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Caring about Health

REFORMING THE PUBLIC HEALTH SYSTEM IN MONGOLIA

Mongolia gained independence from the Soviet Union in 1990 in the course of a peaceful democratic revolution. The following transition brought far-reaching civil liberties, a multi-party system with free and fair elections and the establishment of a market economy. However, it had also huge implications for the Mongolian health system. The existing Soviet-type model suddenly lost its "nerve center" of financing, planning and decision-making and struggled to adapt and reform to the new economic and societal circumstances. Today, life expectancy in Mongolia is 65 years for males, and 73 years for females[1] (Germany: 79/83)[2]. What does a country need in order to increase life expectancy, fight against diseases and prevent illnesses from arising? One indispensable factor is an effective, inclusive and universal health care system. Much has been achieved in the past decades in Mongolia, and a great many people have benefited from reforms. However, there's still a lot to be done, and the difference in life expectancy in comparison to developed countries is one of the most obvious indicators. This report will analyze the current situation of the health system in Mongolia and will discuss challenges and future solutions.

1 Historical roots of the Mongolian health system

The modern Mongolian health care system was planned, organized and established during the early 20th century. It was developed according to the Soviet-type *Semashko model* to ensure equity and broad access to health services. Named after the First People's Commissar of Health of the Russian Soviet Federative Socialist Republic, Nikolai Semashko (1874-1949), Soviet health care was developed as "social health care"[3], trying to also eliminate the social reasons for illness, thus transforming society and economy as a whole. The Semashko system did not, however, embrace preventive health measures but rather emphasized "curative services that relied heavily on hospital-based physicians and an authoritarian management style with a strong central control system"[4]. Private medical care did not exist, and medical aid was mainly delivered by secondary and tertiary facilities while primary care services were often omitted.[5] Subsequently, the Semashko model focused on health care delivery through hospitals and neglected the development of primary care services such as general practitioners, "resulting in a large,

[1] World Health Organization. (2018). *Country Profile Mongolia*. Retrieved from: http://www.who.int/countries/mng/en/ In contrast to other Socialist countries there was no decline of life expectancy after the revolution. See for time series: https://countryeconomy.com/demography/life-expectancy/mongolia

[2] World Health Organization. (2018). *Country Profile Germany*. Retrieved from: http://www.who.int/countries/deu/en/

[3] Trefilova, O.A. (2014). Nikolai Semashko – social activist and health care provider. *Istoriâ mediciny*, *3*(3), 65-72.

[4] European Observatory on Health Systems and Policies. (2007). Mongolia: Health system review. *Health Systems in Transition, 9*(4), 1–151. P. xv

[5] Health care systems can be characterized as follows: Primary care is the most general level of medical care, e.g., at a general practitioner. Primary care is also responsible for coordinating the delegation of a patient to a higher level of care, if necessary. Secondary care comes into play when the patient is transferred in order to receive specialized care, e.g., at a cardiologist. When a patient is hospitalized and in need of highly-specialized and labor-intensive care, the person is referred to tertiary care which offers expertise and high-end equipment.

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fragmented and inefficient hospital sector providing outmoded and low-quality care […]"[6]. This resulted in overcapacities in Mongolian hospitals as well as in hospitalizations of patients with only minor injuries who better should have been taken care of at a lower level.

Even though the Semashko model had its achievements in Mongolia – like universal access and the control of communicable diseases by mass immunizations – its curation-oriented and resource-intensive care as well as its overstaffing (both, in terms of personnel and hospital beds) prevented the introduction of more effective and modern health care delivery. In the years before the collapse of the Soviet Union, Mongolia and the other satellite states of the Union were characterized by ambiguities: on the one side, an enormous amount of hospital beds and trained physicians were available. But on the other side, the health personnel's training was very well below Western standards; salaries were meager so that doctors demanded their patients for informal payments; and the whole system was slow, bureaucratized, underfunded and very much centralized. It is important to stress out that the Soviet Union literally acted as the vital "nerve center" for all its satellite states and planned, financed and decided basically everything in the realm of health policy. Consequently, the sudden disconnection from the "mothership" in the years after gaining independence led to "medical care systems that were in a chronic state of disarray"[7]. Having lost Soviet financial aid after 1990, the health care situation in Mongolia deteriorated dramatically. The first freely elected governments had to act in response to the aforementioned problems and to ensure future funding, modernization and inclusiveness. Thus, the Mongolian government introduced Social Health Insurance (SHI) in 1994 as one of the first measures to put Mongolian health care on a new track towards a modern public health system.

