JLN PRIMARY HEALTH CARE INITIATIVE
PRIVATE SECTOR ENGAGEMENT COLLABORATIVE

REGULATION OF PRIVATE PRIMARY HEALTH CARE IN MONGOLIA

A COUNTRY ASSESSMENT REPORT

ULAANBAATAR CITY | 2018

Mongolian Development Research Institute

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This assessment report is part of a series of country regulatory assessment reports that are contributing to the body of evidence and practical knowledge synthesized in Regulation of Private Primary Health Care: Lessons from JLN Country Experiences.

This report was produced by the Joint Learning Network for Universal Health Coverage (JLN), a community of policymakers and practitioners from around the world who jointly create practical guidance to accelerate country progress toward universal health coverage.

For questions or inquiries about this report or other JLN activities, please contact the JLN Coordinator Team at jln-nc@r4d.org.

This report was translated into English from the original Mongolian.

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PREFACE

In 2016, the JLN Private Sector Engagement (PSE) Collaborative completed the first two modules of a five-part practical guide on private-sector engagement, titled *Engaging the Private Sector in Primary Health Care to Achieve Universal Health Coverage: Advice from Implementers to Implementers*. These first two modules cover initial communications and partnership around primary health care (PHC) and provider mapping. To inform the third module, and to help fill gaps in guidance on the regulation of private PHC in low- and middle-income countries, six JLN countries—Ghana, Indonesia, Kenya, Malaysia, Mongolia, and Morocco—conducted assessments of their regulation of the private health sector. The assessments addressed the following research questions:

- What types of regulations are in place?
- How are the regulations implemented?
- What outcomes are achieved by those regulations?
- What resources are available for developing and implementing such regulations?

The assessments focused only on regulation of PHC service delivery (the process of providing PHC services and treatments). They did not cover other types of regulation, such as for human resources, training institutions, pharmaceuticals, or medical equipment. *Regulation* is broadly defined as the imposition of rules backed by penalties or incentives to ensure compliance with standards—in this case, standards for the safety and quality of health services and providers. Regulations may govern activities such as licensing to open a facility, certification and accreditation, and offering incentives to promote better service quality. In outlining the scope of the assessments, the PSE Collaborative chose to look at regulation of both public and private-sector providers. They also agreed to focus on PHC service delivery, while recognizing that in describing the regulatory system they would inevitably touch on secondary and tertiary care.

The countries each conducted a document review using secondary data sources and collected primary data through in-depth interviews and focus groups involving national and subnational government entities (ministries of health, health financing agencies, regional health directors), regulatory boards and medical councils, professional associations and representatives of provider groups and unions (for both public and private providers), members of the media, academics, and civil society organizations (representing consumers). Each country assessment report describes the country's regulatory context, health sector objectives and strategy, and demographic and health indicators; the regulatory mechanisms currently in use; insights on implementation and performance based on primary and secondary data collection; and conclusions and recommendations for improvement.

This report documents Mongolia's experience in regulating private PHC.

Methodology

Secondary data analyzed as part of the Mongolia assessment included legal documents, resolutions, decrees, rules and standards of health institutions, and the current coordinating mechanisms among system stakeholders. Primary data collection consisted of 31 focus group discussions with a total of 71 participants.

INTRODUCTION

Mongolia is working toward achieving universal health coverage (UHC), with policymakers and researchers working to mobilize resources and gain the cooperation of the private sector. This assessment examines the coordinating mechanism for private health facilities and the possibilities for achieving UHC in Mongolia.

Mongolia Overview

Mongolia has a population of 3 million. About 68% of the population lives in urban areas. Average population growth is around 2%, and life expectancy in 2016 was 69.57 years (65.58 years for males and 75.10 years for females). Mongolia is a landlocked country in Central Asia that is bordered by the People's Republic of China to the south and the Russian Federation to the north. It occupies a total area of 1,566,600 square kilometers and ranks 19th in the world with the size of its territory. Mongolians are nomadic, and 32% of the total population works in animal husbandry, spread out over vast territory.

