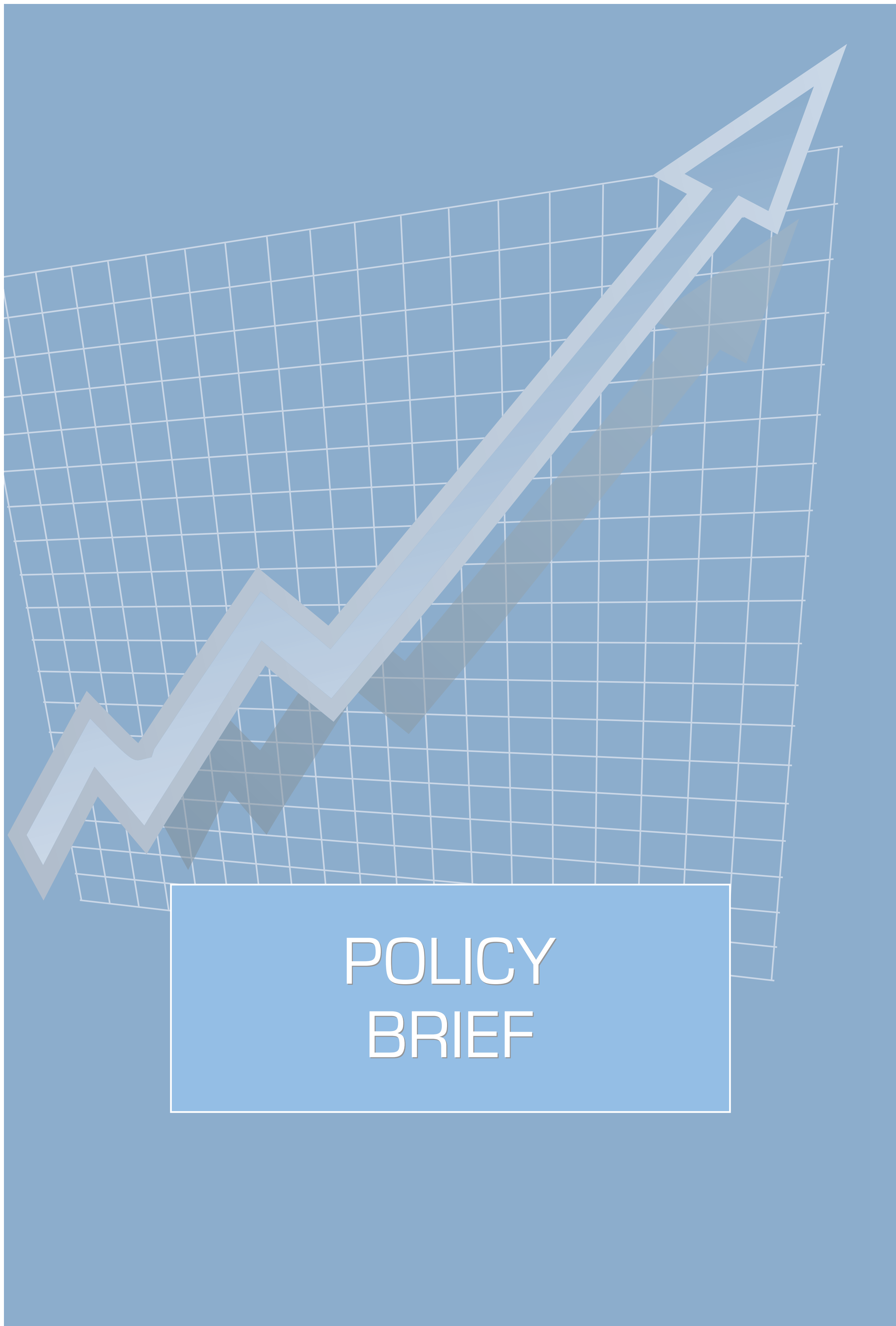

POLICY
BRIEF

# POLICY BRIEF

## Financial Burden of Health Payments in Mongolia

The World Health Report 2010 drew attention to the fact that each year 150 million people globally are facing catastrophic health expenditures, out of which 100 million people are impoverished as a consequence and called for universal protection from health-associated financial risks. The report emphasized that containing the direct payments at 15-20% of the total health expenditures[1] will relatively reduce the financial catastrophe faced by households and avert impoverishment and recommended countries to mobilize resources for health care in advance. Countries of the Southeast Asia and Western Pacific Regions record highest rates of direct payments for health among population, which is an important concern[2]. Therefore, a study on financial burden caused by health care expenditures using WHO methodology was conducted in six countries of the region in 2010-2011, namely, Cambodia, China, Laos, Mongolia, the Philippines and Vietnam. The study was done in each country based on their household income and expenditure surveys, with exception to the health services surveys used in China. Mongolia used data from the 2009 Household Socio-Economic Survey. This survey is nationally-representative of Mongolia's total population.

