Transition to the strategic purchaser model and future sustainability

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1ST INSPIRE HEALTH FORUM

ADB

STRATEGIC PURCHASING REFORM, MONGOLIA

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Overview of Mongolian health system

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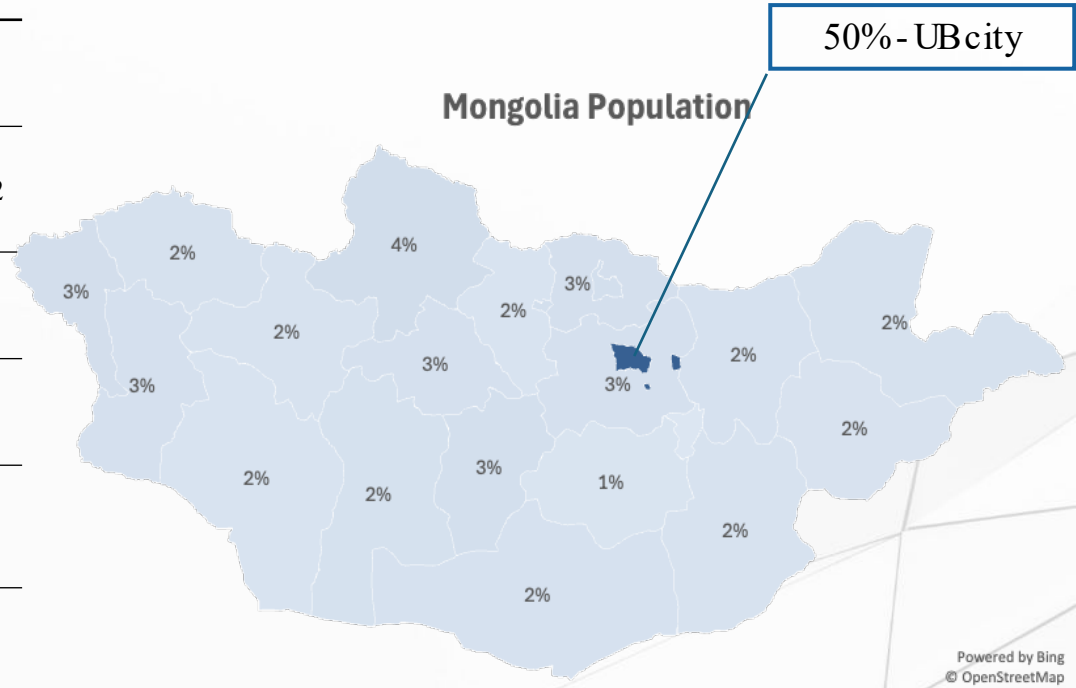
№	Indicators	2020	2021	2022	2023	2024	2025
1	Population	3,357,542	3,409,939	3,457,548	3,504,741	3,544,835	3,593,272
2	GGHE share of GDP	3.1%	4.1%	3.3%	2.8%	3.2%	3.0%
3	GGHE share of GGE	8.3%	11.0%	9.6%	8.9%	8.3%	8.8%
7	PHC budget share of GDP	0.7%	0.8%	0.7%	0.6%	0.8%	0.7%



→50% of the population lives in Ulaanbaatar city.
→The health system is dominated by public hospitals.
→The pharmaceutical supply system has been fully privatized.
→The country has a compulsory social health insurance system with 95% population coverage.
→57% of Health Insurance fund are financed from the state budget.
→According to the 2021 National Health Accounts, OOPs accounted for 33%, with 80% of this amount spent on outpatient medicines.
→"The health system remains inefficient, characterized by an oversupply of human resources and hospital beds, low utilization rates, and a high number of unnecessary hospital admissions."

Transition of Strategic purchasing

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2000-2019

Prepared health financing reform
- Single purchaser
- Transition line item to DRG
- Line item to Capitation
- Health insurance new law
- Medical service law
- Hospital semi autonomy model

2021

Introduced DRG payment for hospital
- Combined FFS, Line item to DRG

2022

Introduced blended PHC PPM
- Doubled PHC funding capitation
- P4P for 9 KPI for all PHC
- Rural hospitals using DRG for emergency, ambulance and inpatient

2023

Introduced DRG version 4.0
- Geographic adjustment
- Incentive for level of care
- % copayment to fixed copayment
- Soft cap to MRI, CT

2024

Introduced DRG version 5.0
- Bundled outpatient DRG which is combined CT, MRI, lab some tests
- Excluded Chemotherapy medicine from DRG
- Introduced salary index

2020

Introduced Health financing reform
- Single purchaser model, HI is main purchaser
- Public hospital semi autonomy model
- Doubled PHC funding

2021

Upgraded claim review system
- Electronic claim review
- Real time monitoring
- UpToDate clinical guidelines

2022

Introduced Selective contracting
- Organized national selective contracting based on quality, standard and population needs

