 2021).

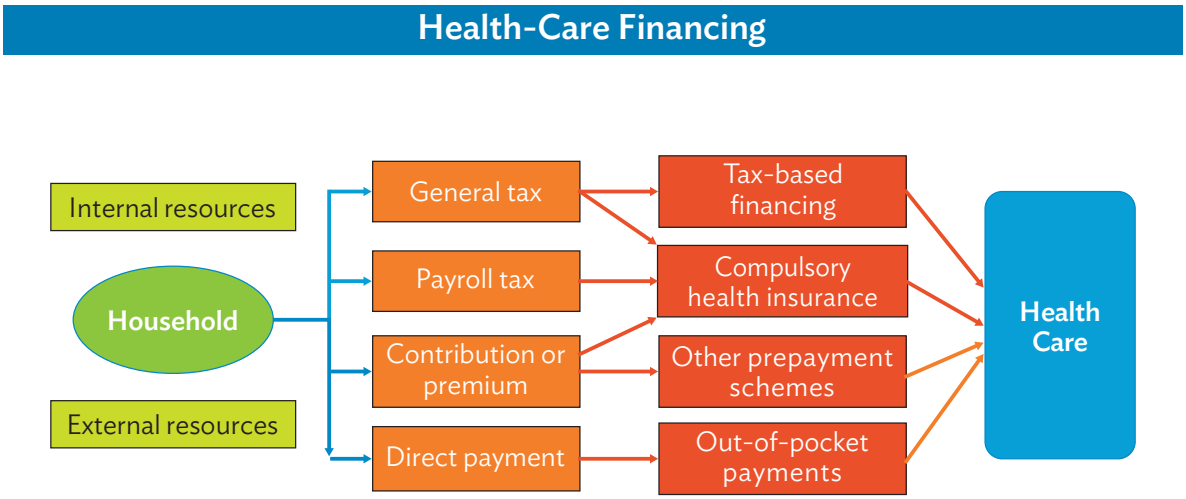
[8] Polyclinics had general physicians, some specialized doctors, and diagnostic sections. Separate polyclinics existed for children and the adult population (footnote 2).

while specialized single-profile hospitals provided services for specific diseases.[9] Coordination between outpatient and inpatient services was inefficient, there was no day care or palliative care, and nursing care was considered only as a supplementary service. This led to the use of acute hospital beds for the long-term care of chronically ill patients. Overall, the hospital sector was characterized by an excessive number of acute beds, a large number of medically unjustified admissions, and long hospital stays.[10]

B. Health-Care Financing in Mongolia before the 1990s

There are diverse ways for financing the health-care system (Figure 1). In the socialist period, Mongolia followed Soviet-type economic development, where the government fully funded health care from central and local government budgets and took responsibility for its delivery. In the late 1980s, Mongolia spent 7% of gross domestic product (GDP) and more than 10% of the total state budget on health.[11] Exclusive tax-based financing funded health-care expenses. Hospital budgets were determined by existing bed capacity and staff numbers and financed through fixed line item allocations such as for staff salaries, operating costs, or medicines. The health sector lacked any private sector input, and the entire population received free access to public health care.

Figure 1: Ways for Financing Health Care



Source: Authors (adopted from various sources).

At the beginning of the 1990s, Mongolia started transitioning from a centrally planned to a market economy. An economic collapse caused by the withdrawal of Soviet assistance in the early 1990s significantly reduced the overall state budget and allocation of resources for public expenses. That led to socioeconomic reforms—including economic restructuring and privatization, the significant

[9] Tertiary-level single-profile hospitals provided care for specific areas such as maternal and child health, infectious diseases (including tuberculosis and sexually transmitted diseases), trauma, psychiatry, oncology, and dermatology. Other hospitals provided care based on the occupation of patients, such as for high-level government officials, railway workers, the military, and special forces.

[10] A. Jigjidsuren, B. Oyun, and N. Habib. 2021. Rationalizing Mongolia's Hospital Services: Experiences, Lessons Learned, and Future Directions. *ADB East Asia Working Paper Series*. No. 37. Manila: ADB.

[11] (a) D. Bayarsaikhan, S. Kwon, and A. Ron. 2005. Development of Social Health Insurance in Mongolia: Successes, Challenges and Lessons. *International Social Security Review*. 58 (4). pp. 27–44; and (b) Soviet assistance played a significant role and reached up to 30% of the Mongolia GDP (ADB. 2008. *Evaluation Study: Rapid Sector Assessment—Mongolia: Health and Social Protection*. Manila).

reduction of public employees, and the closure of nonviable enterprises—resulting in a sharp increase in unemployment and poverty levels. It was accompanied by high inflation and a depreciation of the national currency, which raised the consumer price index to its highest point level during 1991–1992 (with a threefold increase in the prices from 1980), and deteriorated the purchasing power of the local population.[12]

The economic crisis sharply impacted the ability of the government to finance and deliver health-care services. Significant cuts had to be made to the state expenditure on health. The level of state health spending as a proportion of GDP dropped from 6.7% in 1990 to 4.0% in 1992, and public resources covered only 60%–70% of the previous year's health budget in real terms (footnote 11 (a)).

The termination of trade arrangements with the members of the Council for Mutual Economic Assistance led to an acute shortage of most goods, including essential medicines and medical supplies.[13] These factors contributed to a drastic decline in the quality and accessibility of health-care services. The financing gap had to be filled by alternative sources of revenue, including user fees. As a result, patients had to pay for medical expenses that were formally free. The rural nomadic population had an additional financial burden because they were charged for emergency calls and ambulance transportation (footnote 11 (a)).

Under the new economic conditions, it became difficult to maintain free health care through state financing alone. The government needed additional funding resources for the state budget to keep the previously attained levels of health-care quality, access, and coverage. The difficult economic situation triggered a need for a wide range of market-oriented socioeconomic changes, including reforming the health sector financing and service delivery.

II. ADB SUPPORT FOR THE REFORM OF HEALTH-CARE FINANCING

A. Supporting the Establishment of the Social Health Insurance

The state budget—through revenues from general taxation—exclusively financed the health system in Mongolia during the socialist period. Reforms conducted since the early 1990s have seen the addition of other sources of funding. Along with the state budget, the health insurance fund was another significant source for financing health care.[14]

The market-oriented transition that commenced in the early 1990s triggered policy debates on reforming the health system and its financing. The debates focused on introducing market elements into the health sector and reducing the government's role in delivering health-care services through the privatization of public health-care facilities, promoting cost recovery, and introducing cost-sharing mechanisms. The government tried to mitigate possible negative consequences and financial risks for the general population

[12] D. Bayarsaikhan. 1996. *Health Financing*. Ulaanbaatar.

[13] The organization was established in January 1949 to facilitate and coordinate the economic development of the socialist countries belonging to the Soviet bloc.