This policy brief presents the main findings and policy recommendations of the study made on direct payments for health incurred by individuals and households in Mongolia. In addition, the policy brief presents results from a comparative report on access to care and the burden of health payments in six Asian countries, including Mongolia.

## 1. Health financing system of Mongolia

The main sources of health financing are government budget, health insurance fund (HIF), private payments and foreign donations, aid and assistance. Health Department statistics show that, in 2011, 76.0% of national health financing come from government budget, 20.9% from HIF, 3.3% from individual payments and other income[3]. Data from the World Health Statistics show that, as of 2009, 54.8% of total health expenditures come from government budget, 45.2% come from private financing which has risen by 26.6% against the 2008 level. 92.1% of private financing are the direct payments made at a point of service delivery[4].

Figure 1 shows the total health expenditure, broken down into general government and private expenditures on health, as a percentage of GDP for the six countries covered by the study. General government expenditure on health as a percentage of GDP is declining in Mongolia and the Philippines.

1 *Total health expenditures: all expenditures made for health such as private and government financing, health insurance, private hospital payments, drug expenditures etc*

2 *WHO Asia Pacific Regional Health Financing Strategy*

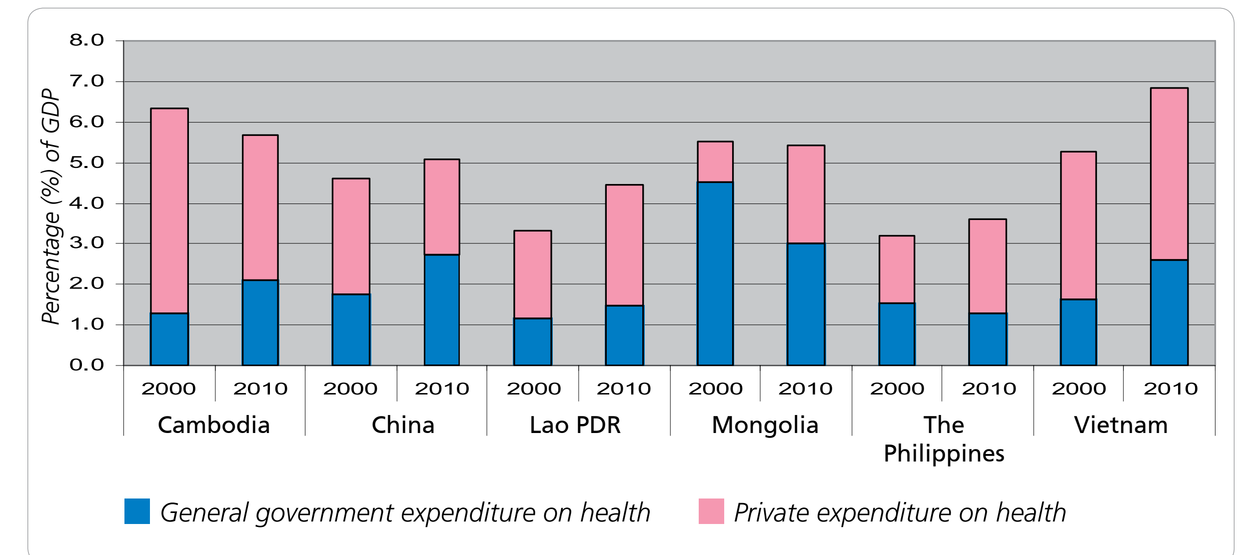
3 *Health indicators, Health Department, 2011*