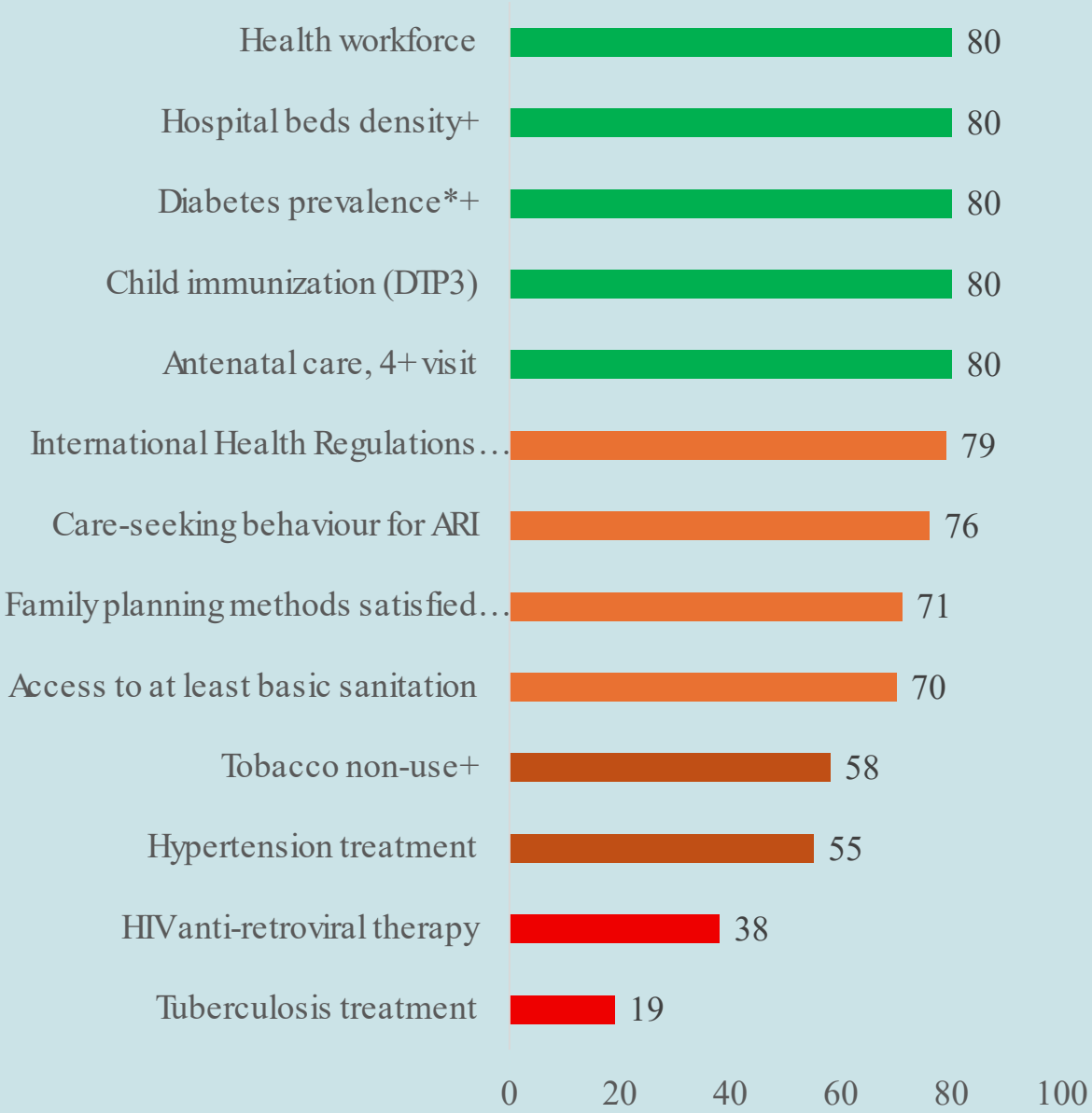
2024

Introduced volume contracting
- Categorized essential and nonessential
- Volume contract with Case mix point

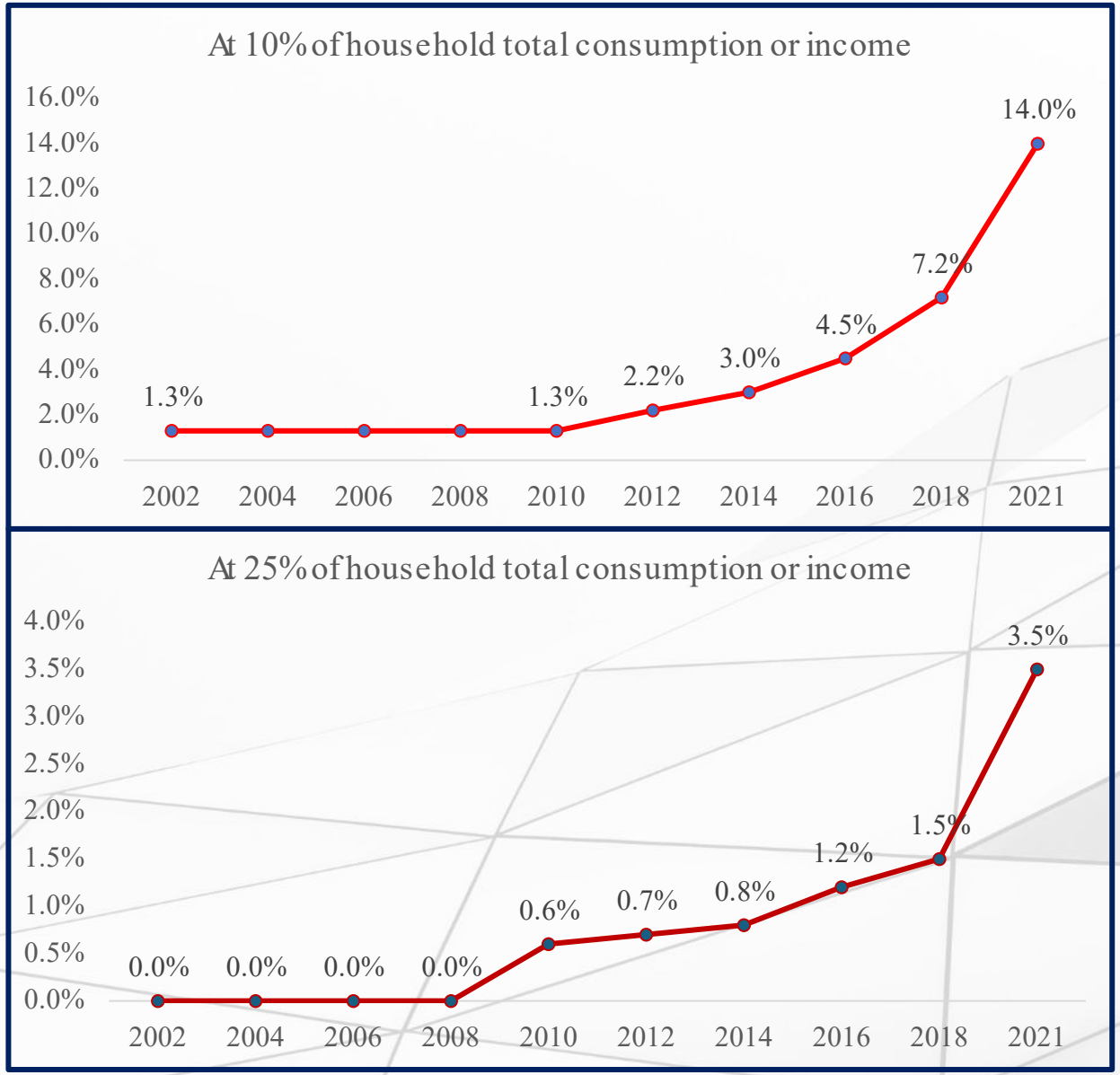
2025

Introduced DRG version 6.0
- Introduced hard and soft volume cap
- Categorized chronic, planned and acute
- Incentive for decentralization
- Volume contract and financing regulation