[6] Asian Development Bank. (2008). *Mongolia: Health and Social Protection*. P. 3 Retrieved from: https://www.oecd.org/countries/mongolia/42227662.pdf

[7] Barr, D. A., Field, M. G. (1996). The current state of health care in the former Soviet Union: implications for health care policy and reform. *American Journal of Public Health*, *86*(3), 307–312. P. 308

2 Social Health Insurance in Mongolia

Immediately after the split from the Soviet Union, the Mongolian Ministry of Health introduced user fees and co-payments for receiving medical services.[8] It then headed towards introducing a nationwide insurance program in which citizens pay mandatory contributions to a comprehensive SHI system. At that time, SHI was already the most common form of health financing in Europe, aimed at funding health services through (often) mandatory contributions by individuals, households, enterprises and the government in order to avoid individual service fees, too expensive to be paid solely by each citizen.[9] Inspired by those well-working SHI-sponsored schemes, the Mongolian government guaranteed in its constitution the rights to health protection and to access to medical care in 1992.[10]

The introduction of SHI in Mongolia after nearly seven decades of "gratuitous" Soviet health services was first and foremost successful because the government decided to subsidize the health premiums of the poorer part of the population and of vulnerable groups, like single parents.[11] Therefore, almost the entire population had been covered after the introduction of the new scheme. However, when the government stopped subsidizing the aforementioned groups in 1999, SHI coverage significantly declined and reached a low of 82.6% in 2010[12] –

[8] Dorjdagva, J., Batbaatar, E., Svensson, M., Dorjsuren, B., Kauhanen, J. (2016). Catastrophic health expenditure and impoverishment in Mongolia. *International Journal for Equity in Health*, *18*(105), 1-9. Retrieved from: https://equityhealthj.biomedcentral.com/track/pdf/10.1186/s12939-016-0395-8

[9] World Health Organization. (2003). *Social Health Insurance. Report of a Regional Expert Group Meeting New Delhi, India*. Retrieved from: http://apps.searo.who.int/PDS_DOCS/B3457.pdf

[10] Article 16 of the 1992 Constitution of Mongolia: "The citizens of Mongolia shall be guaranteed to exercise the following rights and freedoms: […] 6. The right to health protection and to obtain medical care. The procedure and conditions for free medical aid shall be determined by law."

[11] Bayarsaikhan, D., Kwon, S., Ron, A. (2005). Development of social health insurance in Mongolia: Successes, challenges and lessons. *International Social Security Review, 58*(1), 27-44. P. 27

[12] General Authority for Social Insurance. (2014). *Health Insurance Coverage in Mongolia: Challenges and Opportunities.* P. 13 Retrieved from: http://www.undp.org/content/dam/mongolia/docs/InclusiveInsurance2014041617/Presentations/pdf/Day2pdf/Health%20Insurance%20Coverage%20in%20Mongolia_English.pdf

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in sharp contrast to the purpose of SHI to enable universal access and affordability and being mandatory for all Mongolian citizens since 2003. However, the situation improved since then and in 2011, 96.6% of the population had been covered, made possible by a one-time funding that subsidized the then uninsured groups (mostly students and herders). Whether this high level of insurance coverage can be maintained without future additional, tax-funded subsidies is highly unlikely.[13]

