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Key Points

- Despite remarkable achievements since the social health insurance system was established in 1994, the reform process of the system is stalled for over 10 years, resulting in increasing levels of dissatisfaction of its members.
- Fragmented governance arrangements and poor institutional capacity weaken accountability of the social health insurance system and prevent it from developing into a strong purchaser of health services to improve quality of care.
- Establishing an autonomous purchaser of health services, reporting to a National (Health) Insurance Council, will ensure the separation between purchaser and provider of health services, improve the health services purchasing capacity of social health insurance, and prevent inter-ministerial tension to own the social health insurance system.

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Improving Governance of the Social Health Insurance System in Mongolia

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This policy brief aims to contribute to the ongoing debate in Mongolia's social health insurance (SHI) reform.[1] It focuses on the governance and institutional issues of the SHI system, which have stalled the reform process over the past decade. The policy brief consists of three sections: (i) a short analysis of challenges and problems of SHI, (ii) international experience and good practices in SHI implementation, and (iii) policy recommendations for future reform.

Challenges of Mongolia's Social Health Insurance System

Despite achievements, SHI struggles to fulfill its members' expectations. Since its establishment in 1994, SHI in Mongolia has demonstrated some good achievements, including 90% population coverage within 3 years. Health care delivery is also sustained despite severe budget constraints at the onset of the socioeconomic transition in Mongolia. However, those insured are increasingly dissatisfied with SHI because of poor service quality provided by hospitals. Similarly, while the government subsidizes SHI for over 50% of the population, around 15% of mainly poor remained uninsured in 2009.[2] Furthermore, out-of-pocket payments for health services in 2008 stood at 18% of total health spending.[3]

Fragmented governance arrangement weakens SHI accountability. SHI is currently governed by the Health Insurance Sub-Council (HIsC), with members appointed by the National Social Insurance Council (NSIC). The HIsC is chaired by the Ministry of Health (MoH) whose members consist mainly of mid-level decision makers. As such, their decision-making capacity is limited and can easily be overruled by the NSIC, composed of high-level representatives of government, employers, and employees and chaired by the Ministry of Social Welfare and Labour (MSWL). (See figure on Current and Proposed Governance Structure of Social Health Insurance). This structure leads to tension within government, mainly between the MoH and

[1] A draft amended social health insurance law is being discussed in the Parliament (spring 2011).
[2] Since early 2011, government subsidizes the uninsured from the Human Development Fund.
[3] World Health Organization. 2010. *World Health Statistics.* Geneva.

the MSWL and between the HIsC and the NSIC. Most significantly, there are no clear lines of accountability for SHI performance. Moreover, the current legal framework further fragments responsibilities by making the MoH responsible for functions such as designing the benefit package, setting payment tariffs, and selecting service providers. On the contrary, these should be the responsibility of the purchaser of services, namely, the Social Insurance General Office (SIGO). There is also a potential for serious conflicts of interest where the main service provider also sets payment tariffs and selects providers to be reimbursed by SHI.

SHI weak performance is due to poor institutional capacity. SIGO has limited capacity, particularly in terms of service costing, contract negotiations, and monitoring the quality of hospital service. The SHI[4] is merely one of SIGO's departments and is subject to legal restrictions when it comes to staff and operational resource allotment. Over time, this situation has prevented SHI to develop as a strong purchaser of health services on behalf of the insured population.

International Experience in Social Health Insurance Systems

Several principles emerge as recognized good international governance practices of social health insurance.

Health insurers and health care providers are two separate entities. As in Mongolia, health insurance models with a single social health insurer are also found in Europe (Estonia, Hungary, the Kyrgyz Republic, and Slovenia) and Asia (Philippines; Republic of Korea; and Taipei,China). These economies have adapted Western European SHI schemes such as those of Austria, Belgium, Germany, and the Netherlands. In these models, health care provision is separated from the health service purchaser to enforce strong purchaser systems and to ensure accountability. The interests of providers could run counter to the interests of those insured, e.g., increasing tariffs beyond actual service cost or by lowering service quality.

