Mongolian experiences with health insurance: are success factors unique?

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Abstract

We describe the health insurance model implemented in Mongolia after the Soviet Bloc collapsed in 1990, and note some of its good features. We then discuss the structural weaknesses that became evident over the first ten years of use, and some current proposals for reform. Finally, we consider the factors that appear to have affected success. We argue that the main constraints are much the same as in other countries including Australia – and relate more to confusion and disagreement over broad policy issues than to detailed knowledge of technical aspects or the research evidence.

Entering the transition stage in 1990

The government dominated the health sector before 1990. Virtually all care providers were employees of government facilities, which were funded almost wholly from government general revenue.

There were obvious weaknesses in these arrangements. Central planning was occasionally incompetent, and there were few rewards for innovation.

However, there were some strengths. In particular, the old regime had provided Mongolia with a nationwide network of primary health care, backed up by regional and national hospitals, which was quite remarkable for a poor and sparse population in such a difficult physical environment.

The age of command economics in a one-party state ended in 1990. The resultant changes included multiparty elections, formal recognition of freedom of speech and religion, and widespread content as a consequence of the re-establishment of a cohesive Mongolian culture that had remained largely intact but partially hidden for seventy years.

After the initial celebrations, however, Mongolia like other transition countries began to realise it had not only gained in freedom, but also lost social protection. In short, many good features of the old regime were now in jeopardy.

During the next three years, there was much debate (but little action) with regard to redesign of the health care system. Government health care services deteriorated in most respects. This was not only because of the social and political turmoil. There was also a serious economic downturn, mainly because of the loss of financial assistance from eastern Europe and the former Soviet Union in particular, which accounted for nearly 30% of GDP.

Making a start: the new insurance scheme in 1993

The newly independent government adopted a middle road between the free market and social welfare in the health sector, like most of the transitional economies. Its first target was financing reform. Legislation enacted in 1993 saw the establishment of a government health insurance scheme (called the Scheme below) on 1 January 1994. It was to be operated outside the Ministry of Health for the purpose of creating some degree of separation of purchasing and provider functions.

All employers were required to contribute to the Scheme on behalf of their employees. The contributions of people who were unable to pay (or were otherwise considered to be 'vulnerable') were paid directly by the government. Covered services mainly comprised inpatient care. Few outpatient and non-hospital services were covered, and they mostly involved higher levels of copayment. For the most part, however, copayments have been avoided for vulnerable groups.

The dominant policy goal was to reduce the level of health care funding that had to be obtained from government general revenue. Government health care agencies therefore lost some of the revenue that had previously been provided as direct annual budget grants by the government. They were expected to seek replacement revenue from the Scheme by billing largely on an itemised basis, including daily charges for inpatient care.

It was determined that most government care providers would continue to receive annual budget grants for their fixed costs. Payments from the Scheme for the inpatient care of insured people would therefore be based on estimated variable costs (in a manner similar to that applied to the output-based funding models in some Australian States).

A few people argued at the time that the net effect of shifting from general revenue to a health-specific tax would be minimal (and possibly harmful overall) but they were in the minority. However, the government believed a separate tax would be useful because a message would be given to the community – about the high cost of health care, and about being more responsible in demanding services. The government also believed the electorate was expecting something new (and especially something that involved more use of the market).

This appears to have been a common view in almost all the transitional economies: the change to a market economy meant one had to get rid of the old State-dominated health service, and create a health insurance scheme instead. In at least some of the transitional economies, this belief was political in nature: one did not want to keep anything that belonged to the old regime. Few people seemed to have appreciated that many western countries have national health services, which are perfectly compatible with a market economy. In the transitional economies, taking such a view meant one was likely to be criticised for being an "old-style communist". In general, Mongolia (like other transitional economies) found many of the design decisions difficult to make, simply because there was a lack of technical expertise and practical experience.

Some people supported the establishment of a separate agency because it would facilitate the privatisation of health insurance if this were considered desirable at a later date. Others believed that any change would be beneficial if it resulted in bypassing, replacing, or competing with a disillusioned (and perhaps irretrievably inefficient or even corrupt) government health sector. In short, there was a popular view that creation of a new agency might be sensible if the old one would be difficult to reform. In practice, this has often led to an increase in the number of ineffective agencies from one to two.