Service coverage index SDG 3.8.1



Financial protection SDG 3.8.2



Composition of OOPs Mongolia

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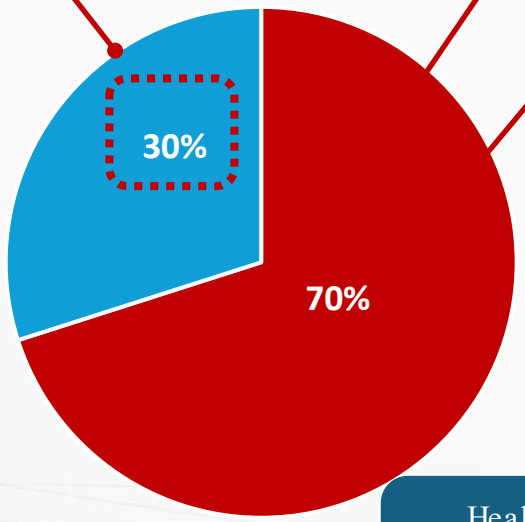
Inpatient medicines and medical devices included DRG tariff

people should pay:

- If not contracted with HIGA hospital or
- not included services of Health insurance benefit package



Nonessential medicines 74%

Essential medicine 26%

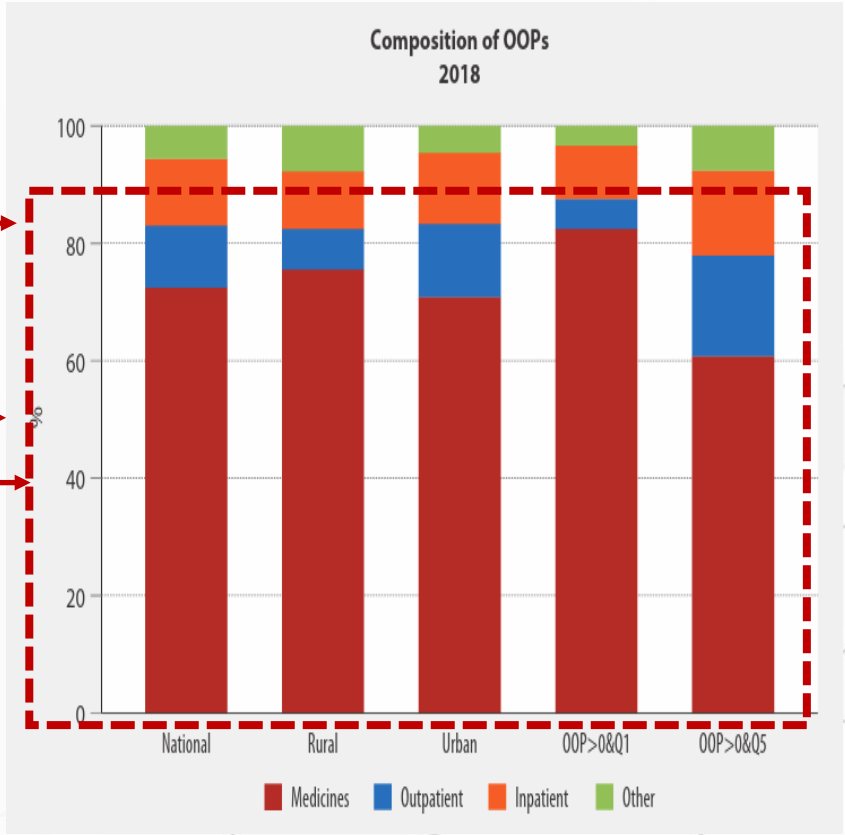
HIGA reimbursement Selection criteria

Yes

No

Copayment

Health insurance drug reimbursement list
- 150 International name
- 30-70 percent discounted



Outpatient medicine is main cost driver of OOPS Mongolia

Recognizing inefficiencies in a resource-abundant yet underperforming system, the government defined the scope of strategic purchasing to drive improvements.