4 *World Health Statistics, 2011, 2012*





*Figure 1: Total, general government, and private expenditures on health as percentages of GDP*




***Source:*** *Access to care and the financial burden of health payments in six Asian countries: a cross-country comparative report, 2012.*

The Law on Health stipulates the government to finance health care services provided during pregnancy and delivery, TB, cancer, public health and primary health care. As for HIF, it finances a certain percentage of aimag (province), district and central hospital outpatient and inpatient services, day care at the aimag and district hospitals, inpatient services of traditional medicine, sanatoria, rehabilitative services, palliative services and discounts on drugs prescribed by bagh and soum [5]doctors.

The Citizens' Health Insurance Law came into force in 1994 and stipulates that every citizen of Mongolia is to be covered by compulsory health insurance. The government pays contributions of vulnerable social groups such as pensioners, children up to 16 and citizens with disabilities. Herders, self-employed, unemployed and students pay their contributions by themselves. In recent years HI coverage of the population did not see significant rises (84.9% - in 2000, 80.7% - in 2007, 77.5% - in 2009, 82.5% - in 2010) but when the Human Development Fund paid their contributions in 2011 the coverage reached 93.4 percent. However, it should be noted that it was a one-time measure and citizens who pay their contributions by themselves are not fully covered by health insurance.

The Mongolian Government approved the National Strategy on Health Financing for 2010-2014 which is being implemented currently. The main purpose of this strategy is to deliver equitable and accessible quality health care services to the population and to protect them from health-associated financial risks. The strategy put forward the goal to contain the amount of OOPs within 25% of the total health expenditures.

5 *Aimag (province) is splitted into smaller district or soum in rural area.*

Mongolia had relatively low rates of direct out-of-pocket (OOPs)[6] health expenditures, but since 2005 has been increasing to reach 41.4% of the total health expenditures in 2010. Table 1 shows this indicator in six countries covered by the study.

*Table 1. Percentage of OOPs in total health expenditures*

| | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Cambodia | 71.2 | 61.7 | 58.9 | 51.6 | 50.6 | 56.3 | 72.5 | 47.3 | 46.7 | 42.3 | 40.4 |
| China | 59.0 | 60.0 | 57.7 | 55.9 | 53.6 | 52.2 | 49.3 | 44.1 | 40.4 | 37.5 | 36.6 |
| Laos | 59.6 | 50.3 | 50.8 | 55.8 | 62.4 | 65.7 | 65.3 | 66.4 | 56.8 | 50.7 | 51.2 |
| Mongolia | 12.1 | 10.5 | 16.9 | 15.2 | 8.7 | 15.8 | 23.2 | 30.3 | 40.0 | 41.6 | 41.4 |
| Philippines | 40.5 | 43.9 | 46.8 | 46.9 | 46.9 | 49.2 | 52.3 | 54.3 | 56.4 | 54.2 | 54.0 |
| Vietnam | 66.0 | 64.5 | 64.3 | 62.9 | 66.5 | 67.6 | 62.1 | 55.7 | 61.2 | 57.9 | 57.6 |

***Source:*** *WHO Global Health Expenditure Database*

User fees exist both in primary health care and medical care. Primary health care providers are financed by capitation method from the government budget. The health insurance fund reimburses pharmacies for discounts of 50-80% on essential drugs prescribed by family group practices and soum health centers which provide primary health care.