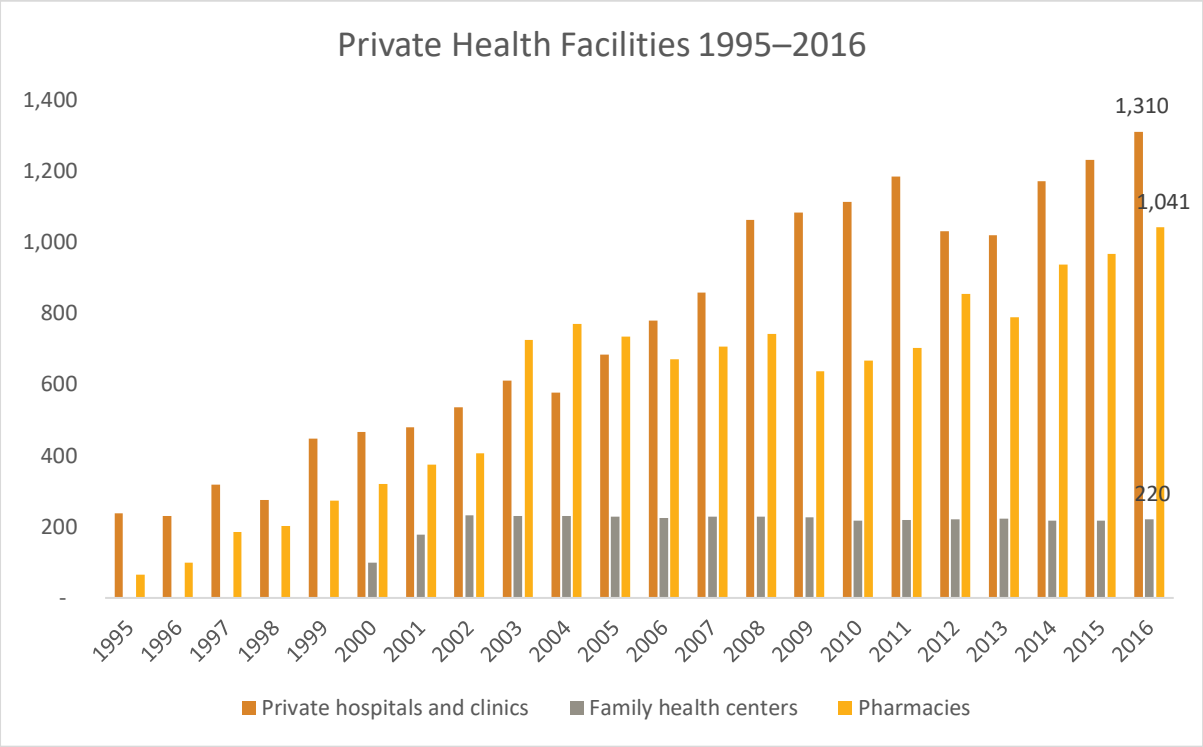
The country is administratively divided into the capital city municipality (Ulaanbaatar) and 21 provinces (*aimags*). Within *aimags* are *soums*, or districts. The average distance from provincial hospitals (*aimag* centers) to district primary health care (PHC) facilities (*soum* health centers) is 101 kilometers, and the average distance between *soum* health centers to remote households in the soum is 100 kilometers. These distances make it difficult to deliver health care to the communities. For those living in urban areas, primary care is available from private family health centers. As of 2015, the number of health care facilities in Mongolia is 3,244, of which 218 are private family health centers in urban areas, 291 are *soum* and village health centers, and 39 are *intersoum* (subdistrict) hospitals.

Mongolia's policy emphasis on reducing maternal and child mortality has led to decline in the maternal mortality rate from 199 deaths per 100,000 live births in 1990 to 69.7 in 2006 and 26.0 in 2015. Mongolia has also achieved a four-fold reduction in infant mortality—from 63.4 deaths per 1,000 live births in 1990 to 15.3 in 2015. Mongolia has achieved the United Nations Millennium Development Goals (MDGs) of reducing both maternal and child mortality.

Mongolia's Health Sector

From 1921 to 1990, Mongolia followed the Soviet-style Semashko model of a centralized economy. In 1990, it transitioned to a market economy, and a private health care sector developed starting in 1995. By 2016, there were 2,573 private health facilities nationwide. By law, primary care is provided free of charge, and PHC funding is provided by the state budget. Since 1999, primary care local hospitals have been transformed into private facilities as part of a public-private partnership.

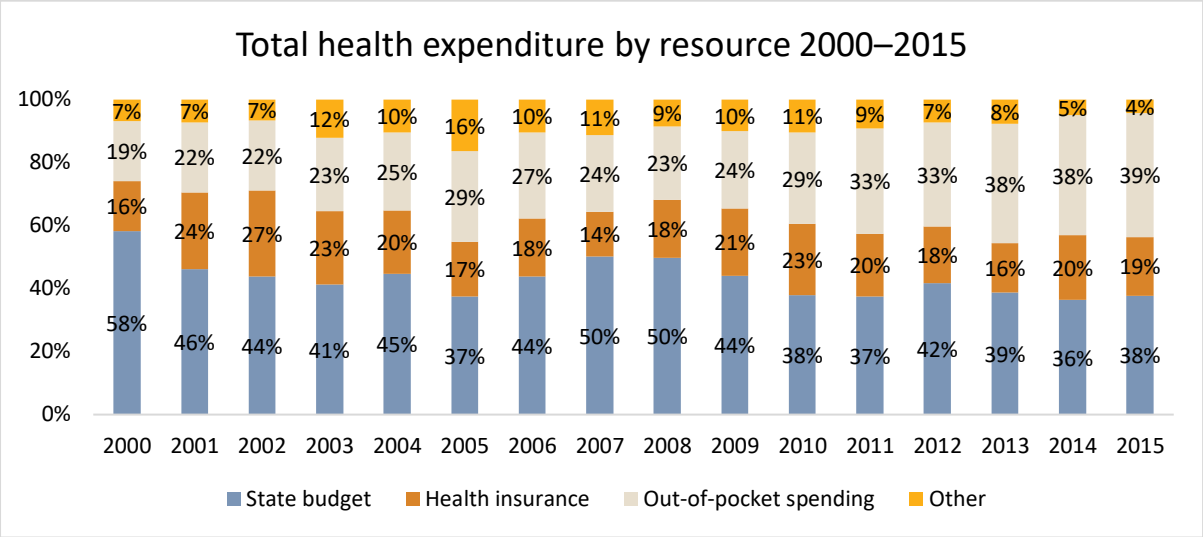
Figure 1. Private Health Facilities 1995–2016



Private-sector health facilities are classified by type. Most are private hospitals and clinics; about 230 provide inpatient care and services, and the remainder are small-scale outpatient clinics.

Figure 2 depicts how the sources of health expenditure structure have changed in recent years, with overall increases in patient out-of-pocket spending and decreases in the state budget for health care. During this period, the number of private health care facilities has increased nearly three-fold. This suggests that the increase in the number of private health facilities may be related to the increase in personal out-of-pocket payments—or that the financing of private health care facilities is related to out-of-pocket fees.