SHI in Mongolia is financed based on individual income and individual living conditions to ensure that no one is left behind – a form of risk pooling ensured through universal and fair contributions. Insurance premiums for SHI are determined by the "Health Insurance Law" of 2003. It defines population groups and their mandatory financial contributions: for employees, an annually adjusted percentage of the monthly income is equally shared between employer and employee; for self-employed people and employers, 1% of the monthly income has to be paid; for part-time students, unemployed people or herders, a monthly *flat rate* incurs; for minors, retired people, military personnel, low-income citizens, full-time students and parents caring for a child, expenses are paid for from the public budget.[14]

3 The structure of the health system and its funding

The public health system in Mongolia is organized according to the 21 *aimags* (provinces) and the capital city of Ulaanbaatar. The *aimags* constitute the second-level administrative unit and stand next to Ulaanbaatar, which is an independent provincial municipality within the Töv *aimag*. The third administrative level consists of 331 *soums,* each with about 5000 inhabitants.

Medical care is offered in each *aimag* based on the already mentioned three-tiered system. Primary care services are provided in Ulaanbaatar and in *aimags* and *soums* mainly by family practices; there are numerous in the capital city, while (in most cases) only one in each *aimag* and *soum*. Secondary care is delivered by general hospitals in Ulaanbaatar and in the *aimags* alike, while tertiary services are mostly located in Ulaanbaatar and in only four *aimag* hospitals. These so-called regional diagnostic and treatment centers were introduced in 2011 in order to deliver secondary and tertiary care to the rural populations in a more timely manner.[15]

As mentioned before, public health care services in Mongolia are financed essentially from two sources: mandatory SHI contributions by the population, and by public funding. The latter goes first and foremost into primary and maternal health care services such as family practices and the small *soum* hospitals. SHI financing, on the other side, focusses on individual clinical care, i.e., on financing and delivering curative care at secondary and tertiary hospitals.[16] However, out-of-pocket (OOP) payments by patients are still required depending on the level of medical care they are receiving; thereby, they constitute a third revenue source for the health care system. OOP payments for primary health care services were eliminated in 2006, but they continue to exist for medical care usage at the secondary and tertiary levels. At these levels, fees are normally charged in all public hospitals for specific services (such as CT scans or X-rays). SHI also calls for co-payments ranging from 10% at secondary level to 15% at tertiary-level hospitals of the total costs that have been spent for the treatment of the patient in question. However, the aforementioned vulnerable groups are exempted from these co-payments at the two superior levels.

How closely (and sometimes weirdly) SHI, government funding and OOP are interlinked, can be seen when looking at the split of costs for drugs listed on the Mongolian "Essential Medicine List". This directory entails the mini-

[13] Asia Pacific Observatory on Health Systems and Policies. (2013). Mongolian Health System Review. *Health Systems in Transition, 3*(2). P. 43

[14] Boslaugh, S. E. (2013). *Health care systems around the world. A comparative guide*. New York, NY: Sage Publications. P. 307f

[15] Asia Pacific Observatory on Health Systems and Policies. (2013). Mongolian Health System Review. *Health Systems in Transition, 3*(2). P. 9

[16] Tumendemberel, N. (2008). Mongolia: Promoting Sustainable Financing and Universal Coverage through Social Health Insurance. *Promoting Sustainable Strategies to Improve Access to Health Care in the Asian and Pacific Region.* Retrieved from: http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.577.2492&rep=rep1&type=pdf

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mally required medicine with the most effective and safe drugs on it. For medicine listed, SHI partially reimburses the costs, but this depends on *who* prescribes the drugs: SHI reimbursement covers only drugs for outpatients at the primary care level (inpatient ones are covered by the government budget), while at the secondary and tertiary levels, SHI covers only inpatient drugs. Outpatient drugs at the two superior levels are covered neither by SHI nor by the government budget,[17] imposing full financial responsibility on the patient in question. Against this background, OOP payments can be seen as an important third pillar of health financing in Mongolia.

4 Problems of and challenges to the health system

Problems of and challenges to the health care system in Mongolia are manifold. They are the result of people's behavior, structural and political shortcomings, inconsistencies in funding and international developments. The most urgent ones are discussed in this chapter.