Prices for drugs provided through outpatient services of other level hospitals are paid by clients themselves. Also, users of outpatient and inpatient services must pay out-of-pocket for some kinds of diagnostics and testing which are regulated by the order of the Health Minister. About 10-15% of expenditures of inpatient services financed from HIF are copayments. Accredited private hospitals and sanatoria are financed by HIF and also collect user fees.

## 2.Findings of the study

### *a) Who is getting what kind of heath care services?*

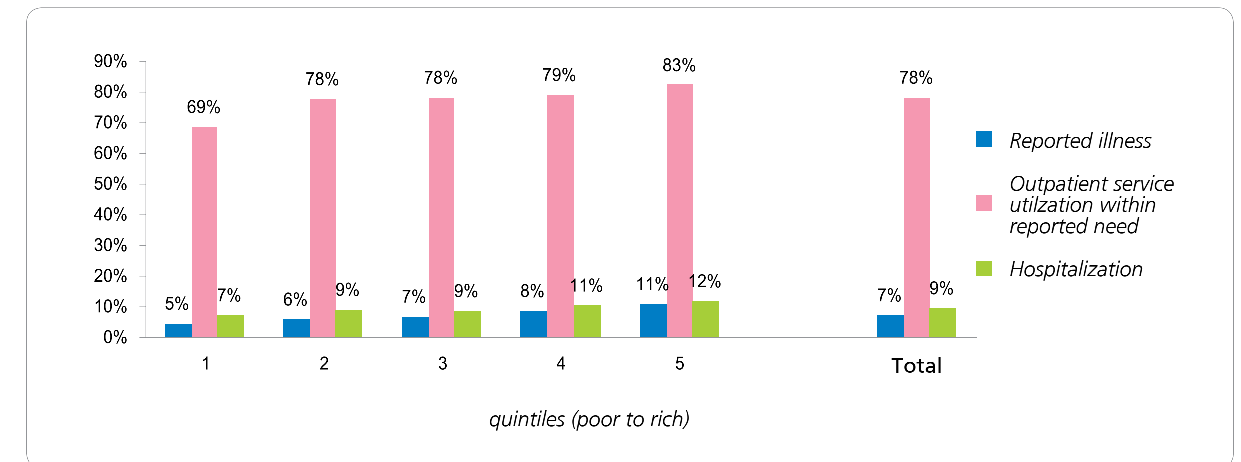
The population covered by the study was divided into quintiles by expenditure level which showed that health care services needs and utilization have increased corresponding to the increase in expenditure. The poorest quintile has the lowest utilization of health care services and other quintiles are more or less at the same level (Graph 2).