Figure 2. Total Health Expenditure by Resource 2000–2015



The Mongolian Health System

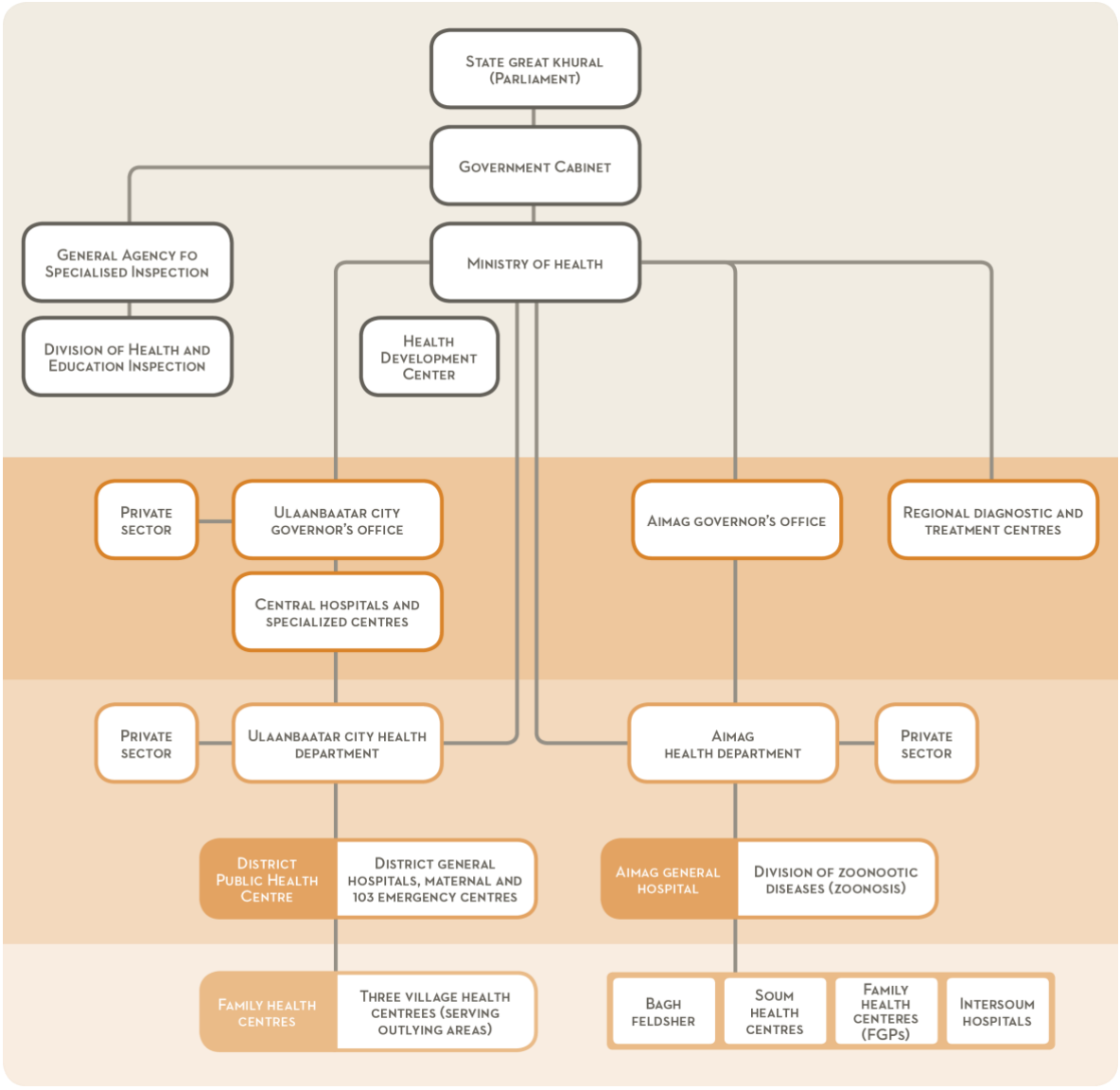
The structure of the Mongolian health system includes the ministries of health and finance, a general health insurance office, a government inspection agency, governors at the *aimag* and city levels, Mongolian citizens, private insurers, and donor organizations.

- **Ministry of Health.** The Ministry of Health defines health sector policy and manages the health sector budget. The health minister stewards performance agreements with heads of central and specialized health care institutions and also delegates purchasing power to *aimag* capital city governors by developing performance agreements with them. The performance agreements cover the types of health services to be delivered, the allocated budget, and performance indicators. The decision to purchase services is based on an evaluation of the quality and performance of delivered services. This evaluation is done by the ministry's department of monitoring, evaluation, and internal auditing. The evaluation is also based on assessments by specialized agencies and audit reports completed by the national audit office and its branches.
- **Ministry of Finance.** Using a line-item budget, the Ministry of Finance allocates funding approved by the Mongolian parliament to the Ministry of Health, including funds allotted to health care providers. These funds are held in an account at the Treasury Department for the Ministry of Health and are disbursed according to an approved allotment schedule. While the Ministry of Finance is responsible for allotment of the funds to the Ministry of Health, it does not monitor quality of care or performance, and it is not considered a health purchaser.
- **Health Insurance General Office.** The Health Insurance General Office (HIGO) is responsible for generating revenue for the Health Insurance Fund and for purchasing health services on behalf of the insured, according to the health insurance law. The HIGO facilitates health insurance contracts with accredited public health care providers and selected private providers. The contracts cover the types and quantities of health services to be delivered, fees, and the total budget. The

purchase of health services is managed by HIGO staff using the HIGO software system. Under the contract, the HIGO has the right to not fund health care services that were not agreed upon or that have not met quality assurance standards. The HIGO can also change the following years' financing. The HIGO has one branch per *aimag* and a total of 21 branches responsible for purchasing provincial health care services. A central office is responsible for purchasing health care services in Ulaanbaatar. The HIGO branches purchase health care services from locally contracted health care providers and monitor the quality of services delivered and provider performance.