[14] Out-of-pocket expenditure is another main source of financing for health care. According to reports, out-of-pocket expenditure reached 41% of total health expenditure in 2011 (J. Dorjdagva et al. 2016. Catastrophic Health Expenditure and Impoverishment in Mongolia. *International Journal for Equity in Health.* 15 (1). Article no. 105. doi: 10.1186/s12939-016-0395-8). International donor contributions have provided another notable source of financing for health care at various times since early 1990s.

associated with this transition, and developed a strategy focused on (i) improving cost-efficiency in health-care service delivery, (ii) the allocation of scarce government resources to public health priorities, and (iii) the mobilization of additional resources for the health sector.[15] Through the state budget, the government retained responsibility for capital investment, preventive public health services, and critical hospital services such as maternal and child health, infectious diseases, cancer, mental health services, and emergency care.[16] Social health insurance—based on the concept of risk-sharing and pooled funding to provide financial protection for the entire population—was earmarked as an additional source of funding for health-care expenses.

The Ministry of Health (MOH) led efforts to design the social health insurance framework. The ministry adopted the Citizen's Law on Health Insurance in 1993, and which came into effect in 1994. It aimed to improve access to necessary health services for the entire population, regardless of income, thus guaranteeing its benefits for vulnerable population categories. All public and newly established private sector employees, and low-income and vulnerable population groups were compulsorily insured by the law. To provide social health protection for the low-income population, the government identified seven vulnerable categories that constituted about 70% of the population and fully subsidized their contribution.[17] Formal sector workers were required to pay a mandatory contribution of 6% of their monthly salary or income (reduced to 4% in 1998), equally shared by employers and employees.[18] To ensure easy coverage for the informal sector, self-employed and unemployed groups were asked to pay a flat rate contribution, which was 20 times lower than the average contribution of salaried workers.

Formal sector contributions funded much of the total income of the health insurance fund, which increased from 58.6% in 1998 to 82.0% in 2006. The government subsidy share for low-income and vulnerable groups was 37.9% in 1998 but decreased to 13.3% in 2006, while the informal sector generated 4.09% of the total health insurance fund revenue.[19]

Since its creation, the health insurance scheme—as set in the law—focused on covering inpatient care provided by secondary and tertiary-level hospitals, traditional medicine facilities, and sanatoriums. The benefits package included inpatient services for internal diseases; nonemergency injuries and surgery; nervous system diseases; eye, ear, bone, and muscle tissue diseases; and partial reimbursement of the price of a limited number of essential medicines prescribed by family doctors. The state budget financed all other services.[20] In 2003, the health insurance scheme benefits package was expanded to include outpatient services and, in 2010, added diagnostic tests and daycare at secondary and tertiary care levels. Primary health care was included in 2003, but was moved back to the state budget financing in 2006

[15] ADB. 1994. *Technical Assistance to Mongolia for Strengthening Health Insurance*. Manila (TA 2279-MON).

[16] 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. 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 health-care-related variable costs. The fixed-cost component of hospitals was linked to budgetary financing (footnote 11 (a)).

[17] Vulnerable groups of population include children under 16, pensioners, women taking care of children under 2, citizens needing social assistance (disabled, orphans, single old persons, and others), full-time students, and herders. Since 1997, students and herders are not classified as vulnerable and are required to pay their contributions.

[18] The formal sector includes civil servants, employees of economic entities, institutions and organizations, and army and police personnel.

[19] State Social Insurance General Office. 2012.

[20] This included services for pregnant women and children; infectious and chronic diseases such as tuberculosis, brucellosis, HIV/AIDS, diabetes, cancer, and mental diseases; medical emergency and ambulance services; and public health programs.

because of concerns that the uninsured faced the prospect of not being able to access the most essential primary health care.[21]

Initially, the state commercial insurance company Mongol Daatgal conducted the health insurance scheme administrative functions including registration, the collection of contributions, claims processing, and payment for service providers. The Health Insurance Council provided guidance on policies and management (footnote 11 (a)). Gradually, the government decided to transfer the administrative functions of the health insurance fund to the State Social Insurance General Office (SSIGO) operated under the Ministry of Labor and Social Welfare.

In 1994, the government asked the Asian Development Bank (ADB) to assist in strengthening the newly introduced health insurance scheme (including the enhancement of the policy framework) and ensuring its smooth transition to the SSIGO. During the difficult initial period of political and economic transition—when the government did not have much expertise or resources—the ADB technical assistance project provided much needed support in solidifying the national health insurance scheme as an additional source of health-care financing (footnote 15). With technical assistance, the government studied health insurance schemes in other countries, reviewed health insurance policies, set up its administrative structures and information systems, and built the capacity of social and health insurance staff. The technical assistance project was instrumental in facilitating the smooth transition of the health insurance scheme to the integrated social insurance system as planned by the government.[22]

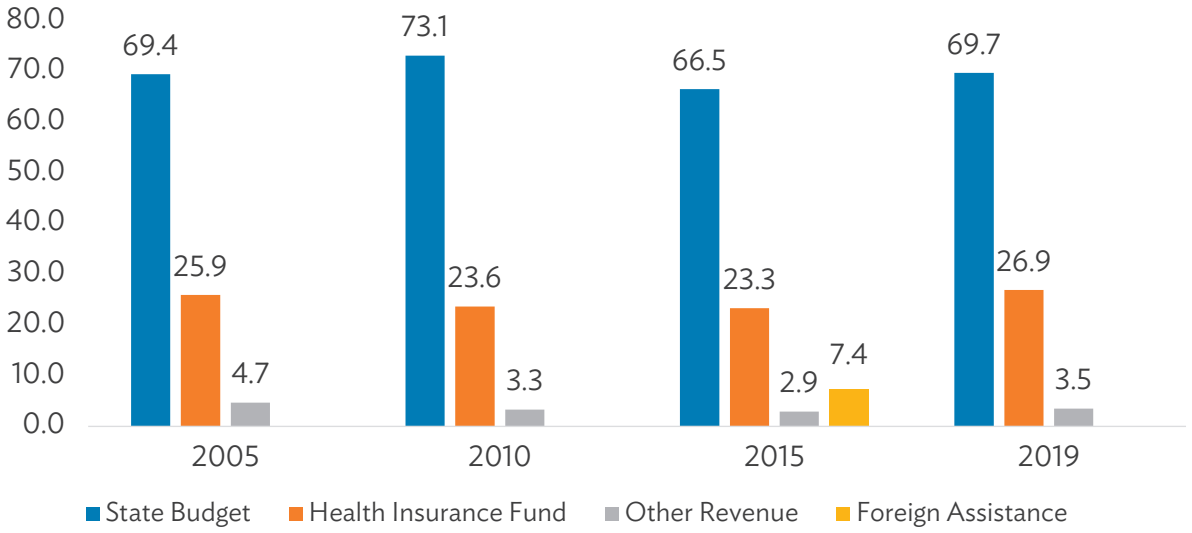
Even though health insurance was a new concept, approximately 95% of the population was covered on a mandatory basis within the first 2 years. This high level of coverage was achieved partly due to the government mandate of covering contributions for vulnerable groups, which accounted for almost 70% of the population.

Overall, the country was able to establish a sound organizational framework for social health insurance. In a relatively short time, health insurance has become one of the vital sources of health-care financing (Figure 2). The government successfully increased its spending on health by adding health insurance without decreasing state funding. Like all countries with a large informal sector, Mongolia subsidizes its vulnerable population in the system, including a large part of its informal sector. The employers and employees in the formal sector share their financial health risks with the poor and the vulnerable, and cross-subsidize the informal sector. This mechanism has ensured that the health-care system generates the resources to cover the basic health-care needs of the population while preventing state budget overload.