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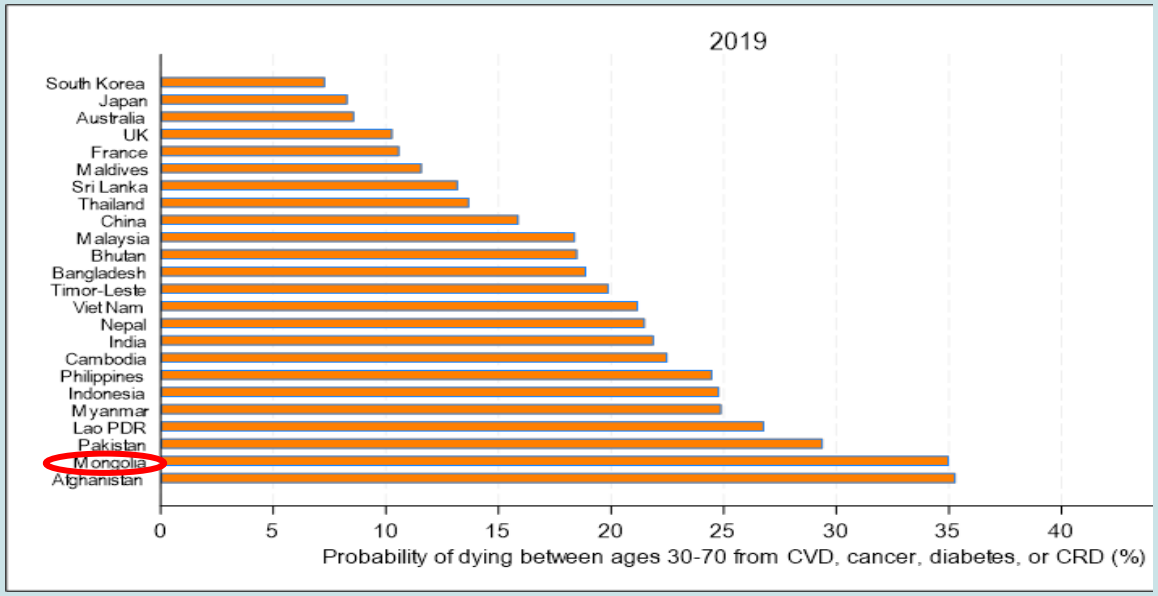
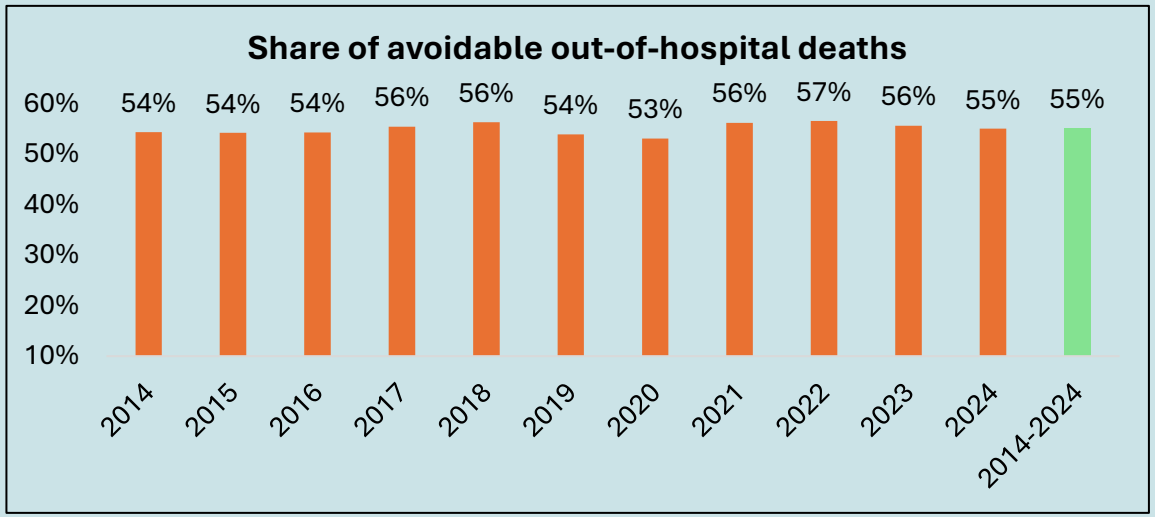
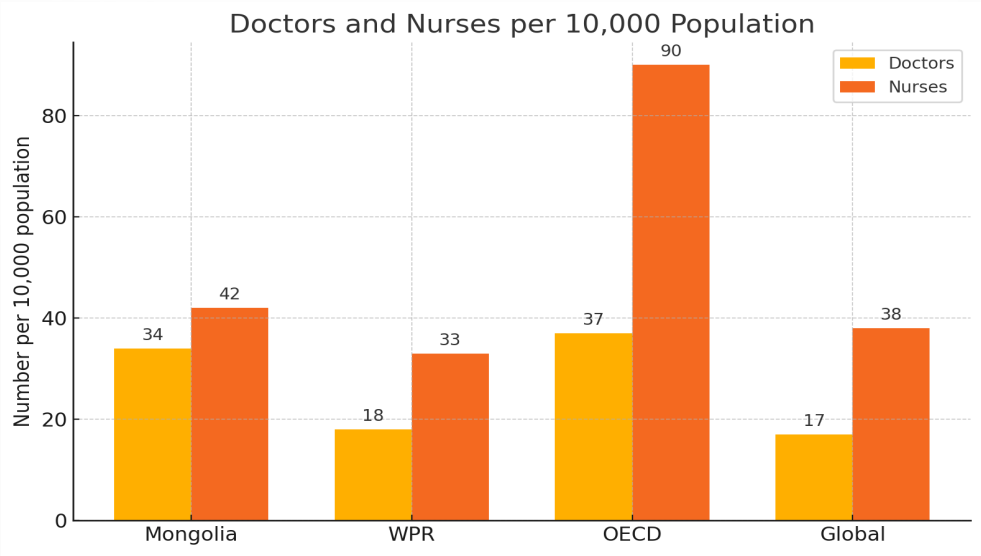
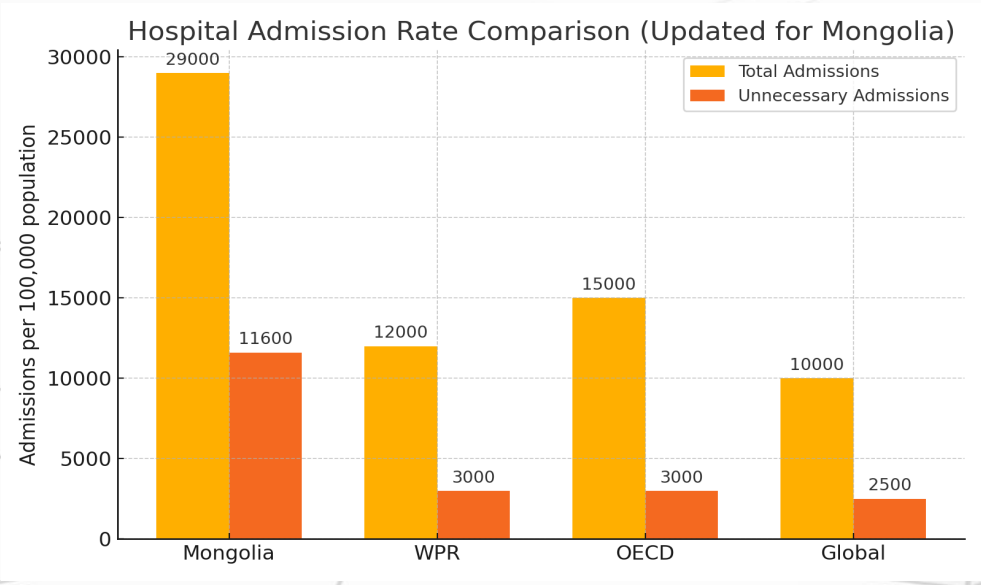
Premature deaths









Health financing policy 2017-2026

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	Policy objectives	Target 2026
Revenue raising	1. Increase the amount of the state budget spent on health 2. Increase the subsidy of vulnerable peoples who are responsible for the contributions from the government 3. Reducing the share of OOPs in total health care spending	• Increase the GGHE expenditure to 5 percent of GDP and 12 percent of GGE • Reducing the THE share of OOPS from 36 percent to 25 percent
Pooling	1. Pooling funds state budget to health insurance fund 2. Increase risk-sharing capabilities 3. Eliminate fragmentation of funding	• By 2026, 40 percent of the state budget will be pooled into the Health Insurance Fund
Purchasing	1. Reduce the passive financing of providers and create a strategic purchasing system 2. Support primary care and services	• Create a strategic purchasing system • Increase funding for primary care and services to 1% of GDP recommended by WHO