- ***Aimag* capital city governor and local treasury division.** *Aimag* capital city governors facilitate the Ministry of Health–created performance agreements with local health care providers. The agreements generally include the provider's total budget and performance goals. They have no impact on budget allotments for *aimag*/district general hospitals, *intersoum* hospitals, or general rural hospitals; the allotments are solely the responsibility of the ministries of health and finance. The funds stipulated in the performance agreements are allotted via the *aimag* capital city's treasury division. Governors have the right to adjust the *soum* health centers' allotments and family practice group budgets, with the approval of the local council (Citizen's Representative Khural).
- **Citizens.** Citizens have the right to select their health care provider and obtain health care services free of charge at the primary care level. They must pay a copayment for the services at specialized health care providers funded by the Health Insurance Fund. There are also direct payments required for certain types of screenings and health care services. Citizens pay direct payments to the Treasury account, and the Treasury transfers this funding to hospitals. The government does not regulate the price list and fee structure of the private sector.
- **Private insurance.** Several private insurers in the market reimburse costs for overseas treatment and services provided by high-end private health care providers. This type of service is underdeveloped in Mongolia but some people with high incomes are using this option.
- **Other financing.** Aid and support from donor organizations and donations from citizens, households, and enterprises are an additional source of financing which for investment, equipment, and specific projects and programs.

Figure 3. Health System Structure



Source: Mongolian National Document

The Mongolian health system is one administrative system with two main divisions: *aimags* (provinces) and the capital city, Ulaanbaatar. The 21 *aimags* are further divided into 330 *soums* (subprovinces), which are further divided into 1,613 *baghs* (the lowest administrative unit). Ulaanbaatar is divided into nine districts, and these districts are divided into 152 *khoroos* (subdistricts). These administrative divisions are represented by a two-tier health system: primary care and referral-based care, including general and specialized care. The specialized care level is mostly based in Ulaanbaatar. A general hospital and regional diagnostic treatment centers are located at the *aimag* level. Every district has a district general hospital, and every *soum* has either a *soum* health center or an *intersoum* hospital. These facilities are described in more detail below.

- ***Soum* health centers, family practice groups, and intersoum hospitals.** In the provinces, the average distance from *aimag* to *soum* is 100 kilometers. The delivery of health services in rural areas is challenging due to extremely low population

density over a large territory. *Soum* health centers and *intersoum* hospitals provide PHC, including maternity care, and some forms of specialized health care, but it can still be challenging for rural populations to access care. In the capital city, Ulaanbaatar, the lowest administrative unit is the *khoroo* (subdistrict), and every *khoroo* has a family practice group. *Soum* health centers and family practice groups provide the same type of health care to their catchment areas and inpatient service. Currently, PHC funding comes entirely from the state budget, but a recent amendment to the health insurance law allows PHC to be sourced from the Health Insurance Fund going forward. *Intersoum* hospitals provide specialized health care services (such as laboratory, dental care, and surgery) for *soums* that are too far from the *aimag* center, where the provincial or department hospital is located. *Intersoum* hospitals are financed from the state budget and the Health Insurance Fund.

- ***Aimag* district general hospitals and health centers.** A total of 32 general hospitals, as well as health centers are located among 21 *aimags* and nine districts. These facilities provide seven major medical services—internal medicine, pediatrics, surgery, obstetrics and gynecology, neurology, infectious diseases, and intensive care—and are funded by the state budget and the Health Insurance Fund. Some specialized providers are located in Ulaanbaatar, including the Mental Health and Narcology Center and Enerel Hospital, which are funded by state line-item budgets.
- **Specialized centers and tertiary-level central hospitals.** Specialized centers provide health care for specific diseases and are located in Ulaanbaatar. Their share of funding depends on the services provided. Tertiary-level hospitals provide general medical services. Specialized centers include the National Centre for Mental Health, National Centre for Infectious Diseases, National Centre of Traumatology and Orthopedics, National Centre for Mother and Child, and National Cancer Centre. According to the health law, the state budget covers services for infectious diseases, psychology, cancer, and maternal and child care; 60% to 90% of the total state budget goes to these facilities. A total of 60% to 70% of the Health Insurance Fund goes to tertiary-level hospitals and the National Centre of Traumatology and Orthopedics and the National Dermatology Center.
- **Public health institutions.** These organizations are responsible for implementing public health policies and cooperating with health care facilities at the national level. The aimag department of health has a public health division, as do district health centers, which implement public health policies in the catchment area. At grassroots-level *soum* health centers, family practice groups are responsible for conducting day-to-day public health activities. The National Centre for Zoonotic Diseases is responsible for the control and management of the spread of zoonotic diseases in Mongolia and has branches in *aimags*.
- **Private hospitals.** Private health organizations operate under licenses issued by the Ministry of Health. Most of them operate in specialized fields and are accredited for a certain period of time to receive funding from the Health Insurance Fund. Some inpatient hospitals are financed by the Health Insurance Fund. The Ministry of Health and the Health Department monitor implementation of medical standards and health policy decisions.

- **Pharmacies.** Pharmacies are also licensed and accredited. Mongolia has about 1,000 pharmacies, about 800 of which are financed by the Health Insurance Fund. Insured patients can get discounted drugs from these pharmacies.
- **Clinics.** Among private health care providers, 42% are specialized clinics that are funded by personal direct payments, with the government providing inspection and control through licensing and accreditation.