[21] The health insurance fund covered primary health care provided by *soum* hospitals and, more recently, family group practices based on risk-adjusted capitation. Changes made to the Health Law in 2006 shifted the funding of primary health from the health insurance fund to the state budget (T. Bolormaa et al. 2007. Mongolia: Health System Review. *Health Systems in Transition.* 9 (4). pp. 1–151).

[22] ADB. 1996. *Technical Assistance Completion Report: Mongolia—Strengthening Health Insurance.* Manila (TA 2279-MON).

Figure 2: Sources of Funding for Health Care in Mongolia, 2005–2019



Sources: Government of Mongolia, Center for Health Development. 2019. *Health Indicators 2019*. Ulaanbaatar; and Government of Mongolia, Ministry of Health. 2017. *Review of State Expenditure for Health and Sports Sectors*. Ulaanbaatar.

B. Support in Strengthening the Health Insurance Scheme and Moving Toward a Strategic Purchasing Model

Despite significant advances, challenges associated with the health insurance scheme soon became apparent. Overall participation declined from initial levels of 95% to around 80% by 2006.[23] The decrease in population coverage was a result of declining satisfaction (and associated compliance) of the insured population because of benefits accruing only from hospitalization combined with the poor quality of services and increased out-of-pocket (OOP) expenditure. About 20% of the population—mostly herders, the self-employed, and the unemployed who were not categorized as vulnerable—dropped out of the health insurance coverage.

Revenues of the health insurance fund were mostly from wage-dependent contributions. A limited part of the population—the formal sector, which comprised 24% of the insured—contributed 80.1% of the health insurance fund's total revenues in 2008, but only consumed 13% of the expenditure. The flat rate contribution of people in the informal sector was meager and did not keep pace with inflation. Similarly, only 13% of total revenues came from government contribution for the subsidized enrollees (60%), who consumed 50% of the total fund expenditures. Government subsidy for the contributions of the vulnerable population was not based on their actual enrollment numbers, but was a historically fixed amount adjusted over the years. High wage-based contributions compensated low government subsidies for vulnerable groups and low flat-rate contributions by the informal sector, leading to increased feelings of unfairness in financing and a lack of equivalency between contributions and access to quality health services. The formal sector also continued to be burdened by co-payments and increased OOP expenditure, contributing to a decreased appetite to support the health insurance system and questioning its solidarity concept.

[23] ADB, Third Health Sector Development Project (THSDP), GVG. 2010. *Review of the Mongolian Health Insurance System*. Ulaanbaatar.

The health insurance scheme was created to be an additional source of financing to complement the existing tax-based state funding system. The state health budget and the health insurance fund had separate benefit packages and different flows of funds and payment methods, creating a fragmentation of financing sources. This fragmentation existed until 2021 when the government decided to pool the state health budget and the health insurance fund and establish a single-purchaser model. Hospitals were funded by both the state budget and the health insurance fund. Fragmentation in service coverage between the state budget and the health insurance fund led to significant gaps in services that patients shouldered through OOP expenditure. Beside different funding sources, the benefits package was also highly fragmented because of the split between types of services (e.g., primary health services and hospital services) and the split across medical interventions (e.g., outpatient, inpatient, and medicines). This situation was not conducive to the effective delivery of health services.

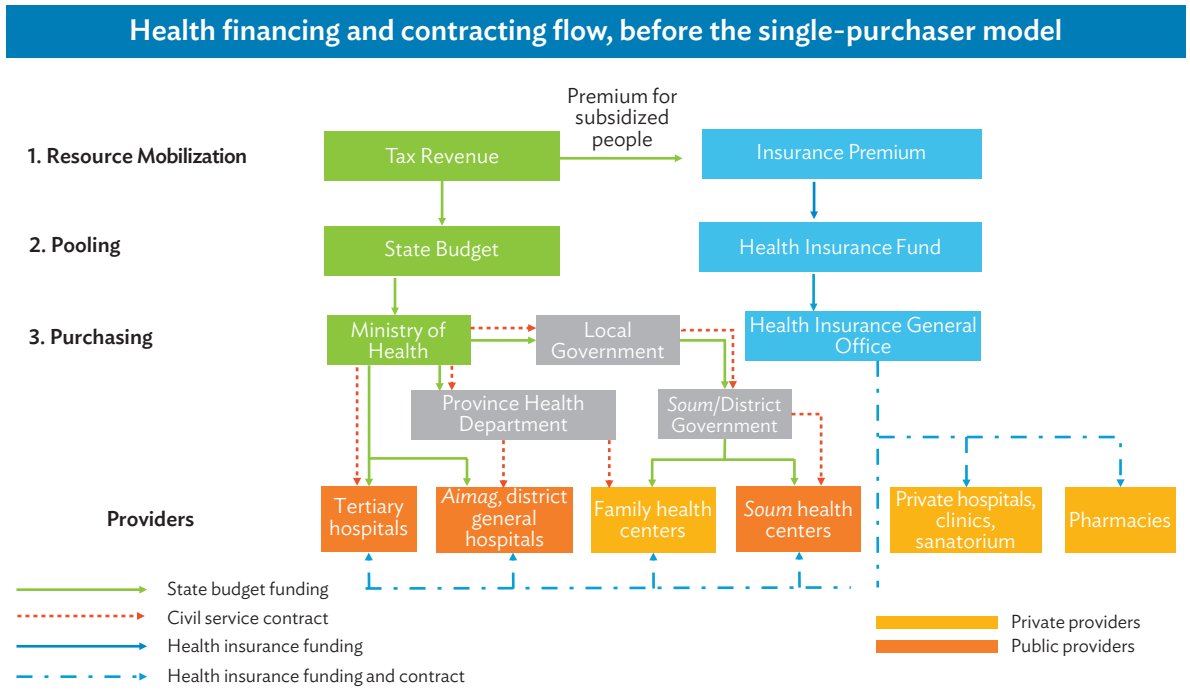
The payment system under the state budget also had inefficiencies. The state budget used a passive method of line item financing for fixed costs based on historical budgets related to hospital operations, poorly linked to the nature and volume of services. The health insurance fund initially used fixed payments per patient day, and hospital revenue was determined by the number of beds and their utilization. It created incentives for hospitalization and resulted in a drastic increase in the traditionally high utilization of costly inpatient services, undermining the financial stability and sustainability of the fund. To correct the situation, in 2006, the health insurance fund started to use the diagnostic-related group (DRG)-like[24] case-based system.[25] The case-based payments covered only variable costs and were not reflective of the actual costs of services and the complexity of cases. It also had low tariffs for outpatient services, which encouraged more expensive inpatient services.

The fragmentation of financing sources also affected the process of purchasing hospital services (Figure 3). The two financing sources had different contracting procedures. For state budget financing, the MOH had contracts with tertiary-level hospitals, national centers, and *aimag*/capital city governor offices to conclude agreements with hospitals under their jurisdiction. The financing agreements reflected annual financing thresholds and included some performance indicators. As the MOH or governor offices provided strict hierarchical oversight and management of public hospitals, there was little autonomy, and the parties barely used the agreement indicators to evaluate hospital performance. The government used rigid financing and accounting procedures, resulting in the inability of public hospitals to reallocate funding between strict line items and savings generated due to cost-effective measures. Public hospitals had to return all residuals to the treasury at the end of the year. On the other side, the SSIGO and its *aimag* branches also contracted public hospitals on an annual basis. In other words, public hospitals had to sign separate contracts and deal administratively with two major payers—the MOH or the local governor offices and the SSIGO—that covered different services and had different payment mechanisms and administrative procedures.