6 *Data came from different sources.*



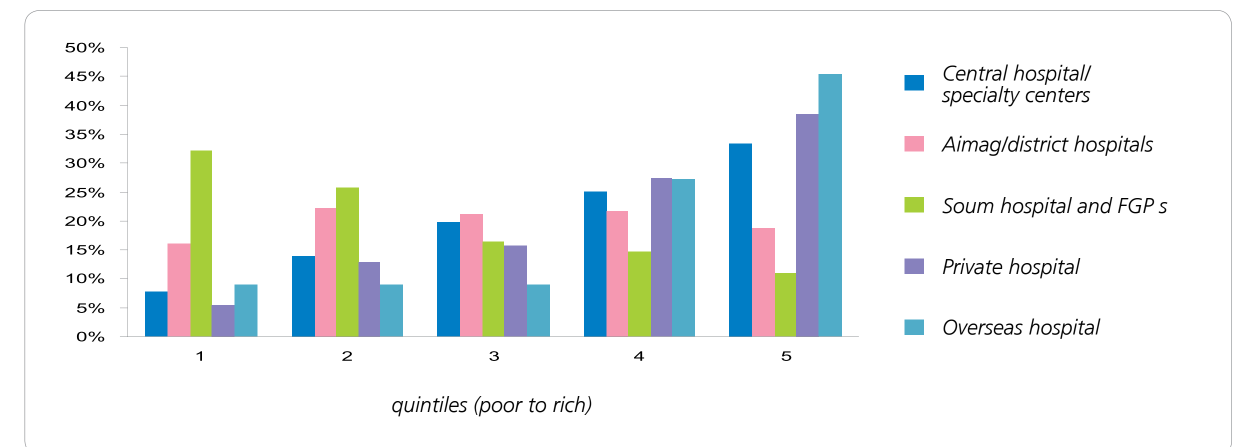


*Graph 2: Needs and utilization of health care services, by expenditure quintiles*




For instance, 7% of the poorest quintile received inpatient services whereas 12% percent of the richest quintile utilized inpatient services. Also the percentage of users of outpatient services among the richest quintile is higher by 14 points. The percentage of people who used inpatient services of central hospitals, specialized centers, private hospitals and hospitals abroad has increased as the expenditure level of the population increased whereas the percentage of users of soum health centers and family group practices has decreased (Graph 3).

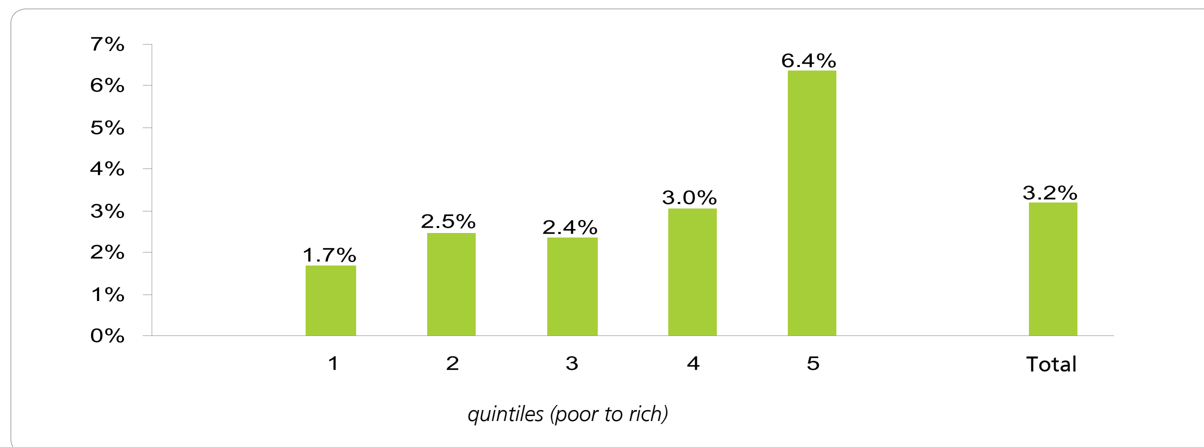
*Graph 3: Utilization of inpatient services among respondents, by expenditure groups*




### *b) Who paid how much for which health care services?*

When disaggregated by income level of population groups it shows that the weight of OOPs in the total household consumption expenditures increased with rise in income (Graph 4). These findings are similar to those in other 5 countries. The poorest quintile has paid 4 times less than the richest quintile and the richest quintile paid 3 times more than the middle quintile. This can be related to utilization and seeking of health care services by the poorest and middle quintiles.