Most social health insurance systems have established a governance structure where the insured rely on their agents to represent and pursue their interests

SHI is administered through a self-governing body involving stakeholders. Most SHI systems in developed and developing countries have established a governance structure where the insured and other contributors (e.g., government and employers) rely on their agents to represent and pursue their interests. This governance system ensures equal participation or contributors and makes decision making consensual. Self-governing structures in Western European countries consist of employers, unions, and government representatives and, at the same time, incorporate a wider range of social actors to increase transparency and improve technical expertise. This idea was subsequently introduced in Japan; the Republic of Korea; Taipei,China; and Thailand; and most Eastern European countries during the post-communist era.

Ownership of SHI organizations can vary. The type of ownership can be *purely public*[5] (Chile, Colombia, Ghana, and Mongolia); *quasi-public or autonomous institution* (Costa Rica, Estonia, the Philippines, the Republic of Korea, and Thailand); or *private nonprofit entities* (The Netherlands and Switzerland). In most countries of Western Europe, in order to improve the capacity to purchase health services, SHI organizations (or sickness funds) operate in a fairly autonomous environment as self-governing corporations or nonprofit quasi-public institutions established under public law. Similar experiences are observed in more recent health insurance reforms (Estonia and the Kyrgyz Republic) partly attributed to the quasi-public status of SHI organizations in charge of purchasing services from health care providers.

The supervisory role of government is crucial. In Western Europe, governments regulate and monitor SHI performance (i) to ensure that SHI best serves society's interests and (ii) because government is an important funder of SHI. Consequently, in most SHI schemes, Parliament and government define the main principles of SHI[6] and check the legal soundness of board decisions. SHI agencies are also regularly consulted by governments to determine benefits, negotiate subsidies, and set health insurance premiums.

[4] In 1994, the SHI system was initially organized by the state-owned Mongol Daatgal Company. Since 1996, it was merged with the newly established State Social Insurance General Office as part of the overall social insurance system.
[5] A quasi public entity is a privately operated corporation with government backing that has a public mandate to provide a given service.
[6] The principles are usually embodied in laws and/or regulations and include solidarity, compulsory enrollment, contributions according to ability to pay, and universal benefit package.

Institutional capacity of the SHI agency is the key to performance. Where administration and management tasks have not been properly managed, the implementation of SHI has not been very successful. This is the case in many Latin American countries, where weak regulation and inefficient institutions have hindered SHI development. On the contrary, the availability of well-trained mid-level staff has played instrumental roles in expanding SHI and improving health services purchasing, as in Estonia and the Republic of Korea.

Policy Recommendations

To strengthen social health insurance in Mongolia, it is recommended to:

Establish an autonomous health insurance organization. Health insurance is currently handled by a department of SIGO under MSWL. The current policy debate proposes either placing SHI under MoH jurisdiction or converting it into an autonomous organization under government supervision. The table below analyzes the pros and cons of these options.

The availability of well-trained mid-level staff has played instrumental roles in expanding social health insurance and improving health services purchasing

If the government intends to (i) implement an effective and efficient purchasing system to build up a countervailing power to providers' interests (purchaser/provider separation), (ii) avoid ad hoc political interference in SHI technical matters, and (iii) strengthen social dialogue with representatives of employers and employees by including them in decision making, then the third option in the table is recommended to establish an independent SHI organization. It is also recommended that the independent legal status of the SHI organization be defined by the SHI legislation as an autonomous entity reporting to the National (Health) Insurance Council as its highest governing body. Under the proposed governance structure, the Parliament would retain its present function,

Analysis of Three Institutional Options for the Social Health Insurance System

	Pros	Cons
OPTION 1. Status quo, i.e., HIO under MSWL	• MSWL has a mandate in social policy and social insurance in addition to having the knowledge and skills • Smooth transitioning toward single purchaser implementation • Less disruptions in retaining the same contribution collection system	• No mandate in improving the health of the nation • Refusal to undertake SHI reforms and stick to old patterns • Power struggle between ministries to persist
OPTION 2. Move HIO under the jurisdiction of MoH	• MoH's mandate in health policy is served through health insurance • MoH to focus more on policy making, regulation, and supervision functions • Relieves MoH from a number of implementation functions and positions	• No experience in managing an insurance system • MoH has other reform priorities relevant to its main mandate of providing health care and therefore might neglect SHI activities • Tension between ministries and existing bureaucracy to continue • Separation of purchaser from providers not implemented
OPTION 3. Make HIO independent and governed by a National Health Insurance Council	• Creates greater HIO independence to improve performance as purchaser of health services • Prevents red tape and the creation of a powerless HIO • Assures balanced responsibilities of the MoH, MoF, and MSWL • Ascertains the actual separation between purchaser and health service providers • Prevents conflict of interest between purchaser and the owner of public health facilities	• Might take time for HIO to become a strong purchaser • Collection of premium contributions less efficient if SHI collection dissociated from current social security contribution system