Another consequence of the Scheme was that copayments became formalised to a greater extent than before, thus further reducing the government's budget pressures. It is not clear whether the total level of self-pay increased. One unknown is the level of 'under-the-counter' charging that was taking place, both before and after the demise of the Soviet Bloc. We suspect, however, that the level of under-the-counter payments has changed very little (they continue to be too common and too high), and that the government's obvious policy objective – to transfer some of its costs to recipients of care – was achieved.

Operation of the Scheme was entrusted to the state-owned insurance company Mongol Daatal, which held about 80% of all insurance business (mainly property) at the time. The company soon realised that operating health insurance under tight government regulation (which included the effective banning of risk rating) was a hard task. Australian private health insurers have had similar experiences.

After two years of operating losses on its health insurance business, Mongol Daatal was happy to see responsibility for the Scheme transferred to the government's social insurance agency, SSIGO. This agency is controlled by the Ministry of Labour and Social Welfare, and thus the transfer reinforced the separation of the Ministry of Health from direct management of health care financing. The Mongolian government, like those of many other countries in the 1980s and 1990s from Chile to China, believed that health care financing is better associated with the financing of other social functions such as retirement and unemployment pensions, than with the regulation and delivery of health care. Again, there is a parallel with recent Australian experiences. Some recent legislation on private health insurance (such as the 30% rebate and lifetime community rating) was more a matter of government fiscal policy than of Australia's health (Clarke 1999; Duckett & Jackson 2000; Hindle 2000; Butler 2001).

The structural weaknesses take effect

The Scheme delivered some immediate practical benefits. In particular, many poor people were again able to access free or low-cost services (or at least regained some assurance about the future), and there were new pressures and opportunities for care providers to improve their services. The specific arrangements set in place for the 'vulnerable' groups gave an explicit message about the nature of Mongolian society. However, many of the design weaknesses have become progressively more obvious in recent years, and we will summarise some of the most important below.

Underpayment of premiums

There is no doubt that many people (both employees and self-employed) are failing to pay what was intended. No-one knows exactly how much underpayment occurs, but almost everyone is aware of the common devices whereby contributions can be reduced or avoided altogether. The most obvious method involves under-reporting of wages (since the contributions are income-rated).

It had been argued in 1993 that a separate health insurance scheme was necessary if only to avoid the risks associated with relying on general revenue given the high level of tax avoidance. Other people have long been arguing that, if you can obtain health insurance contributions from people, then you can tax them (Hindle and McAuley, 2000). As might be expected, Mongolia now has two separate methods of financing that are flawed to some degree. It might have been better to concentrate scarce resources on taxation reform.

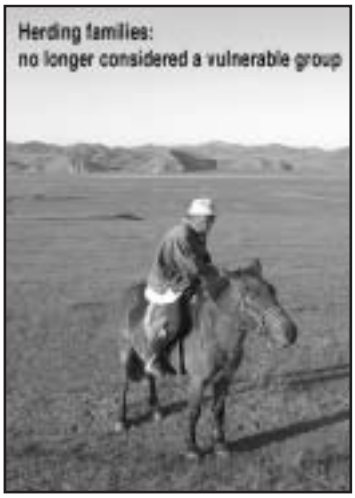
The similarities to Australian experience are less significant in this regard, since we have a relatively effective taxation system. However, it does not seem entirely sensible for the Australian government to encourage more people to have private health insurance, if only because this means wasting around 10% of revenues in operating a parallel collection system. Taxation contributions to health care financing can be obtained at marginal cost, whereas private health insurance contributions cannot.

Reduction of coverage

Another cause of difficulty is that the government has taken further action to reduce its own outlays. Of particular concern, it has progressively restricted the range of people for whom it pays insurance contributions – including herding families and students. The proportion of Mongolians covered by the Scheme declined from 97% in 1995 to 84% in 2001. In terms of the value of contributions, the percentage paid on behalf of vulnerable groups fell from 38% to 26% over the same period.

The government has also reduced the range of services available free or at low cost under the Scheme. There have been pressures to broaden the range of covered services, but with little success. For example, all types of dental care continue to be excluded, excepting that for children, in spite of the evidence of its cost-effectiveness in some circumstances. There is a parallel here with the Australian government's removal of Medicare benefits for dental services for elderly and low income people in 1997. It seems likely that both governments underestimated the broader implications of poor dental health among the elderly.