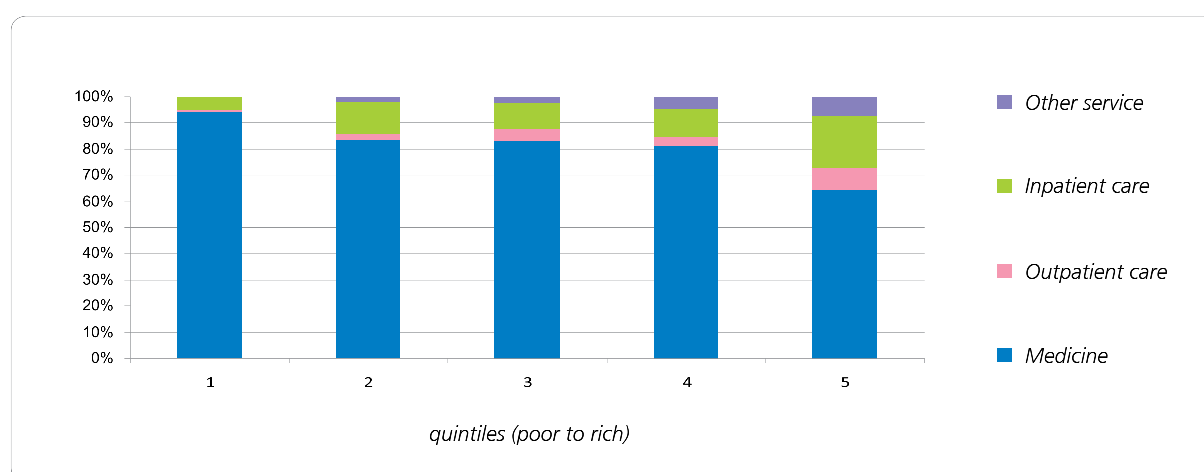
*Graph 4. OOPs for health care services, by expenditure groups*




According to the survey on access to care and the financial burden of health payments in six Asian countries, Mongolia and the Philippines have the largest ratios for OOP health expenditures. The wealthiest quintile in these two countries pay over 20 times the amount of OOP health expenditures compared to the amount that the poorest quintile pays. Drug expenses occupy the largest portion of OOPs in Laos, the Philippines and Mongolia among countries covered by the study. This percentage is about 90% in Laos and 66% in Philippines.

In Mongolia, these expenses constitute 95% of direct health payments among the poorest quintile and 60% of expenses among the richest quintile. This shows that the poorest quintile purchase drugs instead of using inpatient and other services. Also drug discounts are not very effective for insured and not linked with the benefit package, some drugs are sold without prescriptions which contribute to increase of drug expenses.

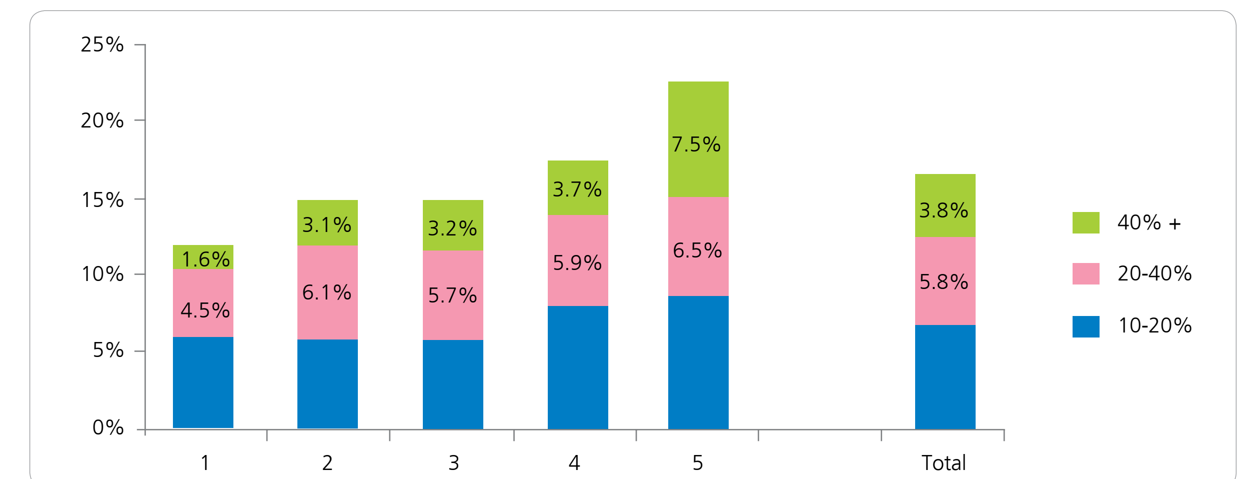
*Graph 5: Structure of OOPs, by expenditure groups*