4.1 Behavioral factors of use

Even today, the heritage of Semashko imposes various hurdles to effective health care delivery. The Semashko model influenced very much how the Mongolian population used medical services over the course of the 20th century. It promoted the usage of secondary and tertiary services and diminished the role of primary care services and preventive health measures.[18] This has led to a situation in which patients seek hospital care or hospitalization with diseases that should rather be examined and treated at the primary care level, resulting in overburdened specialized health services (first and foremost, hospitals). This only aggravates the already precarious situation of understaffed and underfinanced facilities and prevents the public health care sector from reforming. Studies show that the inappropriate use of health care facilities is a major obstacle to timely, equal and efficient health care delivery: a survey conducted in Ulaanbaatar hospitals revealed that nearly one-third of patients suffered from chronic diseases that did not require acute hospital treatment.[19]

This behavior – historically formed by the Semashko ideology – goes hand in hand with another problem: health care services in Mongolia are primarily used for *curative reasons*. After gaining independence from the Soviet Union, the Mongolian health care system failed to shift away from its focus on curative care, resulting in "people perceiving the modern system exclusively in curative terms and not with regard to health preservation and disease prevention"[20]. To put it differently: today, it is quite common that people see a doctor because they are ill, but the underlying reasons for being ill are not reflected and discussed as health education and preventive check-ups are commonly not seen as a part of the consultation process. A clear indicator that health education and preservation, as well as illness prevention, are not widespread and effective in Mongolia is the death rate due to noncommunicable diseases (NCDs), which are most often chronic diseases. In 2014, the World Health Organization concluded that in Mongolia the probability to die from one of the four main NCDs – cancer, diabetes, cardiovascular disease, chronic respiratory disease – is 32% (between the age of 30 and 70)[21].

As a consequence, physicians need to advertise more directly the benefits of a healthy lifestyle and the risks of, e.g., smoking or excessive meat consumption. More incentives for patients to take advantage of primary care services and health education at this level have to be created, including regular mandatory check-ups; fees or higher SHI contributions could be imagined as penalties. Finally, stricter rules for using secondary and tertiary services need to be introduced. One could imagine

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[17] Asia Pacific Observatory on Health Systems and Policies. (2013). Mongolian Health System Review. *Health Systems in Transition, 3*(2). P. 54f

[18] Neumann, N., Warburton, D. (2015). A Review of the Modern Mongolian Healthcare System. *Central Asian Journal of Medical Sciences, 1*(1), 16-21. P. 17

[19] European Observatory on Health Systems and Policies. (2007). Mongolia: Health system review. *Health Systems in Transition, 9*(4), 1–151. P. 105

[20] Neupert, R. F. (1995). Early-age mortality, socio-economic development and the health system in Mongolia. *Health Transition Review 5*(1), 35-57. P. 47 Retrieved from: http://htc.anu.edu.au/pdfs/Neupe1_1.pdf

[21] World Health Organization. (2014). *Noncommunicable Diseases (NCDs). Country Profile: Mongolia.* Retrieved from*:* http://www.who.int/nmh/countries/mng_en.pdf

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guidelines for the hospital administration on the acceptance or transfer of a patient to a primary care physician. This would give the general practitioners and medical services at the primary level more room for health education and illness prevention, leading to better patient care because of more available resources, timely and adequate delivery of medical aid, and an increased budget for chronic disease treatment and for future investments.

4.2 Short-term political planning and lack of stewardship

Another challenge to an effective health care system in Mongolia is short-term political planning especially due to political discontinuity, which massively impacts on the health care system, its efficacy and long-term development. Mongolia has experienced major political changes since 1990 and had frequent changes of government: Since the introduction of the 1992 democratic Constitution, there have been 15 governments in power. The issue of how to keep and secure a long-term vision for the health care system against frequently changing political majorities and ideologies arose and was acknowledged by the Ministry of Health back in 2005. The "Health Sector Strategic Master Plan 2006–2015" was therefore passed with the aim to develop a strategic vision for the development of the health sector. However, "rapid and constant political changes negatively influenced the continuity of policy implementation and planning, which means that short-term planning still dominates"[22].