REGULATORY CONTEXT

Health Sector Objectives and Strategy

The main objective of the Mongolian health sector is to achieve UHC by improving performance on the indicators for achieving the UN Sustainable Development Goals and strengthening PHC systems. Public health is also a priority. Mongolia has achieved its UN Milliennium Development Goal (2000–2015) for maternal mortality. Maternal and child health is a priority, with about 60% of all health services going to mothers and children. With a rapidly growing population, Mongolia is working to strengthen the health insurance system, develop strategic purchasing, and improve the legal environment.

Demographic and Health Outcome Indicators

The health status of mothers and children in Mongolia is critical to health outcomes. In Mongolia, 30% of the total population is under age 15; 67.8% of the population lives in urban areas, with 1.3 million people in the capital city of Ulaanbaatar. Respiratory, cardiovascular, and digestive system diseases are common. The leading causes of these diseases include extreme climates, severe air pollution, poor nutrition, and high levels of fat and meat consumption. Treatment of these diseases has become a high priority in recent years because Mongolia has some of the world's highest mortality rates from cardiovascular disease and liver cancer.

Table 1 shows selected demographic and health outcome indicators for Mongolia.

Table 1. Demographic and Health Outcome Indicators

Indicator	Measure	Year	Source(s)
Total population	3,028,000	2016	World Bank
Population age distribution	Age 0–5: 14.9% Age 6–15: 16.6% Age 16–64: 64.7% Age 65+: 3.8%	2016 (end of year)	National Statistical Office[1]
Urban and rural population	Urban: 67.8% Rural: 32.2%	2016	National Statistical Office
Poverty rate	29.6%	2016	World Bank Mongolia
Infant mortality rate	16.8 per 1,000 live births	2016	Health Indicators report[2]
Under-5 mortality rate	20.8 per 1,000 children under age 5	2016	Health Indicators report
Maternal mortality ratio	48.6 per 100,000 live births	2016	Health Indicators report
Top three illnesses that create demand for health services	Respiratory disease: 1,647.42 per 10,000 inhabitants Digestive disease: 1,231.38 per 10,000 inhabitants Circulatory disease: 1,007.58 per 10,000 inhabitants	2016	Health Indicators report
HIV prevalence	Less than 0.1%	2016	Surveillance Research Office of HIV/Sexual Transmitted Disease
Diabetes prevalence	8.3%	2013	STEPS survey Mongolia (WHO)[3]
Total fertility rate	25.3 per 1,000	2016	Health Indicators report

[1] www.1212.mn
[2] www.chd.mohs.mn/2017/smta/2016%20Health%20indicator.pdf
[3] www.who.int/ncds/surveillance/steps/2009_STEPS_Report_Mongolia.pdf

Indicator	Measure	Year	Source(s)
Percentage of 1-year-olds who have received DTP3	99%	2016	Gavi immunization coverage[4]
Prenatal care coverage (4+ visits)	85%	2016	Health Indicators report

Health System Indicators

Table 2 provides a snapshot of health system indicators in Mongolia, including the mix of public and private resources that go toward PHC and diagnostic services.

Table 2. Health System Indicators

Indicator	Measure	Year	Source(s)
Number of hospital beds per 100,000 population	Total: 21,720 Public: 75.8% Private: 24.2%	2016	Health Indicators report[5]
Bed utilization rate	Total: 72.8% Public: 79.6% Private: 51.7%	2016	Health Indicators report
Outpatient utilization rate (visits per person per year)	Total: 13,606,510 Public: 40% Private: 60%	2016	Health Indicators report
Number of outpatient facilities by type	Total: 2,016 Public: 24.1% Private: 75.9%	2016	Health Indicators report
Number of laboratory facilities	Total: 232 Public: 40.5% Private: 65.9%	2016	Health Indicators report
Number of imaging (X-ray) facilities	Total: 232 Public: 40.5% Private: 65.9%	2016	Health Indicators report

[4] www.gavi.org/country/mongolia/
[5] www.chd.mohs.mn/2017/smta/2016%20Health%20indicator.pdf

Indicator	Measure	Year	Source(s)
Number of pharmacies	Total: 1,696 Public: 22.7% Private: 77.3%	2016	Health Indicators report
Number of health workers (e.g., doctors, nurses, midwives, technicians, pharmacists, health extension workers)	Doctors Total: 2.9 Public: 56% Private: 44% Nurses Total: 3.52 Public: 70.8% Private: 29.2% Midwives Total: 0.29 Public: 95.3% Private: 4.7% Technicians Total: 0.16 Public: 41.8% Private: 58.2% Pharmacists Total: 0.46 Public: 13.4% Private: 86.6% Lab workers Total: 0.34 Public: 81.8% Private: 18.2%	2015	Health Indicators report
Percentage of population covered by a public health insurance plan	90.3%	2015	Department of Health Insurance
Per capita income (nominal and purchasing power parity)	Nominal: US$3,480.50 PPP: US$2,331.60	2016	National statistical office[6]
Total health expenditure (THE) per capita	US$193 Local currency: 350,946 MNT	2014	National health account WHO estimation[7]
THE as a share of GDP	4.73% of GDP	2014	National health account WHO estimation

[6] www.1212.mn
[7] apps.who.int/nha/database/Select/Indicators/en

Indicator	Measure	Year	Source(s)
General government health expenditure (GGHE) per capita and as a share of THE	US$107 per capita 55.3% of THE	2014	National health account WHO estimation
Private health expenditure per capita and as a share of THE	US$86 per capita 44.7% of THE	2014	National health account WHO estimation
External health expenditure per capita and as a share of THE	US$9 per capita 4.67% of THE	2014	National health account WHO estimation
Out-of-pocket expenditure (OOPE) on health per capita and as a share of THE	US$80 per capita 41.6% of THE	2014	National health account WHO estimation
Degree of government decentralization	*Soum* health centers and family health centers are under the local government control. The Ministry of Health contracts with local governors.		