Trends and Dynamics of Health Financing in Mongolia

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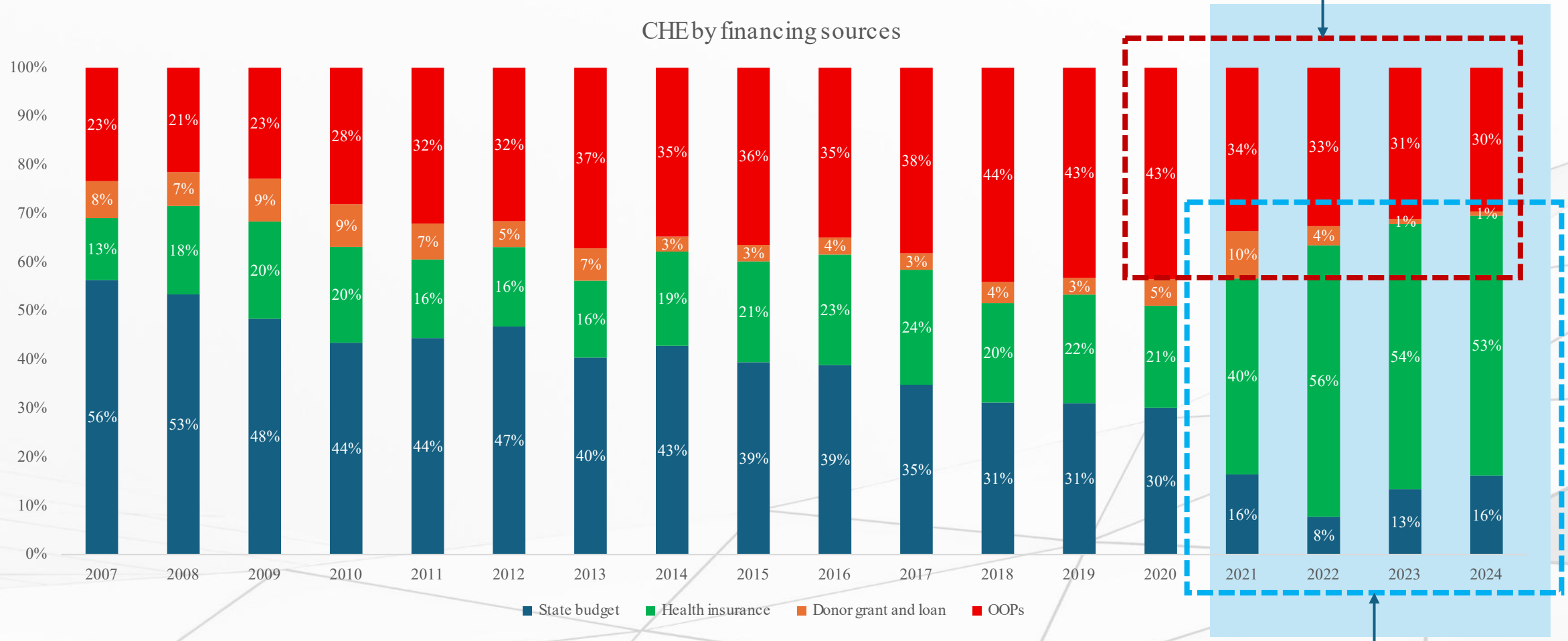
Out-of-Pocket Payments (2007–2022 actuals; 2023–2024 estimates)



A unified national pool was established, designating the Health Insurance Authority as the system's main purchaser.

2021 ESTABLISHED SINGLE NATIONAL POOL, HIGA is main purchaser

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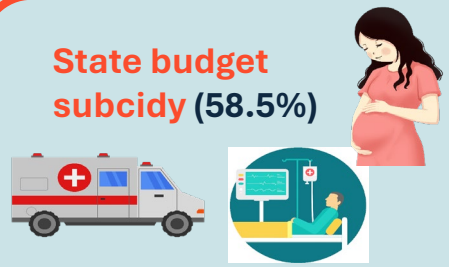
GGHE (9% of GGE)

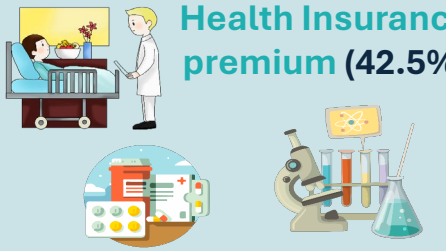
Ministry of Health (18.6% of GGHE)

Investment, Administration, Public health

State budget subcidy (58.5%)



Health Insurance premium (42.5%)



Health Insurance Fund (81.3% of GGHE)

70% for DRGs

- 80% for Public hospitals
- 20% for Private hospitals

21.5% for Capitation

- 24% for Private GPs
- 61% for Public PHC providers

6% Drug reimbursement

2.5% for other

- 95% for private pharmacy

Current Health Insurance Benefit Package and Provider Payment Mechanisms

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Service type	Benefits package	Providers	Tariff	PPM	Share of Health insurance fund budget and copayment
Primary care	• Prevention • Control CDs and NCDs • Treatment	• GP - private • Soum health center – public, located rural remote area	10 USD – 30 USD per capita with geographic adjustment	Risk adjustment Capitation payment with P4P (9 indicators)	• 16.2 % share of HI budget • no copayment
	• Lab test and image • Rehabilitation • Home care • Day care		5 USD – 42 USD depending on the type of services	Case based payment with budget cap	• 2.6 % share of HI budget • no copayment
	• Emergency, ambulance, inpatient care	• Soum health center – public, located rural remote area	• 4.1 USD – 34000 USD • Same tariff, no balance billing	700 DRGs with soft cap	• 4.1 % share of HI budget • no copayment
Drug reimbursement	• Essential medicine list /600 medicine/	• Pharmacy - private	1 USD – 27.7 USD	Fee for service – 30-70 percent	• 6.5 % share of HI budget • 64 % of the total cost is paid out-of-pocket by patients
Hospital care	• Maternal and child services • Inpatient, Outpatient, day care • Emergency care • Other hospital service	• Public hospitals • Private hospitals	• 4.1 USD – 34000 USD • Same tariff, no balance billing	700 DRGs with a soft cap	• 66.7 % share of HI budget • 1.8% copayment • Vulnerable people and acute care copayment exempted
	• Chronic medicine /TB, Mental, Insulin etc/ • Targeted chemotherapy		• 5 – 839 USD per case, depending on service	Global budget	• 1.7 % share of HI budget • no copayment
Screening and Early detection	• Pregnant woman and infant baby screening • 6 type cancer early detection • School based early detection (Teeth, Eye, Hearing)	• PHC providers • Public hospitals • Private hospitals	• 5.5 USD – 150 USD	Case based payment	• 1.5 % share of HI budget • no copayment

Selective contracting – From whom should services be purchased?