One important policy goal since about 1997 has been to shift some of the financing responsibilities to optional health insurance. An example is the recent establishment of ceiling copayments under the Scheme, whereby members' total annual benefit payments have been capped.



The government has been encouraging citizens to respond to this by taking out additional insurance, but there has been no agreement as to how this might best be provided. Some people have argued it should be provided by the government agency responsible for the compulsory scheme (as in Slovenia), while others have favoured provision by private companies (as in Australia). We believe the former would be much better for Mongolia – and probably for Australia too!

Adverse effects of decentralisation

Another cause of increased pressure has been the decentralisation program, which is affecting all sectors including health care. Local governments lack experience in resource allocation in the health care sector. Some of them have diverted resources from health care to other sectors such as education, housing, and transport infrastructure for a mix of good and bad reasons. Few have been able to act in line with the central government's broad policy commitment to the shifting of resources from the hospitals to primary health care services.

Limited gains from an improved general practice program

There have been significant changes in care provision since 1990. One of the most successful appears to be the privatisation of general practice, which has been described in detail elsewhere (Hindle et al, 1999). In brief, salaried government doctors are progressively being dismissed, and offered significant support in establishing themselves in group private practices. The government has retained responsibility for financing, and pays GPs on a risk-adjusted capitation basis. Apart from the general superiority of capitation over fee-for-service or salary arrangements, the new program has created a sensible way of reducing the excessive numbers of GPs and of increasing the rewards for innovative and competent doctors.

However, there have been some penalties as a consequence of GP services not being covered by the Scheme. Most obvious, there have been concerns over cost shifting – and about the danger of relying exclusively on funding from decentralised health budgets.

Flirting with other opportunities to privatise

There has been less enthusiasm over other elements of the government's broad policy of privatisation. In particular, few informed observers have spoken favourably of its plans to sell off government hospitals to private for-profit interests, or of the minor but steadily increasing assistance it is giving to privately owned hospitals and private insurance. As in Australia, the late 1990s has seen an increased separation into two health care systems. A recent report by a WHO consultant noted that Mongolia is "… already developing an American-style two-tier health care system" with high-technology services for the rich and hardly anything for the poor. Moreover, development of the upper tier is being "… subsidised with the money of the poor." Some commentators have said the same about Australia's 30% private health insurance rebate.

In fact, this has been a trend in almost all the transition economies. For example, Tymowska (2001) notes that the emergence of a parallel private system in Poland greatly accelerated after 1990, and has "… increased considerably the significance of household income and education as the factors that differentiate patient inequality." It has even been evident in Germany, where the equity that was present in the east significantly declined after reunification. Here as elsewhere, it was easy for people to assume that, if private businesses in market economies worked better than the command economies overall, there was good reason to apply the same rules to health care.

Weak reforms in the hospital sector

There has been much less progress in reform of hospital services, partly because of weaknesses in the financial incentives. Until 1998, payments from the Scheme for hospital inpatient care were on a per day basis, using a crude classification of days of stay. From that time, use has been made of per case payments. However,

Mongolia lacks the information systems to support classification models like DRGs, and there have consequently been few of the gains that have occurred through per case payment in other countries. Indeed, the casemix classification is little more than a set of hospital categories. As in Australia, the Mongolian payment rates per case have been based mainly on actual average costs in previous periods. However, the penalties for Mongolia have been much greater, if only because last year's practice patterns have usually been much farther from the ideal than in Australia.

Slow progress over quality of care

Quality of care has continued to be of much concern, partly because the Scheme has not been empowered to provide incentives. It may also be the case that the SSIGO simply lacks the knowledge about health that is necessary if quality of care is to be managed. Its specialty is insurance rather than health care.

It has been argued that quality is under control, mainly because of a program run by the Ministry of Health that involves a requirement for hospitals to meet a range of quality standards as a condition of funding. In practice, this is a largely administrative process involving the appointment of a quality committee by each hospital director, and occasional committee meetings where reports are drafted and questionnaires completed. One obvious weakness is that no measures are taken against hospitals reporting poor results in terms of (say) mortality. This is partly a technical matter, since most statistics are not casemix-adjusted. There are attempts to give the quality control program more teeth in the matter of physician group practices, but these quality contracts have not yet been evaluated.