In Mongolia, 24.2% of the hospital beds and 60% to 70% of the infrastructure of health facilities are run by the private sector, but utilization is relatively low, with the private sector accounting for 51.7% of beds in use and 60% of completed outpatient visits.

REGULATORY LANDSCAPE

Public and private health care facilities and providers in Mongolia must abide by the same standards for licensing of health facilities, accreditation based on the quality of services and technology, and the licensing of medical professionals. However, it is difficult for the private-sector providers to meet all of these standards due to their smaller size and lack of resources. State-owned health care providers have an advantage in terms of financing and other support for specialized training, but private-sector family health centers do get investment, financing, and staff development support from the state because they provide primary care services on behalf of the state. They therefore have far more advantages than other private health care providers.

Table 3 describes the regulatory mechanisms used in Mongolia.

Table 3. Regulatory Mechanisms

Mechanism	Instrument(s)	Target(s)	Rationale[8]	Additional Details	Source(s)
Command and control—legal requirements accompanied by sanctions for noncompliance	Health law requiring licensing of all health personnel	Public and private health organizations (all health personnel)	To ensure quality, patient safety, and adherence to clinical guidelines	Prohibition on unlicensed care and services; implementation is good.	Health Law 8.1.17
	Minimum facility requirements	All health facilities	To ensure quality, safety, and capacity to deliver health care services	A key indicator of accreditation and is different for each institution.	Health Law 8.1.4
	Clinical guidelines and standards for care and services	All health facilities	To deliver consistent and standardized health care services	Health care and services inevitably comply with the guidelines and standards, but only 50% of the total standard of care is available.	Standard Law 3.1.2

[8] Often stated in the introduction or preamble of the law or regulation.

	Issuance and extension of licenses (based on geographic location and needs)	All health facilities	To evaluate and ensure whether the requirements for licensing are met	The license is granted for a certain period of time and is extended to meet the requirements.	Health Law 19.25
	Accreditation (evaluates activities, standards, licenses, and risks)	All health facilities	To ensure safety	Accreditation is done by a professional body. Organizations can conduct activities and contract with health insurance only in cases of acceptance of accreditation.	Health Law 22.1
Incentives (financial)—actors change their behavior in response to financial rewards or penalties	Providing funding to private hospitals and pharmacies that contract with the Health Insurance Fund according to indicators	Private inpatient hospitals and pharmacies	To increase access to health care services	Funding for inpatient care and drug discounts is available from the Health Insurance Fund; if service is good, providers are eligible for funding from the Health Insurance Fund.	Health Insurance Law 13.1.1

Self-regulation—provider and professional groups set their own standards of member behavior	Professional subcommittee function	Organizations, groups, and specialists that belong to professional associations	To improve quality of care, build capacity, and protect the interests of consumers	Professional associations provide training, empowerment, and exchange of ideas and help develop, maintain, and promote guidance on standards.	Health Law 8.2

Regulatory Agents

Regulatory agents are actors and institutions or agencies that are responsible for regulation and regulatory activities. This section describes the regulatory agents and their roles in developing and implementing regulations.

National Government—Developing Regulations

According to the Constitution of Mongolia, the president, the government, and the parliament have the right to initiate legislation. The government often develops legal documents on health sector management and regulation in accordance with their respective facilities. It is also possible to make legal reforms with members of parliament for groups and associations. All of these changes are carried out under the Law on Law Development and all are processed in the same way.

National Government—Implementing Regulations

By law, the Ministry of Health is responsible for managing and coordinating the health sector. This includes implementing reforms, legislation, and policies through its units, agencies, and health organizations based on relevant orders and decrees, and reporting to the government about the implementation of these laws and regulations. The Ministry of Health has two regulatory agencies: the Health Insurance Department is responsible for implementation of health insurance, and the Health Development Center is responsible for statistical data and registration and the training and accreditation of health care professionals. Implementation of health policies is managed by health departments at the subnational level.

National Health Financing Agency

Mongolia is in the process of developing a National Health Financing Agency. Currently, the National Health Insurance Fund is operated out of the health insurance office, an agency of the Ministry of Health, which purchases health care and services included in the health insurance package. Under the law, the health insurance office works as an independent agency and reports results to the Ministry of Health. Purchasing of health care services is implemented through contracts with accredited and licensed health organizations.

Subnational Government—Developing Regulations

The law provides certain rights to local health authorities. For example, local health authorities can issue licenses and make decisions about implementation of programs and activities. Issues that are difficult to resolve at the local level are passed on to the Ministry of Health and local governors.

Subnational Government—Implementing Regulations

Subnational governments are responsible for coordinating the health sector at the local level under the local governor, and the governor works with the Ministry of Health on the basis of mutual agreement. Local health departments coordinate local public and private health facilities; these organizations operate under the Law on Health and the Law on Fiscal Budget.

Statutory Boards

The National Council on Health Insurance comprises three representatives from government agencies, three representatives of employers, and three representatives of civil society organizations. Decisions regarding health insurance are issued, and results are reported to the parliament.

Accreditation Organizations

Mongolia has no independent accreditation body; the Health Development Center under the Ministry of Health is responsible for accreditation. Regulations governing accreditation procedures are issued by the Ministry of Health, and accreditation experts are appointed to conduct accreditation activities in health organizations. These experts submit applications to the Ministry of Health for validation.