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Provider Selection Process

Before

- Selection of providers was largely symbolic, with no formal methodology—only document review was conducted.
- Budgets were allocated per contract, and providers claimed any services they preferred within that budget. Private providers often captured the majority of the funds.
- There was limited alignment with national health policy priorities.

After

- Competitive selection is now conducted for specific services.
- **Provider capacity to deliver quality services is assessed prior to contracting.**
- **The process is fully digitalized, and dual practice is prohibited.**
- Efforts are being made to align services with population needs, though full success has yet to be achieved.

Contracting

Before

- The fund frequently lost legal disputes.
- Contracts lacked sufficient legal strength and clarity.
- There were no performance or quality-based evaluation criteria.
- The contract evaluation process was subjective and poorly aligned with national policy.

After

- Legal aspects of contracting were strengthened.
- Improvements were made in linking contracts to legal documents governing termination, penalties, and performance review.
- **Evaluation criteria, scoring methodology, and digital tools were introduced.**
- The new contracting approach has been fully implemented at the primary care level.

Provider payment - How should providers be paid?

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Before

- The system was dominated by rigid line-item budgeting with poor efficiency.
- High-cost services not included in the main insurance package were reimbursed on a fee-for-service basis.
- **Private providers practiced balance billing, charging patients the difference without any regulation.**
- Public hospitals lacked regulation on user charges and often charged for services already covered by insurance.
- In primary care, the main payment method was capitation, accounting for 95%, which incentivized unnecessary referrals to higher-level facilities.

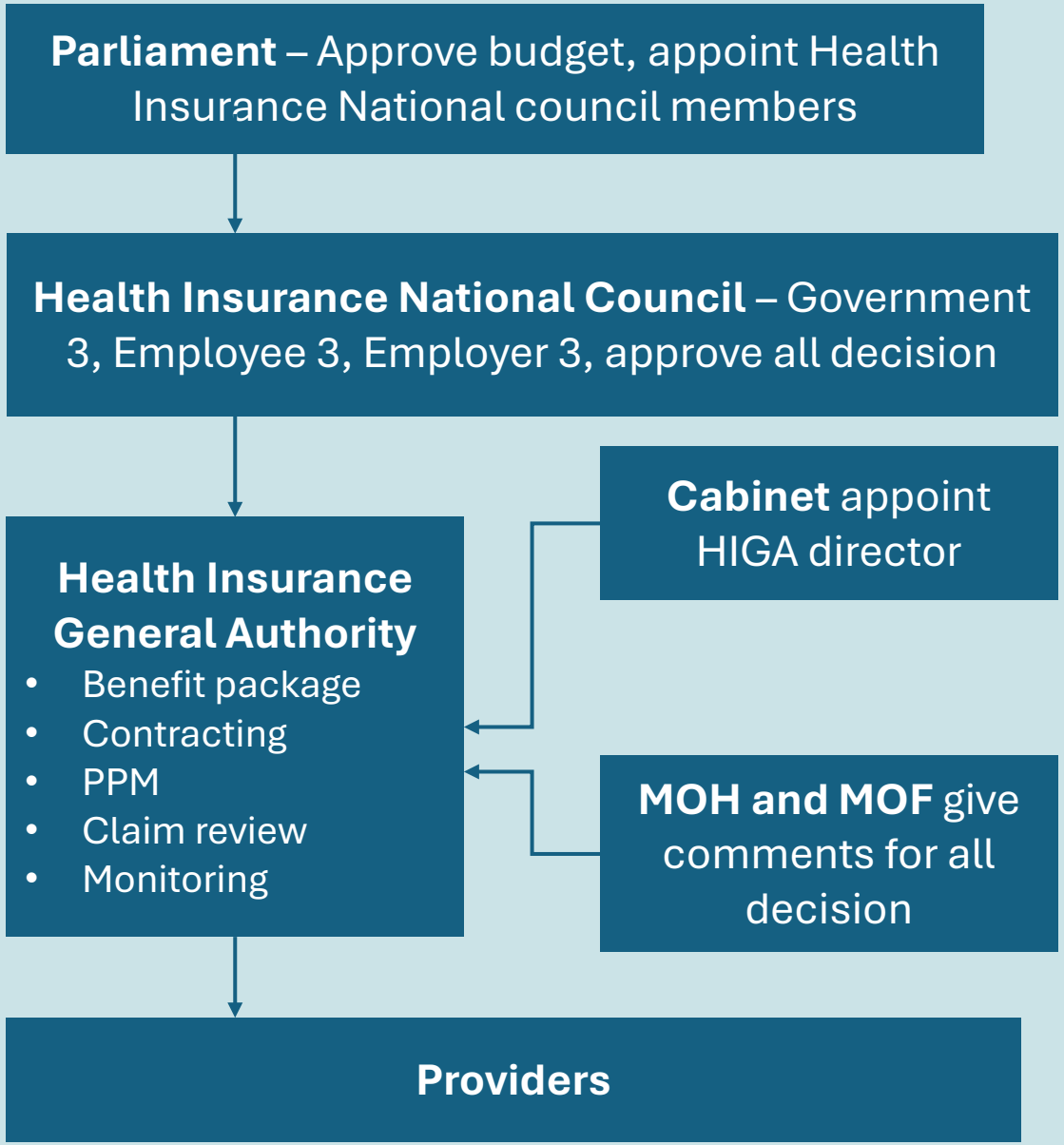
After – Moving Toward Output and Outcome-Based Provider Payment System

- Line-item budgeting was fully replaced with **Diagnosis-Related Groups (DRG)**.
- DRG tariffs were intentionally set below actual cost for low-priority, volume-heavy services to discourage overuse.
- Tariffs for essential and underutilized services were increased and linked to incentives to promote access.

- **Balance billing was strictly prohibited**, and a citizen monitoring mechanism was introduced. Providers are now penalized for charging patients above approved rates.
- Regulations and caps were introduced on paid services in public hospitals, which now account for only 1.8% of total hospital revenue.
- Public hospitals' interest in providing insured services increased, resulting in rising claims and **financial strain on the Health Insurance Fund**, partly due to COVID-19 impacts.

- Starting in 2024, **volume-based budgeting** was introduced:
  - **Hard caps** were applied to chronic disease services
  - **Soft caps** were applied to high-priority, essential services

How is purchasing performance monitored and governed?