An answer to this political problem might be increasing administrative and financial independence from the central Ministry of Health. Efforts to decentralize the Mongolian health system were already initiated by the Mongolian government. But these attempts were less successful due to the lack of capacities at the local levels, the confusion of responsibilities of the different stakeholders involved, as well as reluctance to change existing management schemes.[23] A more determined policy-making in the health sector is pivotal. Health-related responsibilities have to be shifted to the *aimags* and *soums* as part of a bigger decentralization policy that strictly fixes budgetary responsibilities for better adapting to local needs and for implementing stable and long-range plans. This decentralization policy – widely discussed in Mongolia at the moment – would need to entail more than health policy in a narrow understanding: it would have to precisely determine the relationships and responsibilities amongst different administrative levels by yielding competences and financial autonomy to the *aimags* and *soums* in order to shift away from the current highly-centralized state structure.

4.3 Training and medical mindset

The training of the health personnel and the medical mindset are two intertwined factors which had been heavily influenced by the Semashko system and the decades of Soviet medical care planning. Medical training at a Mongolian university currently takes about six years. Since 2015, medical graduates will have to work for two years in a rural and district hospital in a position that matches their core area of interest. This obligation is meant to strengthening countryside hospitals and fight rural exodus. However, during medical training at university and the years at countryside hospitals, Mongolian medical students remain mainly in a passive role, observing but not assuming full responsibility in medical treatment.

A further overhaul of medical studies curricula should put an emphasis on strengthened practical proficiency. This would improve the students' professional capacities at countryside hospitals and, thus, contribute to overcome medical labor force shortages due to an increasing number of people leaving the countryside.

Beyond this, the traditional Semashko way of thinking in diagnosing and treating diseases has to be overcome. Soviet medical care heavily relied on curative measures. Patients' *symptoms* had been analyzed and treated without checking for all other possible reasons of illness (*differential diagnosis*). Today, the latter, internationally used approach has been adopted, but the mindset of teaching physi-

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[22] Asia Pacific Observatory on Health Systems and Policies. (2013). Mongolian Health System Review. *Health Systems in Transition, 3*(2). P. 29

[23] European Observatory on Health Systems and Policies. (2007). Mongolia: Health system review. *Health Systems in Transition, 9*(4), 1–151. P. 27

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cians at universities often remains traditional,[24] contributing to ambiguities and differences in the training of the health personnel. To accomplish a more standardized and modern view on diagnosis and treatment, stricter guidelines for the university curriculums and mandatory live-long training of teachers and practitioners need to be implemented.

4.4 Dramatic rise in health expenditures and the need for structural reform

OOP expenses in Mongolia appear in the form of payments for drugs, services or treatment in general. As already mentioned, OOP expenses are pivotal to the funding of the health care system. They can also be seen, however, as a result of different inherent shortcomings in the Mongolian health care system, "indicating poor services coverage of statutory funding schemes and patchy distribution of health services between the government and SHI"[25].

The problem is hard to overcome: the already mentioned regulations that decide if drugs are covered by SHI or the government – depending on the type of patient *and* the type of care – make the whole system quite opaque. The current situation deters patients from utilizing the health care system in an effective, regular and reasonable way. Patients will be left alone with covering their health expenditures. Those high and frequent OOP expenses exclude a lot of patients from medical care, as the poor "are frequently unable to afford the medicine prescribed by their doctor, choosing to purchase only the cheapest items on the prescription"[26].

OOP expenses impose serious problems for outpatient drugs at secondary and tertiary levels, especially in the light of NCDs in Mongolia. Those diseases are often chronic and do not require inpatient care but rather need long-term and drug-intensive treatment, which imposes a heavy financial burden on the poorer population, not least to the fact that prices for drugs in Mongolia are high in general as most of them are imported.