[24] *Merriam-Webster Online* defines DRGs as payment categories that are used to classify patients for the purpose of reimbursing hospitals for each case in each category with a fixed fee regardless of the actual costs incurred.

[25] It started in 2006 with 22 diagnostic clusters described according to the international classification of diseases (ICD-10), which were refined into 115 diagnostic groups in 2010.

Figure 3: Health-Care Financing Model in Mongolia, 1994–2020



Source: Authors.

Restructuring the health financing system. To overcome the challenges Mongolia faced in the delivery of health-care services, including its financing system, the government developed the Health Sector Master Plan 2006–2015, which outlined a comprehensive set of strategies and measures to make adjustments to the reform of the health system and its financing.

In 2008, the Government of Mongolia requested ADB to resume its support for strengthening the country's health insurance scheme. One of the components of the Third Health Sector Development Project (THSDP)—implemented by the MOH—aimed at "improved health-care financing and health insurance" by addressing the fragmentation of health-care funding.[26] The project proposed the new Health Financing Model for Mongolia that provided the framework for a new system that would pool funds from the state budget and health insurance, introduce a universal benefits package, and establish a single-purchaser model of services.[27] The MOH also conducted advocacy and capacity building for senior staff of ministries and agencies on the benefits of the newly proposed health-care financing model. These efforts built consensus among key stakeholders and the adoption of the principles of pooling of funds and the single-purchaser model in the government health financing strategy, 2010–2015, and its action plan, 2012–2016.[28] The draft of the revised Health Insurance Law—prepared with support from the THSDP and submitted to Parliament in 2010—reflected these principles. Lengthy discussions at Parliament on the revised bill continued until its approval in 2020 because of frequent government changes and disjointed policy discussions.

[26] ADB. 2007. *Report and Recommendation of the President to the Board of Directors: Proposed Grant to Mongolia for the Third Health Sector Development Project*. Manila.

[27] Government of Mongolia, Ministry of Health. 2010. *Third Health Sector Development Program. Health Financing Model for Mongolia*. Ulaanbaatar.

[28] Government of Mongolia. 2010. *Resolution No. 63: Health Financing Strategy*. Ulaanbaatar.

The THSDP sustained effort through the next technical assistance project, which focused on improving the capacity of health insurance organization.[29] The project advocated for a new financing model and the establishment of an independent and autonomous health insurance organization. Due in part to the sustained advocacy, the government was able to separate the health insurance fund from other social funds, and the administration of the health insurance fund was transferred from the SSIGO to the newly established Health Insurance General Office (HIGO) under the MOH from 1 January 2018.[30] The project improved the capacity of the HIGO in monitoring the quality of hospital services, updated contracting and claims review processes, and analyzed the cost of basic health interventions.

At the same time, the government sought technical assistance to address the fragmentation and improve the efficiency of the system by advocating the concept of pooling funds and upgrading the HIGO into a single purchaser. The Ministry of Finance (MOF) executed a technical assistance project supporting the development of amendments to the Health Law and the Health Insurance Law to pool funds from the state health budget and health insurance fund under the HIGO, which would act as a single purchaser of health-care services from all public and eligible private providers.[31]

In 2020, the government enforced its efforts to establish the HIGO as a single purchaser of health services by including it as one of the core policy actions to improve governance of the health sector within a programmatic policy-based loan to strengthen health security and deepen ADB support for the coronavirus disease (COVID-19) response in Mongolia.[32]

Parliament approved proposed amendments to the Health Law and the Health Insurance Law in 2020, which took effect on 1 January 2021. The National Council of the Health Insurance Fund unified the decision-making process to define the benefits, contracting, purchasing, and quality control under its jurisdiction. The state budget started transferring funds for purchasing services under government responsibility to the health insurance fund, with the HIGO acting as a purchaser on behalf of both funding sources: the state budget and the health insurance fund (Figure 4). The MOF executed a technical assistance project that assisted in building the capacities of health-care administrators of ministries and agencies at all levels and public and private hospital managers in new health-care financing arrangements.[33] These effects are being continued as at 2022 under the MOH-executed Sixth Health Sector Development Program, which began in 2019.[34]

[29] ADB. 2013. *Technical Assistance to Mongolia for Strengthening the Health Insurance System*. Manila (TA 8466-MON).

[30] Government of Mongolia. 2017. *Resolution No. 344: About Establishing an Agency.* Ulaanbaatar.

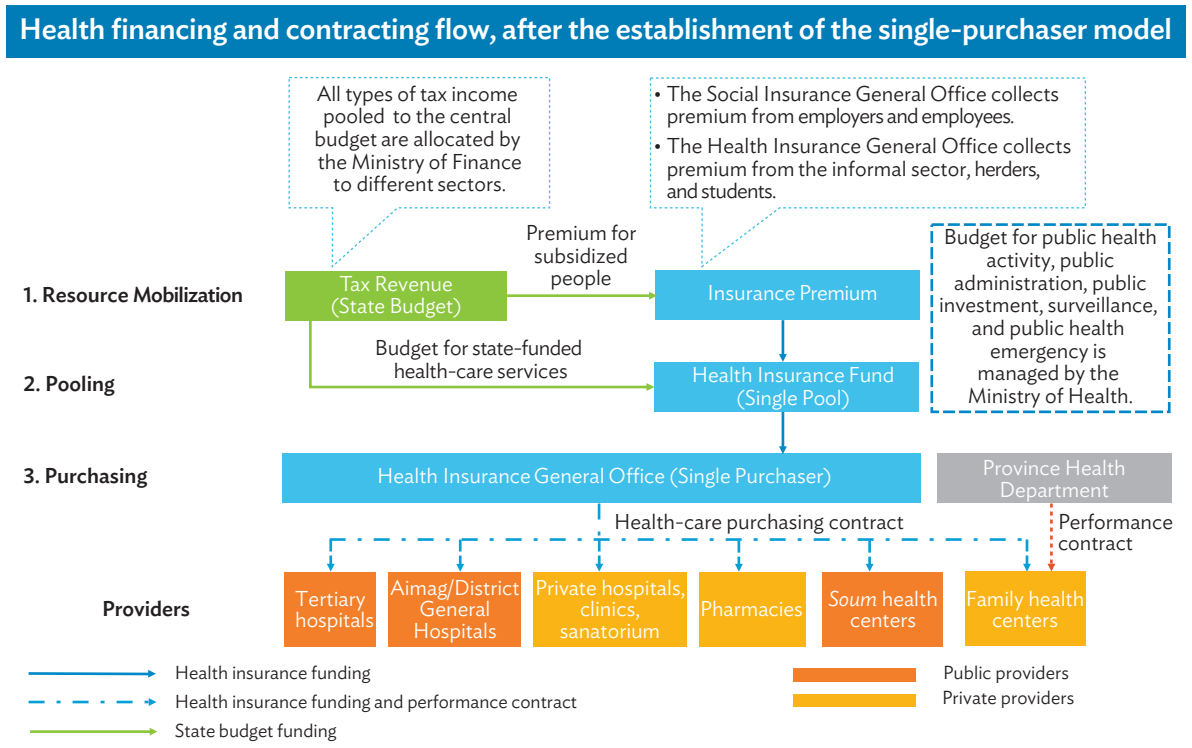
[31] ADB. 2018. *Technical Assistance to Mongolia for Improving Health Care Financing for Universal Health Coverage.* Manila (TA 9701-MON).