HIO = Health Insurance Organization, MoF = Ministry of Finance, MoH = Ministry of Health, MSWL = Ministry of Social Welfare and Labour.

Source: Authors.

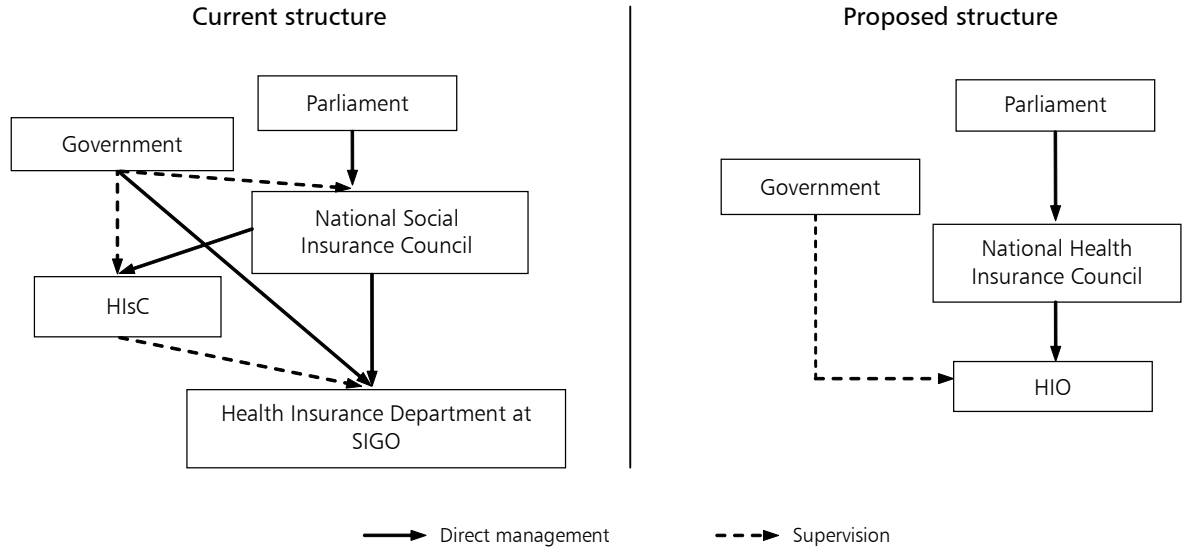
i.e., to approve the SHI budget and appoint the members of the National (Health) Insurance Council.

Separate purchaser from provider to strengthen the purchasing function of SHI. In Mongolia, there is no real separation between the purchaser and the provider of health services. Key SHI policies are still dominated by the MoH, which is the country's major provider of health services. As a consequence, there is little incentive to strengthen the purchasing function of the SHI organization. Clear delineation of roles of the purchaser and service providers should form part of SHI future reforms in Mongolia.

Ensure the SHI organization operates within the legal framework and is supervised by government authorities. Government must ensure that the National Insurance Council obeys laws and that the insurance organization acts within the budget restrictions and does not make decisions which could have far-reaching consequences (e.g., jeopardizing the financial sustainability of the SHI organization). At the same time, the government should not administer and operate the insurance system and should not be allowed to make decisions at whim or delay approvals, especially if decisions are within the SHI organization's mandate.

Substantially strengthen the institutional capacity of the SHI. It is strongly recommended that the SHI should have sufficient and skilled human resources, sound information technology systems, as well as strong financial management capacities. For this reason, the SHI needs to be independent of the public finance system and have a legal status not subject to civil service and government agency restrictions.

Current and Proposed Governance Structure of Social Health Insurance



HIO = Health Insurance Organization, HIsC = Health Insurance Sub-Council, SIGO = Social Insurance General Office.
Source: Authors.

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