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Key Achievements

- All health service claims were fully digitalized and transitioned to a real-time system.
- **A performance monitoring system was established, and dashboards were developed for claims, contracting, financing, and quality control.**
- Annual performance reports are now produced based on routine monitoring data.

Challenges

- **Although key policy decisions are made by the National Health Insurance Council (NHIC), the Ministry of Health remains heavily involved in operational decisions.** For example, COVID-19-related decisions led to financial liabilities for the Health Insurance Fund.
- The NHIC lacks authority to appoint the Director of the Health Insurance Organization; political influence remains high.

The main challenge is maintaining the financial balance of the Health Insurance Fund. However, tangible results have been achieved through targeted measures.

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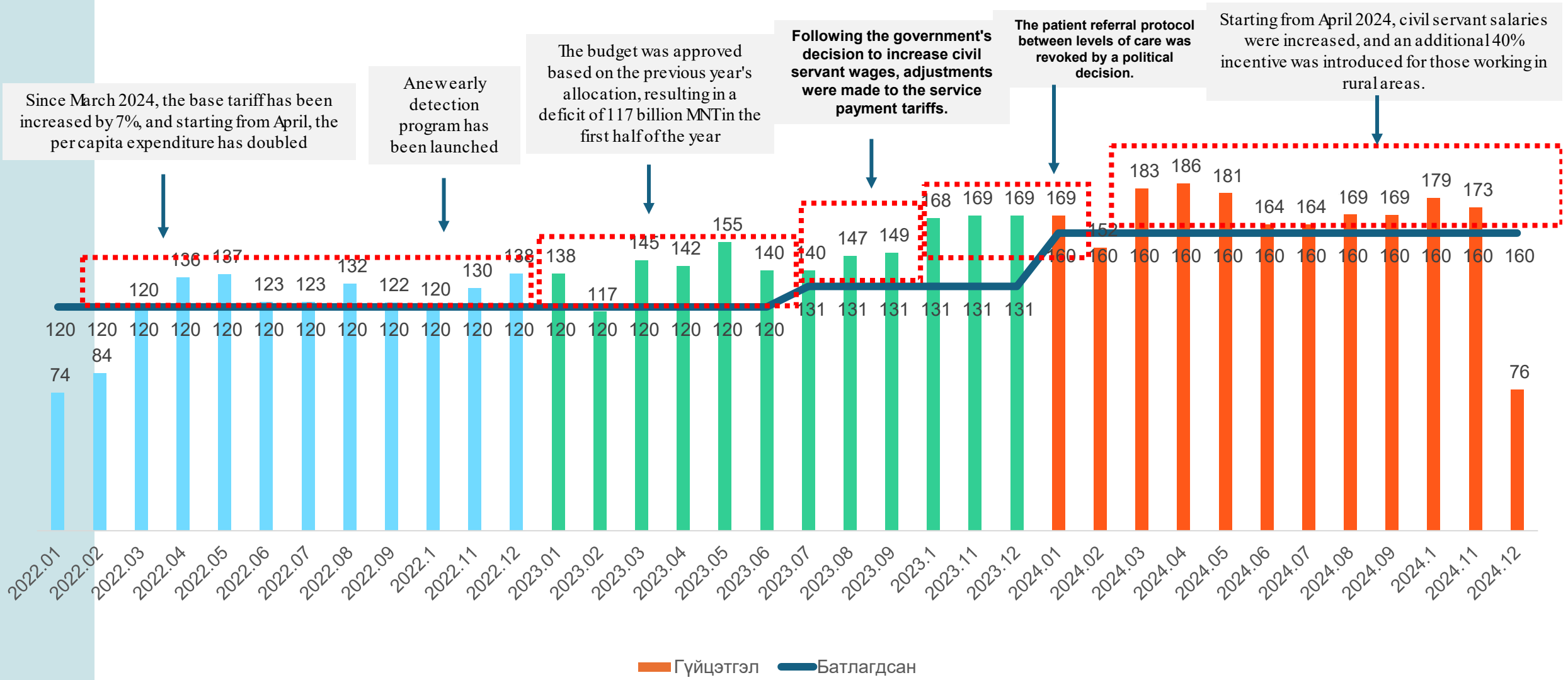

Key Achievements Following the Introduction of Strategic purchasing

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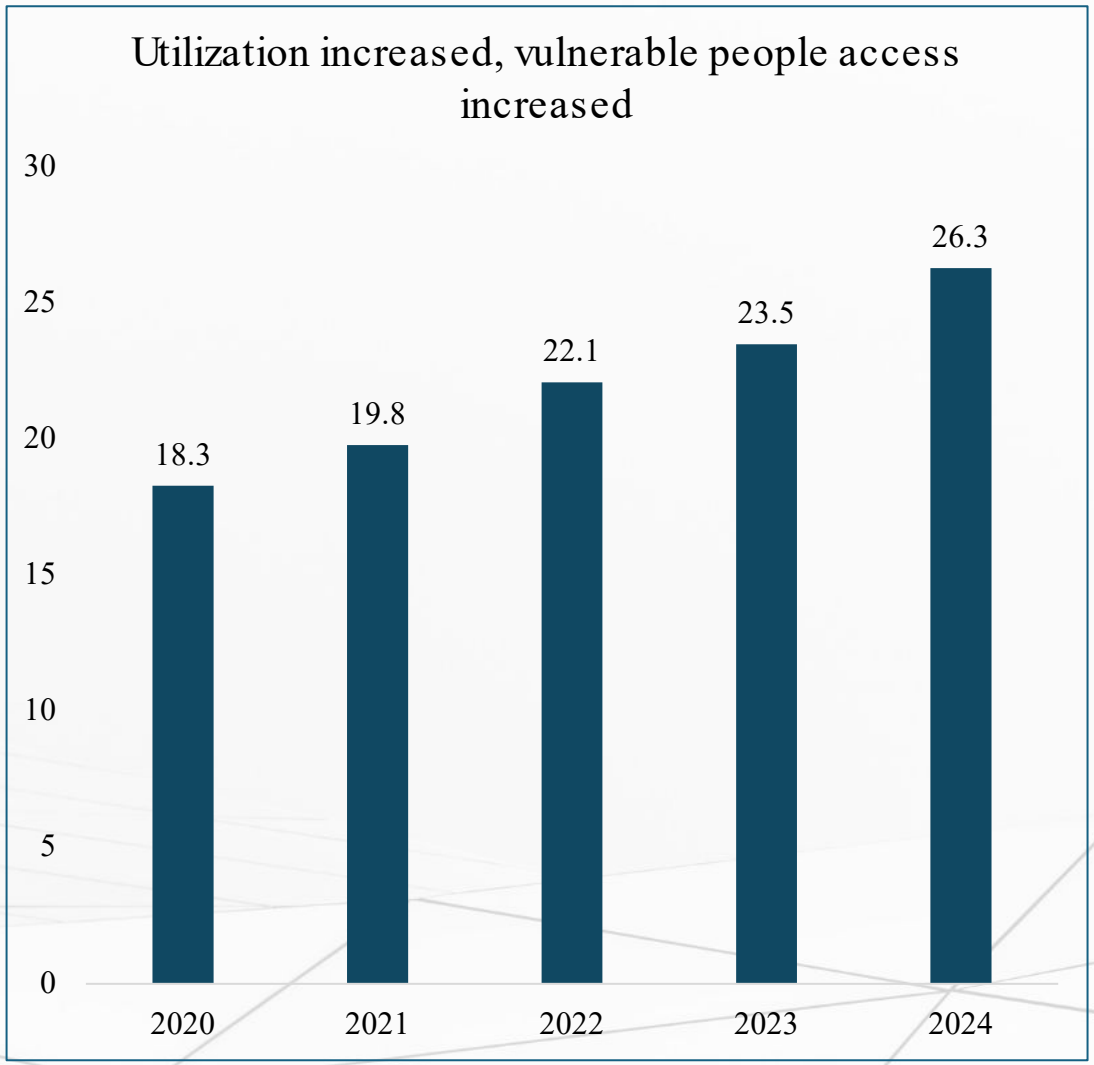