[32] ADB. 2021. *Report and Recommendation of the President to the Board of Directors: Proposed Programmatic Approach and Policy-Based Loan for Subprogram 1 to Mongolia for Strengthening Health Security Program.* Manila.

[33] ADB, and Government of Mongolia, Ministry of Finance and Ministry of Health. 2021. *Midterm Review Report: Mongolia—Improving Health Care Financing for Universal Health Coverage.* Ulaanbaatar (TA 9701-MON).

[34] ADB. 2019. *Report and Recommendation of the President to the Board of Directors: Proposed Multitranche Financing Facility to Mongolia for Improving Access to Health Services for Disadvantaged Groups Investment Program.* Manila.

Figure 4: Health-Care Financing Model in Mongolia in 2022



Source: Authors.

These developments serve as a significant set of outcomes achieved by the sustained policy dialogue and investment assistance from ADB to address the fragmentation of the health-care financing system in Mongolia. It took a decade to implement principles of pooling funds and single purchasing, as recommended and advocated by the THSDP, because of the frequent change of governments and corresponding changes in policies and plans.

Streamlining the benefits package. The new health financing model proposed by the THSDP envisaged a unified benefits package. There were efforts to minimize the gap in service coverage by adding some omitted services (outpatient, day care, and some diagnostic services) in the health insurance benefits package and removing disease-specific services (such as palliative care for cancer patients and high-cost interventions) to reduce service fragmentation. However, progress in addressing the fragmentation in the benefits package was made only recently, in 2021–2022, under the MOF's technical assistance project (footnote 31). The pooling of funds allowed the consolidation of two benefits packages into a unified package and its redesign to cover services that were previously omitted. The new benefits package, approved in 2022, covers inpatient and outpatient care at primary and referral levels and is based on the leading causes of mortality and disability and other needs of the population. Its new set of services includes the cost of medicines, diagnostics, and medical devices—which patients previously shouldered—reducing the OOP financial burden on people. The new benefits package focuses on promoting day care and outpatient care and reducing the extensive use of acute hospital beds for unjustified admissions by selecting evidence-based, cost-effective services and adjusting tariffs. The project also redefined the list and reimbursement level of medicines for outpatients by selecting cost-effective medicines essential for treating the most common conditions.

Improving the provider payment system. The government also strived to introduce more effective payment methods in health-care facilities. The MOH (through an ADB-funded project implemented

during 1997–2003) established family health centers and introduced a new concept of primary health care based on family medicine and its new payment system ("capitation payment"), with risk adjustments such as higher fees for the poor and the vulnerable.[35] The challenge with per-capita payment was the low rate set by the government, which could not cover the actual costs of services that family health centers are supposed to provide.[36] Partnerships that operate family health centers were required to follow the strict financial reporting system applicable to budgetary organizations, giving them little flexibility in managing their finances. Low capitation payment tariffs and a rigid financial reporting system resulted in poor quality and availability of services. In 2019, the government doubled the per-capita payment rates for family health centers. In 2022, the per-capita payment rates were doubled again, and geographical coefficients were introduced for *soum* health centers factoring in their remoteness, roadblocks, and sparsity of catchment area population, which helped increase the accessibility of primary health-care services in remote areas.[37] Amendments made to the health insurance law in 2015 accommodated, at the primary level, additional case-based payments on top of the per-capita payments from the health insurance fund for basic diagnostic services, day care, rehabilitation, and home care.[38]

In terms of hospital service financing, the MOH—through the Second Health Sector Development Project—introduced a new concept of case-based financing. The project helped build the capacity of government staff and developed and piloted case-based payments based on diagnostic-related groups (DRGs) in the initial five state-level hospitals and national centers, which later was rolled out nationally. With technical assistance projects, the government conducted cost studies of health interventions to further upgrade the case-based payment system and tariffs. It defined costs of commonly reimbursed DRGs that burden the fund (footnote 29), defined new DRGs for hospital services funded from the state budget,[39] and revised DRG tariffs covered by health insurance to cover fixed and variable costs.[40] With technical assistance, the government made a smooth transition to unified payment systems (regardless of funding source), linked the payments with contracting and provider performance, and introduced equal payment tariffs for public and private hospitals to allow fair competition among providers. The number of DRGs was gradually increased from an initial 22 (in 2006) to 705 (in 2022) and fine-tuned to reflect the nature and complexity of cases and reimbursement levels.[41] All technical assistance projects had extensive capacity building activities for various stakeholders—particularly for the MOH and the HIGO—in service costing and other management areas such as claims reviews, contracting, fund sustainability analysis, and service quality monitoring.

Improving contracting and provider selection. Along with the introduction of new output-based payment mechanisms, an important change was made to shift from passive financing to active purchasing by selecting competent providers that provide quality care. The HIGO was restructured to have a dedicated department responsible for selecting and contracting providers. The MOF's executed technical assistance project provided support for developing new contracting procedures,[42] a sample

[35] ADB. 1997. *Report and Recommendation of the President to the Board of Directors: Proposed Loans and Technical Assistance to Mongolia for the Health Sector Development Program.* Manila.

[36] From 2000 to 2019, the capitation payment rate was equivalent to $4–$5 per person per year.

[37] The average annual per capita payment for family health centers is MNT60,000 as of April 2022 (National Council for Health Insurance. 2022. *Resolution No. 05: About Approving Tariffs, Payment Methods and Guidelines.* Ulaanbaatar).

[38] Parliament of Mongolia. 2015. *Law of Mongolia on Social Health Insurance.* Ulaanbaatar.

[39] ADB. 2015. *Technical Assistance to Mongolia for Strengthening Hospital Autonomy.* Manila (TA 9037-MON).

[40] Government of Mongolia, Ministry of Health; ADB; and GFA Consulting Group. 2019. *Mongolia: Strengthening Hospital Autonomy.* Final report. Ulaanbaatar (TA 9037 MON).

[41] National Council for Health Insurance. 2022. *Resolution No. 01: About Approving Revised List, Payment Tariffs, Payment Methods, and Guidelines.* Ulaanbaatar.