The frailties of customer choice

One interesting matter concerns the interaction between quality of care, the range of services covered by the Scheme, and a feature of the existing legislation that allows beneficiaries a high degree of choice of service providers. Indeed, it is widely interpreted that the Constitution of Mongolia guarantees free choice of doctor. As in China, there has been a downward spiral leading to over-use of hospitals higher in the referral system. This is partly a consequence of the growing view that the tertiary hospitals provide the best (and also the most expensive) care, and therefore the tendency for beneficiaries (and particularly the less poor) to bypass local hospitals and other health care facilities. Declining revenues for some local health care facilities have resulted in loss of the more competent staff and failure adequately to maintain and upgrade the infrastructure, thus further strengthening the perception that they should be bypassed whenever possible.

Weak control over drugs use

One obvious example of perverse financial incentives concerns drugs: they are largely free of charge where care is provided on a hospital inpatient basis, but significant copayments apply elsewhere, and therefore there is an incentive to admit unnecessarily simply to relieve the patient's financial burden. The government has encouraged the use of low-cost generic drugs, especially outside hospitals, in order to control the copayment levels. However, this has had a partially detrimental effect. As in some other countries including the Philippines, there has been a growing view that cheaper, non-branded drugs are less effective. As in other countries, there has been concern in Mongolia over the degree to which drugs prescribing has been adversely affected by the commercial self-interest of some pharmaceutical companies, retail pharmacists, and doctors.

Confusion over the relevance of fixed and variable costs

We mentioned earlier that the fixed costs of hospitals have been paid by government grant from general revenue, whereas the Scheme has paid by volume at rates intended to reflect variable costs. In passing, it is worth noting that fixed costs are defined to include clinical staff salaries (and this may add to the barriers to flexibility and innovation).

It is unclear why this idea emerged, although it seems that one factor was that the amount that the Scheme could contribute happened to approximate someone's estimate of the split between fixed and variable costs. It is easier to find out why (say) the South Australian government used a fixed-plus-variable funding model for public hospitals – there is good documentation – but the logic seems weak to us.

There are more serious problems in Mongolia. Perhaps because documentation on the original decision has many gaps, there is widespread reluctance to reconsider it. In ignorance, there may be more likelihood of believing there were good reasons.

A case in point is recent work intended to change the method of payment of the lowest level of hospital (the Sum hospital) from expenditure history to capitation. The idea is fundamentally sound, but difficulties were experienced when trying to separate costs into fixed and variable so that the shares of the budget to be provided by the Scheme and from general government revenue might be determined. It took only a few minutes to convince the design team that fixed and variable costs were irrelevant: the amount that can be contributed by the Scheme depends on how much it can raise through premiums (which is a matter of government fiscal policy), and not on they way that hospitals choose to spend their revenue in terms of fixed assets, salaries, and so on.

In summary, the Mongolian health care system has long performed relatively well in terms of cost-effectiveness and equity in spite of chronic poverty. Some of the constraints to progress were self-imposed, such as excessive (and often incompetent) central planning and an inability to encourage and reward innovation. Other constraints were largely immovable (such as the topography, distance and climate) or difficult to manage in any country (such as the need to respond to population migration that means health care facilities are in the wrong locations).

The transitional period provided opportunities to address the self-imposed constraints, and considerable progress occurred. However, there has been growing concern about many of the features of the first model. By 2001, it had become clear to many Mongolians that changes needed to be considered.

Having a second go: proposed changes in the health insurance law

At the time of writing, the Mongolian government is considering legislative changes in several forums including parliament. It is difficult to predict the how the proposals will be modified during the committee stage, or during debate in the house. However, this is not important in the context of our paper: we will describe the main elements that are under consideration only to illustrate the thinking processes.

A single purchasing agency

One of the elements under consideration is the transfer of all purchasing functions to a single agency. The arguments in favour of such a change seem overwhelming to us. For example, there would be a reduction of duplication in design and implementation of service contracts, and reduction of the risk (which is a reality at present) that multiple purchasers will give conflicting incentives. There would be a reduction in cost shifting behaviour (which not only leads to ineffective purchasing but also consumes much of the time of senior managers whose efforts would be more productively employed elsewhere). In short, the arguments are much the same as those that have been used for at least fifty years in Australia, in such contexts as payment of GPs by the Commonwealth, and of hospitals and home care services by the State.