Professional Associations

Professional associations in the health sector make decisions within the relevant subject matter. A general specialist of the professional association works as a professional nonstaff member of the Ministry of Health and can be consulted for professional advocacy and conclusions.

Consumers

All health facilities in Mongolia have units that respond to consumer complaints about health care services. Consumers can also comment on issues related to supplies, fraudulent medicines, and other issues.
Table 4 decribes the regulatory agents in Mongolia, their roles in developing and implementing PHC, and their interaction with other agencies.

Table 4. Roles of Regulatory Actors

Regulatory Actor	Regulatory Role		Interaction with Other Agencies (Collaborations or Conflicts)
	Development	Implementation	
National Government (Ministry of Health)	Identify current problems, develop and modify relevant legal documents, and collaborate with international organizations, projects, and programs to develop policy.	Implements policy, conducts monitoring, evaluation, and takes necessary measures, develops guidelines and rules, and enforces them.	Other ministries and agencies, health insurance departments, the private sector, professional associations, and local health departments
National Health Financing Agency	Under the law, this is an implementing agency with limited direct policymaking options. (The National Council decides on their respective changes.)	Coordinates regulation, monitors implementation, establishes and oversees contracting, and provides incentives, based on approved legislation, policies, and strategies.	Ministry of Health, other ministries, local insurance organizations, health care providers
Statutory boards	The National Council for Health Insurance is responsible for policy development.	The council develops policy and makes decisions and regulations related to health insurance.	Government and health organizations

Regulatory Actor	Regulatory Role		Interaction with Other Agencies (Collaborations or Conflicts)
	Development	Implementation	
Subnational governments	Subnational governments have the right to implement and coordinate with Ministry of Health policies, but also they have also their own policies and strategies for their catchment areas.	Implement compliance policies and laws, execute and evaluate contracts, make decisions, and integrate with local policies.	Government and local organizations
Accreditation organizations	No policy development role. Problems encountered during the accreditation process are handled by the Ministry of Health.	Assess and evaluate quality and safety at health care institutions seeking to be accredited.	Ministry of Health, Professional Inspection Agency, Standard Measurement Department, and others
Professional organizations	Professional nonstaff members work within the Ministry of Health and help formulate policy at each stage.	Train specialists in the field, develop guidelines and standards, and provide professional advice to implementing organizations.	Government, service providers, civil society organizations, and international organizations
Consumers / civil society organizations	No explicit policy development role, but consumers can share opinions through civil society organizations to help shape policy.	Make decisions about accessing health care services and help shape health policy.	Health organizations and civil society organizations

Resources for Regulation

To carry out their roles effectively, regulatory actors need adequate resources, including human resources, financial resources, equipment, infrastructure, grants, and in-kind resources. Table 5 summarizes resources used for regulation in Mongolia.

Table 5. Resources for Regulation

Regulatory Agent	Technical and Support Staff (numbers and qualifications)	Budget (US$ and Source)	Other Resources
National Government (Ministry of Health)	90 technical staff 10 support staff	US$5.4 Million Ministry of Health (transparency financing information)	
National Health Financing Agency	52 technical staff 12 support staff	US$1.6 Million Ministry of Finance, Fiscal Policy department	
Statutory boards	9 decision-makers 10 support staff	US$375,000 Ministry of Finance, Fiscal Policy department	
Subnational governments	40 technical officers 5–8 support staff	US$700,000 Ministry of Finance, Fiscal Policy department	
Accreditation organization	5 accreditation officers	US$500 to $1,000 per accreditation	Vehicles and fuel for monitoring visits
Professional organizations	N/A	N/A	
Consumers / civil society organizations	N/A	N/A	

Tracking and Reporting on Regulatory Efforts and Performance

All health care facilities, regardless of ownership, use the H-Info 3 program to collect health care data and generate records and reports. Data are coded using ICD-10 codes.

Table 6. Regulatory Activities and Performance

Regulatory Activity	Performance Indicators	Performance Period	Source
Facility inspections conducted	Number done for accreditation	Jan–Dec 2017	Interviews
Complaints received	317	Jan–Dec 2017	Interviews
Complaints reviewed	183	Jan–Dec 2017	Interviews
Sanctions imposed on facilities due to complaints	Number of complaints received	Jan–Dec 2017	Interviews
Sanctions imposed on provider personnel due to complaints	Number of complaints received	Jan–Dec 2017	Interviews

Summary—Regulatory Efforts

Mongolia's health sector policy goals are based on the concept of sustainable development, but current structures and regulations support the system's historical organization, which has focused on larger public facilities rather than on the private sector. The system should instead be based on population structure and disease prevalence.

Current rules and regulations focus mostly on measuring inputs. For example, accreditation, licensing, and institutional and operational standards measure inputs but do not capture information about process and outputs. In recent years, these regulations have been modified to align with standards on health facility structure and functions. Standards for specific types of health facilities, such as pharmacies, general hospitals, and clinics, detail requirements related to construction, human resources, and equipment. These standards encourage large public-sector facilities with sufficient resources to meet staff and equipment requirements but do not create incentives for smaller private-sector facilities, which cannot afford to meet those standards. For instance, hospital beds are regulated by a general hospital standard that requires an average of 200 beds and 300 to 600 employees; this is a huge barrier for private hospitals, most of which have 20 to 50 beds and 30 employees. Regulatory reforms in recent years have supported state-run health care organizations but have had a profoundly negative effect on private health care facilities.

The current health system is based on the former socialist Semashko system, which focuses mostly on system inputs rather than strategic financing and performance measurement.