[42] National Council for Health Insurance. 2022. *Resolution No. 02: About Approving Revised Guidelines*. Ulaanbaatar.

of contracts, and key performance indicators for selecting providers.[43] The project also assisted in developing an information technology system for the online application of requests by health-care providers for contracting services. Early results show that some services previously delivered by a single public specialized center (for instance, chemotherapy, trauma surgery, and stroke care) are now offered by other hospitals, increasing access to services for the insured.[44]

Improving financial protection. From its outset, the health insurance system in Mongolia focused on the vulnerable and informal sectors, and the coverage rate has historically been high. However, the insured segments (particularly, the poor and the vulnerable) have been at the receiving end of high OOP expenditure and even catastrophic payments when accessing health services. The THSDP conducted a study to investigate the extent of financial barriers and implications of OOP expenditure for the uninsured—as well as the poor and the disadvantaged—and provided recommendations on reducing fragmentation in financing and the delivery of services, minimizing service gaps, and reducing formal and nonformal OOP expenditure.[45] In 2021, the government focused on decreasing the direct OOP expenditure of the insured. The government entirely exempted vulnerable groups (such as children, the elderly, and people with disabilities) from co-payments[46] and removed the annual reimbursement threshold per person, which is essential for people with severe conditions and low income.[47] The government also reprioritized high-priority and expensive care. The health insurance fund now fully covers the cost of all essential and costly care (such as for stroke, intensive care, emergency care, cancer, trauma, and burns) without co-payments from the insurers.

III. RESULTS ACHIEVED

Since 1994, ADB has been providing support across the full spectrum of the Mongolia health sector with a focus on—and sustained assistance to—reform of health-care financing. Earlier efforts supported the strengthening of the newly established social health insurance system, later shifting toward developing the strategic purchasing model. During this evolution, Mongolia's health-care financing system transitioned from the input-based financing model to the output-oriented model in use in 2022 that is better suited to the realities of a market economy. The ADB package of policy and investment projects built on each other, reinforcing the gains made in earlier years (Appendix). This gradual approach ensured reform continuation even amidst political volatility and frequent institutional changes.

The introduction of the national health insurance scheme represents a major outcome of the overall health financing reform. In addition to financing through the state budget, the health insurance fund became an important source of health-care financing. Legally, health insurance in Mongolia is mandatory for all citizens and the system has consistently maintained high population coverage since its establishment in 1994. Political commitment to ensure the enrollment of all citizens—especially the

[43] National Council for Health Insurance. 2021. *Resolution No. 13: About Approving a Sample Contract for Purchasing Health Care and Services.* Ulaanbaatar.

[44] In 2021, the number of hospitals providing trauma surgery in Ulaanbaatar increased by 16, and provincial hospitals performed about 150 cancer surgeries.

[45] ADB. 2015. *Grant Completion Report: Third Health Sector Development Project in Mongolia.* Manila (Grant 0086-MON).

[46] Co-payments of 10%–15% of the case cost were mandatory for all insured to receive inpatient services.

[47] Until 2021—according 2021, according to the Health Insurance Law, health insurance had a reimbursement ceiling of up to MNT2 million per person per year for hospitalization and MNT165,000 per person per quarter for diagnostic tests.

vulnerable—was crucial in ensuring the sustainability of the newly introduced health insurance scheme. The wide support of the population contributed to the success of the new scheme.

Another significant result of the reform was the pooling of two major sources of health-care financing—the state budget and the health insurance fund—under the HIGO, which acts as a single purchaser of health services. The pooling addressed the fragmentation of the Mongolia health-care financing system, unified the service package, and consolidated purchasing functions and monitoring mechanisms. At the health facility level, this reduces the administrative burden of interacting with purchasers.

The health-care financing reform introduced more efficient output-oriented payment mechanisms, replacing rigid input-based line item financing (as shown in the table below). New payment mechanisms allow more flexibility for public health-care entities to manage finances, reduce unjustified admissions and extended hospital stays, and encourages day care and other more efficient means of providing care. Primary health care uses the risk-adjusted capitation payment, and case-based fees are for specific medical services. Output-oriented payment systems link to performance and promote quality of care. Payment mechanisms also encourage equal participation and competition among public and private sector providers by introducing similar tariffs. The government intends to regularly update payment tariffs based on cost analysis.

Comparison Before and After the Introduction of the Single Purchaser

	Before introduction of the single purchaser				After introduction of the single purchaser			
	Services	Purchaser	Financing Source	Payment Method	Services	Purchaser	Financing Source	Payment Method
Primary Health Care								
***Soum* Health Centers**	(i) Outpatient care (ii) Inpatient care (iii) Deliveries, antenatal, and postnatal care (iv) Minor surgery (v) Ambulance services (vi) Emergency care (vii) Home visits (viii) Early detection (ix) Public health services (x) Vaccination	*Aimag*/city government	State budget	Line items	(i) Outpatient care (ii) Antenatal and postnatal care (iii) Minor procedures (iv) Home visits (v) Early detection (vi) Public health services (vii) Vaccination	HIGO	Single pool	Capitation payment
					(i) Inpatient care (including deliveries) (ii) Ambulance services (iii) Emergency (iv) Dental care	HIGO	Single pool	Case-based DRG
	(i) Basic diagnostics (ii) Daycare (iii) Rehabilitation (iv) Home care	HIGO	Health Insurance Fund	Case-based payment	(i) Basic diagnostics (ii) Daycare (iii) Rehabilitation (iv) Home care	HIGO	Single pool	Case-based payment
Family Health Centers	(i) Outpatient care (ii) Home visits (iii) Early detection (iv) Public health services	*Aimag*/city government	State budget	Capitation payment	(i) Outpatient care (ii) Home visits (iii) Early detection (iv) Public health services	HIGO	Single pool	Capitation payment
	(i) Basic diagnostics (ii) Daycare (iii) Rehabilitation (iv) Home care	HIGO	Health Insurance Fund	Case-based payment	(i) Basic diagnostics (ii) Daycare (iii) Rehabilitation (iv) Home care	HIGO	Single pool	Case-based payment

Continued on next page

Table from previous page continued

	Before introduction of the single purchaser				After introduction of the single purchaser			
	Services	Purchaser	Financing Source	Payment Method	Services	Purchaser	Financing Source	Payment Method
Hospital/Referral Care								
Public hospitals	(i) Outpatient services (ii) Inpatient services (iii) Emergency care (iv) Ambulance service (v) Diagnostics (vi) Long-term care	MOH and *aimag*/city government	State budget	Line items	(i) Outpatient care (ii) Inpatient care (iii) Emergency care (iv) Ambulance service (v) Diagnostics (vi) Long-term care (vii) Rehabilitation (viii) Daycare	HIGO	Single pool	Case-based payment DRG
	(i) Outpatient services (ii) Inpatient services	HIGO	Health Insurance Fund	Case-based DRG				
Private hospitals	(i) Inpatient care (ii) Sanatorium/spa	HIGO	Health Insurance Fund	Case-based DRG (lower tariffs)	(i) Outpatient care (ii) Inpatient care (iii) Emergency care (iv) Diagnostics (v) Long-term care (vi) Rehabilitation (vii) Daycare	HIGO	Single pool	Case-based payment DRG (same tariffs as for public providers)

DRG = diagnostic-related group, HIGO = Health Insurance General Office, MOH = Ministry of Health.
Source: Asian Development Bank staff.