To cut a long story short: reforms need to be passed to make the funding mechanisms of the health care system more transparent and patient-friendly. OOP expenses need to be drastically curtailed to tackle the problem of dramatically rising health expenditures which lead to financial hardship and to the exclusion of poorer population groups. Costs for medical services have to be distributed in a fair way across the whole population in order to fight financial burden and social hardship. More public funding – simultaneous to the constant increase of the gross domestic product – and more financial resources from insurance premiums have to be assured, as fees to be paid by the individual patient for specific medical services and drugs are against the idea of an equal and inclusive SHI. Studies show that removing user fees significantly improves curative care as well as preventive care utilization.[27] Risk pooling – the core of SHI – cannot continue to be counteracted by high and often unaffordable costs in the form of OOP expenses.

4.5 Distances and sparse population density

Mongolia, with more than four times the size of Germany, is the 19th largest country and the second largest landlocked state in the world. Because of this vast territory and a small population of roughly three million people, is Mongolia considered to be the most sparsely populated country in the world. The majority of people lives in urban areas (68.5% in 2014)[28], and Ulaanbaatar is by far the country's largest city with nearly half of the Mongolian population living in it.

This large territory with a sparse population unequally distributed and the dramatic lack of

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[24] Neumann, N., Warburton, D. (2015). A Review of the Modern Mongolian Healthcare System. *Central Asian Journal of Medical Sciences, 1*(1), 16-21. P. 20

[25] Asia Pacific Observatory on Health Systems and Policies. (2013). Mongolian Health System Review. *Health Systems in Transition, 3*(2). P. 64

[26] Asian Development Bank. (2012). *Hospital Subsector Analysis*. P. 1 Retrieved from: https://www.adb.org/sites/default/files/linked-documents/41243-01-mon-oth-01.pdf

[27] Lagarde, M., Palmer, N. (2008). The impact of user fees on health service utilization in low- and middle-income countries: how strong is the evidence? *Bulletin of the World Health Organization, 86*(11), 839-848. P. 842f

[28] World Health Organization. (2014*). Noncommunicable Diseases (NCD) Country Profile: Mongolia.* Retrieved from: http://www.who.int/nmh/countries/mng_en.pdf

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infrastructure in rural areas poses serious hurdles to the Mongolian health system. Thus, the main challenge for health care providers remains "to reach the scattered and constantly moving nomadic population"[29]. This situation is made even more difficult when one looks at the uneven distribution of physicians across the country: doctors tend to go or stay in Ulaanbaatar after medical school[30]. Because of the low population density, it is difficult in *aimags* like Ömnögovi – the least populated aimag of Mongolia located in the Gobi Desert, with more than four times the size of Switzerland, but a population of only slightly over 60.000 (2010)[31] – to provide high-quality specialized care with well-trained physicians and state-of-the-art technology. But even in Ulaanbaatar, we can find an uneven distribution of health facilities: public hospitals are located in the downtown area about an hour-long drive away from the *ger*-districts in which most of the (poorer) city population lives.[32]

A possible solution for the problem of large distances and sparse rural populations could be better use of telemedicine. Telemedicine aims at establishing contact between health facilities – e.g., between a city-based highly-specialized tertiary care hospital and a rural primary care center – to exchange information for the diagnosis, treatment and prevention of illnesses, but also for educational purposes.[33] Better-trained and experienced physicians in secondary and tertiary facilities could assist a general practitioner in the diagnosis and treatment of rare diseases by exchanging the relevant patient data. Increasing the exchange could lead to better knowledge and experience on both sides.