*c) How OOPs affect household finances?*

The percentage of households which incurred catastrophic health payments among countries covered by the comparative study varies between 1.2% (Philippines) and 5.5% (Vietnam). In 2009 3.8% of total households of Mongolia have incurred catastrophic expenditures on health[7]. This means 27,442 households. Also in Mongolia, not only poor but also rich households face catastrophic expenditures on health.

*Graph 6: Percentage of households which faced catastrophic expenditures, by income groups*




In terms of expenditure groups, 1.6% of households in the poorest quintile and 7.5% of households in the richest quintile incurred catastrophic expenditures on health. The study found that better-off households mostly use services of private hospitals and hospitals abroad.

## 3. Policy recommendations

Following recommendations are formulated as a result of the study:

*a) Improve health financing policy at the national level*

- The health financing system should aim at universal health coverage and protection of population from health associated risks. In order to achieve this purpose, it is needed to improve the health insurance system in line with the national health financing strategy and to formulate a long-term policy to reach universal coverage through health insurance. It is necessary to establish an independent health insurance organization and develop it as a strong purchaser. In order to make purchasing effective, it is needed to gradually integrate the government budget funds into HIF.
- In order to define an evidence-based policy, it is necessary to conduct studies such as this one on a regular basis, to use household socio-economic surveys, and to create capacity to regularly update national health accounts.

*b) Increase access of health care services for poor*

- There is a need to increase HI coverage of very poor and by doing so enable them to receive outpatient and inpatient services. On this end, it is necessary to create a policy and mechanism to target specific groups like the very poor and social groups that pay contributions by themselves such as herder and students.

7 Catastrophic health expenditures mean the percentage of direct payments for health care services equal or exceed 40 percent of expenses spent on non-food items of the household.

- OOPs made for health care and drugs are the biggest factor affecting utilization of health care by the poor. Therefore, there is a need to review the current policy to free poor citizens from user fees. Also implementation of such mechanisms as providing incentives to health facilities that provide health care services to very poor and incorporate such provisions in the contracts established with HI organization can be effective. Also, drug discounts can apply to all drugs prescribed by doctors of primary health care.
- The study showed that family and soum health centers are the main organizations that provide health care services to poor and vulnerable groups. Therefore, in order to create a mechanism to promote health care provided to the poor and vulnerable, it is needed to increase the amount of payments made to family and soum hospitals by capitation method.

*c) Protect population from health associated financial risks*

- In order to protect the population from health associated financial risks, it is recommended to expand the benefit package, increase population coverage of the fund made of prepayments, cut the amount of official and unofficial direct payments and to implement a policy to improve quality of health care. The benefit package, first of all, needs to aim at financial risk protection. The benefit package is to be expanded by inclusion of health care services with high OOPs to possible extent.
- Because drug purchase expenses constitute the largest portion of OOPs for both wealthy and poor households, it is important to cover outpatient drugs by HIF. The current system of drug discounts funded by HIF is not realized to satisfactory level because the discounts are not profitable to pharmacies, doctor's prescriptions do not have incentives and clients have limited knowledge about the system.
- In order to protect wealthy citizens from health-associated financial risks, it is important not only to provide outpatient drug price discounts but also to improve quality of health care and increase public trust in providers. It is important to implement financial and non-financial incentive mechanisms to support improvement of health care quality in public hospitals. Health insurance with purchasing capacity is to play a crucial role in this and will facilitate implementation of other policies. Also, it will help monitor expenditures spent by the population on private hospitals and hospitals abroad.