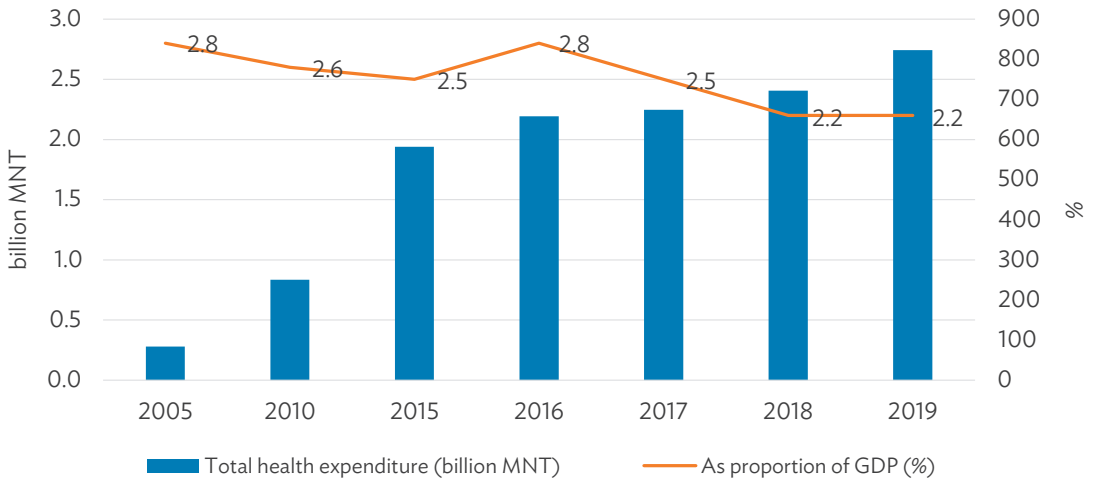
Despite limitations, the reformed health-care financing system is contributing to protecting people from the health-associated financial burden and risks. Primary health care is freely accessible for all citizens regardless of insurance coverage. Insured people can access legally defined hospital services with 10%–15% co-payments. The government decision to pool two financing sources into one and unify the benefits package, exempting most essential hospital services from co-payments and annulling the reimbursement ceilings aim to reduce OOP expenditure and the financial burden on the vulnerable. The pooling of funds also positively affects the health insurance fund, raising its obligations and financial and operational capabilities.

IV. CHALLENGES

Insufficient public funding. This remained a major challenge for the health system in Mongolia. According to the official data, the government has constantly increased the total state health expenditure (Figure 5). However, as a proportion of GDP, it remains well below the average of countries of the World Health Organization Western Pacific Region (7.1% as of 2018).[48]

[48] World Health Organization. The Global Health Observatory. Current health expenditure as percentage of gross domestic product. https://www.who.int/data/gho/data/indicators/indicator-details/GHO/current-health-expenditure-(che)-as-percentage-of-gross-domestic-product-(gdp)-(-) (accessed 28 November 2022).

Figure 5: Total State Health Expenditure in Mongolia, 2005–2019



GDP = gross domestic product, MNT = togrog.

Source: Government of Mongolia, Center for Health Development. 2019. *Health Indicators 2019*. Ulaanbaatar.

Ensuring equity in health care financing. High coverage of the Mongolian population in the health insurance scheme does not necessarily mean that all households have the same access to health services. One indication is increasing OOP expenditure. High OOP expenditure exacerbates the financial risks of households—especially the vulnerable—and often leads to catastrophic health expenditure and impoverishment. The World Health Organization Health Account Global Health Expenditure Data Base[49] estimates that the proportion of OOP expenditure—as a proportion of health spending in Mongolia—is continually increasing (19.7% in 2000, 33.9% in 2018).[50] According to other sources, OOP expenditure was reaching 41% of the total health expenditure.[51] Different factors contribute to the increase of OOP expenditure, including unregulated growth of the private sector that relies on direct user fees as a primary source of funding and often leads to cost escalation and unnecessary treatments. Analysis in 2021 suggests that even patients with health insurance coverage face the prospect of high OOP expenditure in public hospitals.[52] Despite government efforts to subsidize the cost of most essential medicines, medicines are the most significant reason for OOP expenditure and continue to burden household budgets. The rural population in Mongolia that resides in remote areas has more barriers to accessing specialized health services and experiences higher OOP expenditure than those living in the capital city. This challenge is not unique to Mongolia. Many countries, such as Indonesia, the People's Republic of China, and the Philippines, introduced newly developed health financing schemes to improve the financial protection of their people.[53]

More effective use of available resources. Downsizing the physical infrastructure of the hospital sector to reduce high maintenance costs remains an issue in Mongolia. The share of spending on fixed

[49] Health accounts are a way for countries to monitor health spending across multiple streams, regardless of the entity or institution that financed and managed that spending.

[50] World Health Organization. Global Health Expenditure Database. https://apps.who.int/nha/database/country_profile/Index/en(accessed 28 November 2022).

[51] J. Dorjdagva et al. 2016. Catastrophic Health Expenditure and Impoverishment in Mongolia. *International Journal for Equity in Health.* 15 (1). Article no. 105. doi: 10.1186/s12939-016-0395-8.

[52] J. Dorjdagva et al. 2021. Does Social Health Insurance Prevent Financial Hardship in Mongolia? Inpatient Care: A Case in Point. *PLoS ONE*. 16 (3). e0248518. doi: 10.1371/journal.pone.0248518.

[53] Asia Pacific Observatory on Health Systems and Policies. 2016. Strategic Purchasing in China, Indonesia and the Philippines. *Comparative Country Studies*. 2 (1).

costs associated with the system structure (e.g., public utilities, personnel) compared to spending related to patient treatment (e.g., medicines, medical supplies) could serve as a relevant indicator of efficiency.[54] This is highly relevant for Mongolia, which needs to rationalize its excessive hospital sector (footnote 10). The health financing reforms should be complemented with the optimization of services through the gradual shift of resources from referral hospitals to primary health care and improvements in coordination between these two layers of the health-care system to ensure better quality. The 2019 financing allocated for primary health care (23%) remains insufficient and much lower than for hospitals (77%). It is also low compared to countries at a similar level of development, which levels cannot support the provision of good quality essential services.[55]

V. LESSONS LEARNED AND FUTURE DIRECTIONS

Along with the noteworthy results, ADB assistance in reforming health-care financing in Mongolia offers lessons for consideration for implementing future programs and projects. For instance, it took considerable time to realize valuable recommendations and actions formulated based on the best international practices. Time is required to introduce and advocate new concepts, conduct extensive consultation, overcome possible resistance due to narrow institutional interests, and build consensus and capacity of key stakeholders. Stakeholders involved in health-care financing are usually from different sectors—with competing priorities—and bringing them together for the health reform agenda is often challenging.

The reform often requires restructuring the existing system, which may go in several phases, as was the case with establishing the HIGO. Health insurance was first separated from other social security funds and then set as an independent fund managed by a new agency. It requires government expenses, political will, and a favorable economic situation. Changes in key personnel interrupt the process, and there is a need to reintroduce new concepts.

Embedding financial reform into the health system is challenging since health-care workers and even senior health managers do not sufficiently understand health-care financing mechanisms. There is a lack of experts specialized in health-care financing with practical experience to conduct the reform. Introducing benefits that health-care financing reform would bring and continuous capacity building within the health system—before and after introducing changes into the health-care financing—are crucial for the reform.

Building on the results achieved—and considering challenges that remain and lessons learned—Mongolia needs to move toward strategic purchasing, where allocations for service providers are linked to the efficiency of their performance and the health needs of the population they serve while prioritizing financial protection of the people. The government must provide a stewardship role, with clear and consistent national policies. The State Policy on Health 2017–2026,[56] and the Action Plan for Implementation of the State Policy on Health (Health Sector Master Plan), 2020–2026, outline the immediate and medium-term priorities for the health sector, including health-care

[54] J. Kutzin. 2008. *Health Financing Policy: A Guide for Decision-Makers.* Copenhagen: World Health Organization Regional Office for Europe.