It would be possible to establish integrated purchasing in Mongolia without the need for legislation. A national or provincial authority could require the various purchasers to collaborate, and to enter into a single contractual agreement with each care provider. Indeed, this is 'plan B'. We have been working with interested provincial governments on ways of moving towards integrated purchasing regardless of the outcome of the regulatory process. This said, we believe it may be difficult for many provincial governments to manage the social and political, as well as the technical complexities. It seems sensible to attempt to make the changes once at the national level.

The most logical arrangement might be to cause government grants to be made to the insurance agency, rather than directly to care providers. However, the particular assignment of responsibilities may not be the main issue. Who does the actual work of paying, auditing, and so on is not as important as making sure all parties make the resource allocation decisions in a rigorous, open, and collaborative way.

Regardless of the organisational arrangements, more needs to be done to improve the processes of purchasing of care. Ensor (1999) assessed the lessons to be learned by the transitional economies from Latin American experiences of many decades with employment-based health insurance. He argued that the success of operation of a separate insurance fund critically depends on rapid development of its purchasing function. Otherwise "… it is unclear what value is added to the (national health system) model."

Better management of voluntary, compulsory, and private insurance schemes

The proposed legislation would formally recognise the difference between compulsory and universal government-sponsored insurance that provides access to essential services for everyone, and voluntary insurance that is available from a mix of non-government agencies. The existing law fails clearly to define (and consequently to allow management of) the balance between health care that is essential for social solidarity, and the less cost-effective services that cannot reasonably be denied for the more wealthy members of society who are willing and able to pay.

Nor does the existing law recognise the potentially valuable role that could be played by non-profit agencies. Perhaps as a consequence of 70 years of command economy, the tendency has been to assume that, if it is not government, it must then be for-profit. As in most other transitional economies, non-profit agencies are relatively rare in all sectors. Mongolians are surprised to discover that much of the non-government health insurance is provided by mutual associations in many mixed economies including Australia.

Building bridges between regulation, purchasing and care provision

It is proposed that the redefined Scheme be under the joint control of the ministries of finance, health and social welfare. This may seem to be a trivial change. As noted earlier, government agencies could collaborate even without the legislative requirement to do so. However, we again believe the proposed legislation is justified.

Australian experiences tend to support this view. We have spent several decades trying to improve integration between Federal- and State-funded services. The lack of formal structures for integration has often been used as a reason for slow progress. This is probably a rationalisation, but we might do better if one of the lame excuses were taken away.

Redefinition of covered services

It is proposed that a greater emphasis be placed on outpatient and non-hospital care. We noted earlier that benefits are predominantly for inpatient care: indeed, 92% of benefits related to inpatients in 1995. The proportion had declined to 87% in 2001, but this was largely as a consequence of health care trends (such as growth of prescribing of drugs) rather than as a consequence of a strategic view about cost-effectiveness.

One important element of the current proposals is that essential drugs would become free for both inpatient and outpatient care. Another is that primary care (and particularly GP services) would become major components of covered services.

These ideas are being strenuously opposed at the time of writing. One factor is the simple concern that it is easier to add benefits than to take them away. Some parties are sceptical of the argument that a wider range of benefits can be financed from efficiency increases and reductions in unnecessary care.

Adjustments to copayments

There has been a minority view that all copayments should be eliminated on the grounds that they unfairly penalise the poor and the sick, and that the goal of cost containment is better met through restriction of the range of covered services and improvement of provider incentives to control utilisation.

However, many people remain unconvinced that provider incentives will work. Therefore it seems likely that a compromise position will be taken, whereby copayment rates will be varied to a greater extent to reflect the service category and will become more strongly income-dependent. There has been pressure from some parties to eliminate the ceiling on annual benefit payments, but this seems unlikely to happen.

Primary care providers as gatekeepers

The proposed new law would control referrals through requiring beneficiaries to register with only one primary care provider of their choice, and by restricting insurance benefits to care provided on referral by the selected primary provider. This rule would not apply for emergency care.

The advantages of such an arrangement have been widely reported in the literature, and include important matters like ensuring there is coordination of care. However, as with other elements of the proposals, there is

significant opposition. As might be expected, secondary and tertiary care providers have been lobbying on the grounds that they doubt the abilities of primary care providers. A counter-argument has been that postponement of gatekeeping will be self-defeating: restriction of the power of primary care providers will mean there is less reason to give priority to increasing their skills, that their work continues to be considered of minor importance, that the better doctors will continue to be attracted to hospitals, and so on.