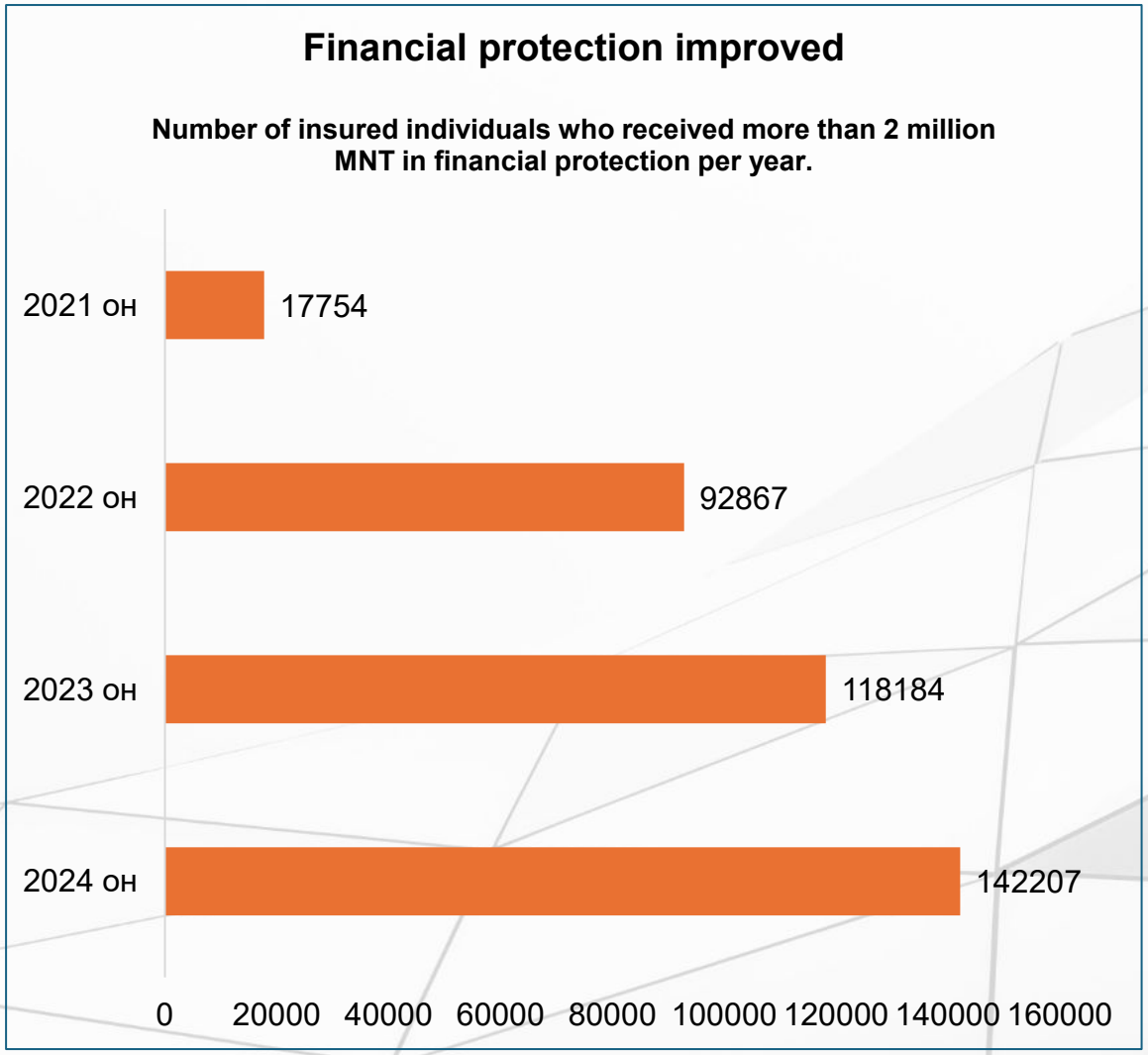

Key Lessons and Future Actions

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Lessons Learned

- Beyond technical aspects, effective implementation of strategic purchasing requires strong process management and attention to political economy factors.
- The reform significantly improved data availability. Regular data use, analysis, performance evaluation, and continuous improvement are essential.
- Financing reforms alone are not sufficient; progress depends on simultaneous strengthening of other health system building blocks.

Further Actions

- There is a growing need to better estimate population health needs and manage resources accordingly. A population needs assessment is currently underway.
- To ensure the long-term sustainability of health financing, efforts are being made to diversify and strengthen health funding sources.
- Studies are ongoing to improve system efficiency by optimizing investment, health workforce planning, service delivery organization, and reducing duplication.
- Institutional reform options are being explored to transform the Health Insurance Organization into an autonomous corporation with stronger performance and human resource capacity.

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Thank you