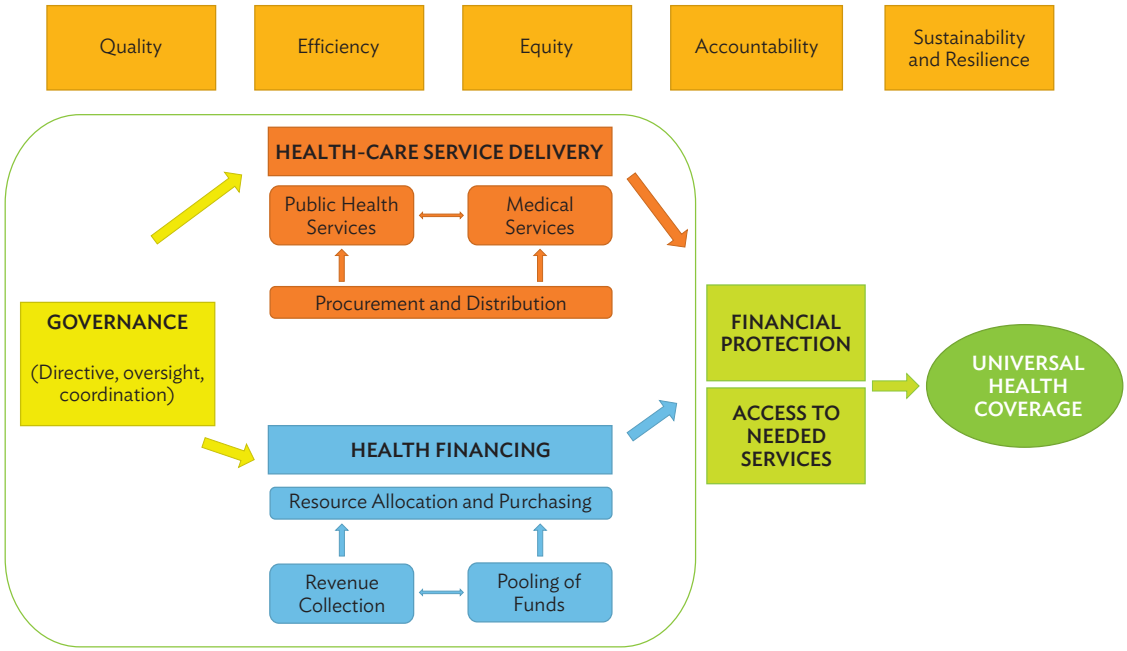
[55] On average, primary health-care expenditure in 36 low- and middle-income countries ranges from $15 to $60 per capita (N. V. Maele et al. 2019. Measuring Primary Expenditure in Low-Income and Lower Middle-Income Countries. *BMJ Global Health*. 4 (1). e001497).

[56] Government of Mongolia, Ministry of Health. 2020. *Order of the Minister of Health A/103.* Ulaanbaatar.

financing.[57] These national policy documents envision further development of the health-care system with the objectives stating the need to move toward strategic purchasing and universal health coverage (UHC), increasing financing for health and primary health care, and decreasing OOP expenditure. The Health Sector Master Plan intends to be a foundation for coordinated actions of all stakeholders involved in the health sector. ADB intends to leverage reforms in the health sector through policy-based loans and building on long engagement.[58]

The national objectives are consistent with global health policies. Strategic purchasing is viewed in 2022 as essential to reforming the health-care financing system and achieving UHC.[59] Strategic purchasing will improve health systems performance by promoting quality, efficiency, equity, and responsiveness of health-care service provision and facilitating UHC. From the 2022 international perspective, health-care financing reform is viewed as part of a whole health system approach (Figure 6)—with key attributes such as quality, efficiency, equity, accountability, sustainability, and resilience—which ensures access to needed services and the financial protection of people.[60]

Figure 6: Financing as a Part of the Whole Health System Approach



Source: Authors (adopted from various sources).

[57] Government of Mongolia, Ministry of Health. 2020. *Order of the Minister of Health A/103: About Approving the Action Plan for Implementation of the State Policy on Health.* Ulaanbaatar. (Developed with the assistance from ADB and the Japan Fund for Poverty Reduction.)

[58] ADB. 2021. *Country Partnership Strategy: Mongolia, 2021–2024—Laying Resilient Foundations for Inclusive and Sustainable Growth.* Manila.

[59] UHC means that all people have access to the health services they need, when and where they need them, without financial hardship. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care. UHC is at the center of global health policies. In a high-level meeting in 2019, the United Nations General Assembly aimed to accelerate progress toward UHC, including financial risk protection; access to quality essential health-care services; and access to safe, effective, high quality, and affordable essential medicines and vaccines for all. Reform of health-care financing has a critical role in moving toward UHC.

[60] World Health Organization, Regional Office for the Western Pacific. 2016. *Universal Health Coverage. Moving Towards Better Health. Action Framework for the Western Pacific Region*. Manila.

APPENDIX

ADB-Funded Projects that Assisted Health-Care Financing Reform in Mongolia

Project Name	Years Implemented
Strengthening the Health Insurance (TA)	1994–1996
Health Sector Development Project (Loan)	1997–2001
Second Health Sector Development Project (Loan)	2003–2010
Third Health Sector Development Project (Grant)	2007–2014
Strengthening the Social Health Insurance (TA)	2013–2017
Strengthening Hospital Autonomy (TA)	2015–2018
Development of the Health Sector Master Plan, 2019–2027 (TA)	2017–2020
Improving Health Care Financing for Universal Health Coverage (TA)	2018–2021
Improving Access to Health Services for Disadvantaged Groups Investment Program (MFF, tranche 1) (Loan and Grant)	2019–ongoing
Strengthening Health Security Program, Subprogram 1 (PBL)	2020–2021

MFF = multitranche financing facility, PBL = policy-based loan, TA = technical assistance.
Source: Asian Development Bank.

Supporting Health-Care Financing Reform in Mongolia

Experiences, Lessons Learned, and Future Directions

This paper describes Mongolia's health-care financing system and associated reforms that started in the early 1990s. Before the 1990s, the state was entirely responsible for funding and delivering health-care services in Mongolia. At the beginning of the 1990s, Mongolia transitioned from a centrally planned to a market economy. Under the new economic conditions, it became difficult to maintain free health care through state financing alone. The reform of the health-care financing system in Mongolia has seen the establishment of health insurance as an additional source of funding, and the transition from an exclusively input-oriented financing model to the output-oriented model in use in 2022 that is better suited to the realities of a market economy. The Asian Development Bank's assistance in reforming health-care financing in Mongolia offers lessons that could be useful in supporting other countries across the region.

About the Asian Development Bank

ADB is committed to achieving a prosperous, inclusive, resilient, and sustainable Asia and the Pacific, while sustaining its efforts to eradicate extreme poverty. Established in 1966, it is owned by 68 members —49 from the region. Its main instruments for helping its developing member countries are policy dialogue, loans, equity investments, guarantees, grants, and technical assistance.

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