Improved provider payment models

Although there is no need to modify the capitation payment model for GPs, there would be major changes in the methods of payment of secondary and higher levels of service providers. We mentioned the plan to change to a risk-adjusted capitation payment model for the lowest hospital level. For regional and national hospitals (secondary and tertiary), it is proposed that a simple casemix classification would be employed for which per case payments would be made by the Scheme. The payment would be all-inclusive and made by the single purchaser as noted above.

Several other sensible changes are envisaged, but we will not mention them here. Moreover, several kinds of changes were considered and then excluded from the current debate because it was thought that their controversial nature might lead to delays in making any changes whatever.

We have, however, encouraged the placing of many possibilities on the agenda in the hope that they will become more acceptable ideas over time through loss of novelty. For example, one change that we believe is obviously desirable but probably not politically acceptable or technically feasible in the short term is that of linking the collection of health insurance premiums to the taxation system.

Are Mongolians taking too long to see the light?

It is easy to be critical of Mongolia's decisions about health care financing, and the associated aspects of resource allocation and care provision. It is clear that the mistakes that are now being addressed could have easily been avoided if the evidence had been consulted after 1990. However, we have been surprised by the extent to which mistakes were avoided, given the fact that many worse decisions have been made in countries with much more knowledge and experience in health system reform than Mongolia. We will return to this point later.

One aspect of health system design where Mongolia appears to have made relatively few mistakes concerns privatisation in its many related manifestations including outsourcing and corporatisation. After ten years of rhetoric about markets, Mongolia has made few significant changes, apart from the largely successful privatisation of GP care provision (but not of financing). It has certainly been flirting with privatisation in other parts of the health care system, but with relatively little success in the face of strong technical and political opposition from within Mongolia.

The UK, with its corporatisation of care delivery and the private financing initiative (PFI), has gone much further in the last decade. This is in spite of the lack of evidence that corporatisation has delivered any benefits, and of the overwhelming evidence that the PFI makes no sense at all.

The same may be said of many other countries. For example, there is no doubt that Australia's moves towards privatisation of hospitals have been pursued largely without reference to the evidence – or even without serious mention of the possibility that the idea might have drawbacks. New Zealand's efforts at privatisation (or corporatisation in particular) came earlier and often with more vigour than those in Australia, but at least there is now a widespread awareness that some of the ideas were ill-founded. Many Australians are still waiting for the age of enlightenment.

In creating a separate government agency for health care financing in 1993, the Mongolian government paid little attention to the logic or the evidence. However, it was not alone. By 1993, virtually every transition state had declared its intention to change, and several countries (including Hungary, the Czech Republic, Slovakia, and the Russian Federation) had already activated their schemes (Vienonen and Wlodarczyk, 1993).

Other countries outside the transitional group were also moving in the same direction. For example, The Philippines took health care purchasing out of the Ministry of Health in 1995, and China has been progressively establishing a multiplicity of separate government insurance agencies under the supervision of the Ministry of Labour and Social Security since the mid-1980s.

Is the Australian experience much different? The case of the ACT suggests that it is not. There was at least the equivalent degree of careless thinking when the purchaser-provider split was implemented in the mid-1990s. It is perhaps an extreme example of policy driven by dogma, given that there are only two hospitals and one community health care agency of significance on the provider side.

Mongolia's flirtation with ideas like privatisation and the purchaser-provider split might be more easily excused. After all, countries like the UK and Australia have several decades of critical analysis and debate on which to draw. As Muetzelfeldt (2000) puts it, Australians should know by now that there are demonstrable human, social, and political losses and no more than allegations of cost reductions from "… reducing government to a service function that can be contracted out".

We are unsure of the extent to which external influences have played a part. It is certainly the case that many of the first visiting experts promoted a free market model because it was in their own interests to do so (and because it was the only model with which they had significant personal experience). However, some foreign experts have at least been apologetic. One Australian expert, invited to talk about privatisation models from Australia and elsewhere, said "… I can tell you what to do if you want to follow our experiences, but why would you ever want to do so?"