Telemedicine is more and more used in Mongolia, e.g., in the field of maternal and newborn health. Here, "[T]he early detection of pregnancy complications and timely management with the distance consultation of an expert team had contributed significantly to the reduction of maternal and newborn morbidity and mortality […]"[34]. With the implementation of telemedicine initiatives across the country, people do not have to travel long distances for tertiary medical care anymore; there is less need to drive or fly to Ulaanbaatar for the highly-specialized maternal care centers that are located only there.[35]

In 2009, a national telemedicine network was set up that connects hospitals and health departments to a virtual private network using high-speed internet for immediate transmissions. A new health department dedicated to the development of telemedicine was created,[36] which underlines the political acknowledgement of the important role of telemedicine in Mongolia. Telemedicine seems to be on a promising way for improving Mongolia's health system in the future.

4.6 Private medical care and outbound medical tourism

The Mongolian health care system cannot be seen as isolated from international developments. This chapter will analyze two challenges that stem from international trends in health care delivery: the expansion of private medical care and (outbound) medical tourism.

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[29] Manaseki, S. (1993). Mongolia: a health system in transition. *BMJ: British Medical Journal*, *307*(6919), 1609–1611. P. 1610

[30] Neumann, N., Warburton, D. (2015). A Review of the Modern Mongolian Healthcare System. *Central Asian Journal of Medical Sciences, 1*(1), 16-21. P. 17

[31] National Statistical Office. (2018). *2010 Population and Housing Census.* Retrieved from: http://www.toollogo2010.mn/medee_ID=239.html

[32] Neumann, N., Warburton, D. (2015). A Review of the Modern Mongolian Healthcare System. *Central Asian Journal of Medical Sciences, 1*(1), 16-21. P. 18

[33] World Health Organization. (2010). *Telemedicine. Opportunities and developments in Member States.* Retrieved from: http://www.who.int/goe/publications/goe_telemedicine_2010.pdf For more information on telemedicine in Mongolia, see also: Hefele, P., Reinold, M. (2018). Nachhaltige Entwicklung durch Digitalisierung? Wirtschaftliche, politische und soziale Perspektiven für die Mongolei. *KAS-Länderbericht.*

[34] Baatar, T., Suldsuren, S., Bayanbileg., Seded, K. (2012). Telemedicine Support of Maternal and Newborn Health to Remote Provinces. *Studies in Health Technology and Informatics*, *182*, 27-35. P. 27

[35] United Nations Population Fund. (2015*). In remote Mongolia, telemedicine connects pregnant women to faraway care.* Retrieved from: https://www.unfpa.org/news/remote-mongolia-telemedicine-connects-pregnant-women-faraway-care

[36] Asia Pacific Observatory on Health Systems and Policies. (2013). Mongolian Health System Review. *Health Systems in Transition, 3*(2). P. 91

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In Mongolia, an increasing number of private clinics and hospitals opened in recent years. Until the end of the 1990s, private health services have played a negligible role in the Mongolian health care system, mostly due to "past socialist values and state commitment to maintain the access to health services through a high population coverage of public prepaid schemes"[37]. Private health services expanded after gaining independence and after the opening of the economy for profit-oriented health providers. According to a World Health Organization study, the number of private clinics in Mongolia more than doubled between 2005 and 2016, with now more than 1076 medical facilities in place. In 2005, 1.982 beds were available in private hospitals; in 2016, this number has nearly tripled, making up approximately a quarter (!) of all hospital beds available in the country. In 2016, over two million outpatient visits were counted in private clinics and hospitals.[38] Yet, these private medical facilities have often only limited capacities, are highly specialized and located mostly in Ulaanbaatar. Nonetheless, private medical care in Mongolia is now a growing market with strong potential for growth and will heavily influence public health care delivery in the future.

Alongside the expansion of private medical care services in Mongolia, travelling to a different country for medical care became a new global phenomenon, known as *medical tourism*. Medical tourism is often the result of high prices for the medical intervention or inferior quality of medical care in many countries.[39] Outbound medical tourism from Mongolia to other countries can be seen as the result of "a lack of faith in the domestic health system combined with the hope for treatment afforded by seemingly limitless options abroad"[40]. Other reasons are e.g., the "provision of alternative ways and preventive examination"[41]. Mongolian doctors simply cannot perform difficult, high-end operations requiring state-of-the-art technology, which then forces patients to travel abroad and to pay by their own for necessary interventions.