Indeed, the system offers no incentives to improve the quantity, accessibility, and quality of health care services. This issue is especially acute in state-owned health organizations, but private health care organizations lack funding and leverage. The health care arrangements seem to be overregulated by the state-owned health organizations and the lack of private sector regulation.

The government pays particular attention to state-owned health care organizations and supports them with subsidies and support, which does not encourage the use of private-sector resources and encourages excessive monopolies. Government-based coordination should take into account both public and private capacity to deliver quality and accessible health services nationwide. The current arrangements also do not support efficiency. Regulations should be developed and implemented based on official data, such as disease records, the ongoing health insurance electronic system, and financial reports. No performance evaluation criteria are available, especially the required process and output criteria. With process and output indicators in place, like bed occupation rate or number of completed vaccinations per population, it is possible to improve control of inputs, processes, and outputs for all public and private health care institutions.

IMPLEMENTATION AND PERFORMANCE OF REGULATORY ACTIVITIES

This section documents how current regulatory activities are being implemented in practice and identifies gaps between theory and practice. it summarizes primary data from interviews and focus groups (with policymakers, regulatory boards, private providers, academics, and members of the media) on the status and experience of regulatory implementation.

Table 7. Implementation and Performance of Regulatory Activities

Stakeholder	Interview Date	To what extent are regulations fulfilling their mandate? 1 = strongly disagree 2= disagree 3 = neutral 4 = agree 5 = strongly agree	Implementation and Performance Strengths	Implementation and Performance Weaknesses	Suggested Changes
Regulators Ministry of Health	10 Oct 2017	5	It is possible to build, remove, or transfer necessary resources of health care services in accordance with accreditation and licensing services.	At present, implementation is ineffective because of the focus on inputs. Other nonaccreditation arrangements, particularly financial and nonfinancial incentives, are not used.	Take measures to optimize processes and output performance in accordance with accreditation and licensing.

Stakeholder	Interview Date	To what extent are regulations fulfilling their mandate? 1 = strongly disagree 2= disagree 3 = neutral 4 = agree 5 = strongly agree	Implementation and Performance Strengths	Implementation and Performance Weaknesses	Suggested Changes
Regulated (e.g., representative of professional or provider association)	11 Oct 2017	3	A strong regulatory tool of the government.	There is no involvement of professionals in accreditation and outcome evaluation.	Include professional judgments and assessments in measuring performance and results.
Consumers (e.g., represented by civil society organizations)	11 Oct 2017	5	It is important to have a good system in place for the government on behalf of citizens.	Civil society (representing consumers) involvement in regulation is limited.	Connect civic monitoring with information systems.
Academics (e.g., key professors at medical training institutions)	13 Oct 2017	4	Good regulations improve quality and squeeze weak service providers out of the market.	Academics have the capacity to support training and help improve service quality but are underutilized.	Licensing and accreditation should include independent experts and researchers.

CONCLUSIONS

The following conclusions can be drawn from examining the regulation of private PHC in Mongolia.

- In the health sector, legal documents and regulatory functions are more favorable to state-owned health care organizations and are difficult to implement in private health care facilities.
- The vast majority of health sector resources are in the private sector, but lack of state regulation leads to capital inefficiency, unnecessary admissions, and unnecessary diagnoses and medical examinations, thereby increasing direct out-of-pocket cost for patients.
- The current health system is based on the old socialist system, and its structure results in inefficiencies in resource use and does not support quality improvements or limit out-of-pocket payments.
- Standards and guidelines and accreditation and licensing processes outline the minimum level of input needed to provide services. This encourages greater focus on system inputs than on process quality and results. This is a weakness of the current system.
- The absence of incentives and financial support from private health care institutions, lack of coordination, and weak connections with what is happening “on the ground” indicates that the regulatory efforts are inadequate for developing the private health sector and encouraging competition.
- In Mongolia, public-private health centers have been established using a partnership model, providing infrastructure to deliver PHC efficiently and at low cost.
- Under the current regulatory system, regulations are relevant only to the state-owned entity and not to private health care providers.
- Mongolia must assess the effectiveness of the different resources in the country and look into opportunities for their use—for instance, to use process, output, and impact-based indicators to measure system performance, regulate care, and coordinate necessary monitoring and evaluation. This will allow for faster results at lower cost, thereby reducing conflicts and negative influences between public and private health care providers.

RECOMMENDATIONS

Table 8 lists recommendations for improving the regulatory system in Mongolia is based on findings from a review of existing regulations and from key informant interviews.

Table 8. Recommendations

Recommendation	Rationale	Impact on Private Health Sector	Priority Level
Consider public-private engagement to allow for potential efficiencies of sharing resources across the public and private sectors.	The private sector has resources and equipment that are not available to members of the public sector. State-owned health care institutions should pay the private sector for use of those resources and that equipment instead of purchasing new equipment.	The public sector could help improve the sustainability of the private sector by paying to use equipment and resources.	1
Develop input-based standards that are specific to private facilities.	Current standards are relevant only to the public sector, which has larger facilities and larger numbers of staff. They do not apply to small- and medium-sized private-sector facilities.	Standards that are relevant to private-sector facilities, which are smaller, will help the private sector comply with regulations and compete with public facilities. They will also give citizens more options for effective and high-quality health care services.	2
Review policies and orders and develop indicators for inputs, processes, and outputs that measure impact and performance.	Currently, the input-based indicators used for accreditation and licensing are inadequate for assessing small facilities (which are mostly in the private sector). Facilities with more resources (usually public ones) are often overestimated and highly valued.	Public and private facilities will be able to compete on quality and will receive equal financial and nonfinancial support.	3

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