One other comparison is worth making, in partial defence of Mongolia's reforms. The Russian Federation changed from a 'national health service' to a 'social insurance' model at about the same time, and many of its features resemble the Mongolian scheme. For example, funding from government general revenue was largely replaced by contributions by employers to a specific health insurance fund. Like the Mongolian scheme, the contributions of unemployed and various other disadvantaged groups are paid from government general revenue.

There were, however, important differences. For example, insurance schemes were established at regional rather than national level, thus penalising the less wealthy areas and increasing the administrative costs. The insurance schemes do not purchase care directly, but rather contract third party private insurance companies who then enter into their own contractual arrangements with the providers. One obvious penalty is complexity: each care provider has to contract with multiple insurers (which, like Australian private health insurers, tend to negotiate different terms including prices and service categories). Another penalty is that competition between the third party private insurers has led to increased administrative costs for marketing and other reasons (Field 1999).

Most commentators are critical. For example, Chernichovsky and Potachik (1997) note that implementation of the new Russian scheme was "… slow and unstructured due to a lack of appropriate administrative and financial mechanisms." Sheiman (1994) argues that the reforms that were required in health care provision after 1990 would have been better handled through regulation and improved management than in response to the new market in health insurance and health care purchasing.

Shishkin (1999) notes that the decisions to establish the new players, and particularly the insurance carriers and third party purchasing agencies, were made without recourse to evidence that they might help, and that their operations thus far have not added to the evidence. He also observes that the introduction of copayments in the Russian social insurance scheme was no more than a rapid and simple way of relieving the immediate and serious budget problems of the public health sector, and that their long-term implications were largely ignored. Burger, Field, and Twigg (1998) note the decline in health status of the Russian population during the 1990s, and conclude that "… Russia may simply not be ready for market-based medical insurance along Western lines."

Finally, Field (1999) argues that the Russian experiences may be characterised as "… an instructive experiment with the premature introduction of a scheme touted as an 'anti-model' to socialised medicine and geared to market and legal arrangements that are, as yet, largely non-existent." In total, the new scheme has been the main cause of "… the polarisation of the population into those few who can afford private care, and the vast majority for whom this care is difficult to obtain, or unobtainable. This has ominous political implications."

What factors appear to have constrained success?

There may be important factors that are peculiar to Mongolia, or at least to a subset of similar countries. For example, there is the matter of recent social upheaval. This typically provides the best opportunities for major change – as was the case when, say, the UK implemented its National Health Service after World War 2 and

when the USA implemented its Medicare and Medicaid programs during the decade of civil rights. Australia missed its opportunity after World War 2, and had then to wait for 25 years (until the period of change associated with the Vietnam War and student unrest) for another opportunity to implement an adequate health insurance scheme (Hindle & Perkins 1999).

The post-communist countries may have special difficulties in responding to such opportunities. They had been less open to consideration of options than, say, the UK or Australia (where the new models had been the subject of continual debate for several decades). When the world changed in 1990, there was little warning and many people had simplistic and ill-informed ideas about capitalism, management and market. Vienonen and Wlodarczyk (1993) argue that "… popular slogans of privatisation and market economy" are hardly sufficient bases for major system redesign during periods of political instability. Unfortunately, one-sided beliefs about these matters were encouraged by such institutions as the World Bank, who should (and actually do) know better.

In passing, there is reason to wonder whether Mongolia's window of opportunity might soon close. Some of the transitional countries made changes while the memories of social unrest were still fresh, and have subsequently found great difficulty in fixing bad decisions that were made in haste. This point has been argued with respect to the German health reforms that followed reunification.

Other explanations for differences are less plausible. For example, we have heard it said that privatisation is necessary because Mongolia is so poor, and that copayments are needed because Mongolians are more sensitive to personal financial signals than people in other cultures.

We suspect these are rationalisations. The Mongolian trends we have summarised in this paper appear to be similar to those in many other countries that are quite different in terms of history, social and political structures, wealth, demography, and so on. In short, it seems there are other factors that have led to design weaknesses, and that they are much the same in any country. We will conclude by asserting what those factors might be.

First, there is the power of for-profit parties. Most obvious, there is the pharmaceutical industry, which makes the same arguments in every country and achieves similar results. A good example is the practice of threatening that, if the government (Australian, Chinese, Mongolian, or whatever) over-regulates to control drug prices it will be necessary to take drug manufacturing (and associated jobs) to another country. An example of specific relevance to Mongolia is the practice of some drug companies of offering large prizes to retail pharmacists for the meeting of sales targets. It is a particularly damaging practice in Mongolia, because an unreasonably large proportion of pharmaceuticals are available without prescription including most antibiotics.