In recent years, Mongolia's population was identified as a target market for international companies that provide medical services: recruitment offices from private, profit-oriented hospitals from Thailand, Israel and Korea have opened in Mongolia,[42] and a bilateral memorandum of understanding between Mongolia and South Korea had been signed to "facilitat[e] the development of the medical tourism industry between the two nations including the transfer of children with cardiac ailments to a Korean hospital"[43]. In South Korea, Mongolians were the fifth largest nationality (in 2010) seeking medical care.[44] Alongside South Korea, Mongolia's population is also one of the seven most important target markets for the Indian health industry.[45]

Both, the expansion of private medical facilities and outbound medical tourism impose various challenges to the Mongolian health care system. With the domestic expansion of private clinics and hospitals, inequalities between public and private medical facilities might increase. This could lead to a two-class health system: as the middle and upper classes grow, the demand for comprehensive, fast and up-to-date

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high-quality treatment will also increase. As the Asian Development Bank noted, there is a real danger that "the health system will become a dual system in which public facilities are used by the poor and private facilities by the better off"[46].

But there are also challenges that derive from the growth of outbound medical tourism: Medical tourism is not compatible with the World Health Organization's vision of universal, primary-care oriented health care delivery, because it increases inequalities and hampers the modernization of the domestic health care system. It might also pose risks to the traveling patient, not only because of strenuous flights after medical treatment, but also because of interrupted care and medical malpractice abroad.[47]

With the expansion of domestic private medical facilities and Mongolians seeking medical care abroad, the country might also face a "brain drain" of skilled medical labor force from public facilities to the private ones. Brain drain in the medical sphere is defined as "the migration of health personnel in search of the better standard of living and quality of life, higher salaries, access to advanced technology and more stable political conditions in different places worldwide"[48]. In Mongolia, domestic as well as outbound public-to-private brain drain is already a widespread phenomenon. Pull factors are, amongst others, "shorter hours, less bureaucracy, and salaries up to five times higher"[49].

How can the Mongolian public health care system cope with these two challenges? To some extent, both originate from wide-spread dissatisfaction with the national health care system and medical care delivery. Outbound medical tourism growth highlights this dissatisfaction even more as patients cannot obtain an adequate treatment in Mongolia and travel thus abroad. Utilization of private and international health services is therefore a good indicator of the shortcomings of the domestic health care system.

The Mongolian health care system will only be able to cope with these two developments - and with all the above-mentioned challenges - by significantly improving its performance in various fields:

- new (economic) incentives need to change patient behavior in using medical care;
- primary care and preventive medicine have to be strengthened;
- political, administrative and fiscal responsibilities have to be shifted from the central level to *aimags* and *soums*;
- teaching methods have to be modernized and teaching personnel have to attend further education;
- the scope of medical services covered by SHI and by the public budget has to be clarified; in this context, OOP payments have to be drastically curtailed for reasons of social justice;
- health-related spending will contribute to the growth and diversification of the Mongolian economy. Amongst others, telemedicine and digitalization will play an important role in this respect.

All these steps will lead to a more efficient, modern, comprehensive and truly universal health system that satisfies the needs of the Mongolian people but keeps health personnel in the public health care system of Mongolia.

5 Conclusion

The Mongolian health care system has changed drastically since the country gained independence from the Soviet Union. It managed to reform and adapt in order to counterbalance the loss of the Soviet "nerve center" that financed, planned and decided everything in the realm of health policy over seven decades. New devel-

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opments like the rapid growth of private hospitals and medical tourism, as well as the heritage of the Semashko model still pose considerable obstacles towards a more effective, inclusive and universal health system that Mongolia urgently needs. Reforms have to take even more into account international developments, historical roots, behavioral patterns and spatial factors. Determined, stable and long-term policy-making has to be set up as a reliable framework both for the public as well as the private sector. Any further development of the country is closely connected to an improved health situation of its people.

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