Second, there are the short-term perspectives of elected governments. Take the case of Australia's implementation of the 30% rebate on private health insurance contributions: it is hard to imagine it could form a part of a carefully considered long-term strategy in any country. Indeed, it became evident that the Howard government had not even looked carefully at the budget burden more than a year ahead – and was somewhat surprised to find that it would rise from around $1.5 billion to $2.2 billion. In some respects, the previous Labor government's private health insurance policies were no better prepared.

This factor is widely recognised in Mongolia at present. Indeed, most policymakers talk about four-year planning (which is the normal term of office) and have a strong conviction that any actions that are not firmly embedded during one term are likely to be reversed in the next cycle.

Third, there is the peculiar degree of disinvolvement of most health care professionals from the debate about health care futures. This point may be illustrated with reference to the situation that currently applies in Mongolia with regard to drugs benefits. We have met no health care professional (doctor, nurse, or administrator) who believes it is sensible to provide free drugs for inpatient care and not for outpatient care. Nearly all of them are well aware of the unfortunate consequences, such as the unnecessary admissions noted above, and are able to define a better way if challenged to do so. However, they are more or less unanimous in claiming that they could not possibly have any influence, and that they have long accepted there is no point in their having a view.

Fourth, there is the widespread view that health care lacks managers. If there were better managers (people from other industries like insurance and brewing), it would be easy to find better ways. The reality is that health care is one of the most complicated industries to manage. Looking for new managers who can see the 'obvious answers' has the effect of diverting the attention away from the real need – which is to put increasingly more

effort and intelligence into the harder and older tasks. A similar point might be made about the tendency to seek improvement through reorganisation: the underlying motive is often little more than a belief that the system will work better if only responsibilities were re-assigned to the right managers.

Fifth, there are different visions of society, which can be characterised in part as an ongoing battle between equity (associated with ideas like universality, rights, and community) and privilege (associated with ideas like choice, market, prudence, and self-reliance). This is not necessarily damaging to progress. However, if it is poorly understood or not able to be discussed openly, the risks of bad decisions are greatly increased. In Mongolia, the battle has manifested itself at the margins at the government level, in terms of the differences of emphasis between the Mongolian People's Party (the old communists) and the 'social democrats'. Some people suggest that the tensions did not exist before 1990, in that the equity model was accepted to be right. In fact, most Mongolians recognise that there was privilege before that date, but it was assigned on a different basis – that is, mainly to people who had power within the Party.

Finally, there is a widespread misunderstanding of the basic differences between markets for health care and for other products. Australia has a long history of finding people who did not understand. One of the more surprising examples is the attempt of the Labor government in 1990 to introduce copayments for outpatient services (which was abandoned because the Minister was willing to listen to good advice). The current debate in Mongolia over copayments appears to be similarly founded on elementary misunderstandings about their effects on equity and efficiency, and about the choice than can be made between consumer and provider incentives to control utilisation.

We noted some serious mistakes that have been made in Mongolia, but expressed surprise that they were relatively few in number. Perhaps we should not have been surprised at all. Our assertion is that important decisions about health care are rarely based exclusively on an objective and value-free assessment of the evidence anywhere in the world. The fact that there was less knowledge and experience in Mongolia might not have been a major limitation.

If the main problems are systemic to health systems around the world, then the way to improve decisions in Mongolia might not be exclusively through increasing the knowledge of health systems managers with respect to topics like (say) evidence-based health care, assessment of value for money to support formal rationing, or methods of needs- or output-based funding. These kinds of topics have in fact been the main components of international technical assistance over the last decade.

Rather, much more attention might need to be paid to the matters listed above: helping health politicians to understand market ideas and health care, how to manage commercial interests, and so on. For example, it may be unwise to present proposals on copayments to the Mongolian parliament as if they were purely technical matters. Whether Mongolian (or Australian) politicians would welcome such an idea is uncertain, but more effort may be merited.

If this approach were taken, there would still be some significant technical content. In particular, we believe it is important to illustrate the ideas by describing experiences with various policies and structures in other countries – about which there is a considerable degree of ignorance. It is easier for many people to understand the successes and (especially) the failures when they are presented in a context other than their own.

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