Community involvement in health in Mongolia: hospital boards and other participatory structures

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Abstract

Under the Soviet central planning model that operated until 1990, the Mongolian population had little or no involvement in decision-making about health care. As part of overall health sector reform in Mongolia, hospital boards have been established, with significant community representation, to guide strategic and financial management and to assist in developing services according to community needs and expectations. We discuss experiences, and steps taken to resolve initial problems. We also describe other more recent participatory models including the family group practice initiative which involves the community choosing their doctor, community management of revolving drug funds, establishment of community health volunteer networks, and the government's information campaign strategy on the reforms.

The community participation models in Mongolia are part of an ongoing process of openness and emphasise the commitment to change in that country. We argue that these experiences have the potential to guide and inform similar measures in other transitional countries.

Mongolian health care: background

In common with other countries influenced by the Soviet model, the Mongolian health system was centrally planned, dominated by the hospital sector with no network of primary health care, and exclusive of community involvement or participation (Vang and Hajioff 2002). Patients were regarded as passive consumers of services prescribed and organised by largely anonymous bureaucrats (WHO 1999).

Since the transition to a market economy in the early 1990s, health reform is now firmly on the agenda. One of the major vehicles for health service reform in the country is the Health Sector Development Program (HSDP), an initiative funded by Asian Development Bank loans (O'Rourke and Hindle 2001). The HSDP includes the promotion of primary health care, private sector involvement in the delivery of health services, rationalisation of health facilities, rationalisation and retraining of the health workforce, refinement of health care financing and management capacity, and protection of access to health services for vulnerable groups (RRP 1997). The program was agreed by the Mongolian Government after extensive consultation through workshops, position papers and public debate – processes that were previously quite unknown.

Involving the community in health

Rifkin (1990) describes community involvement in health development as a process by which a partnership is established between the Government and local communities in the planning, implementation and utilisation of health activities in order to benefit from increased local self-reliance and social control. These ideas are not new. The 1978 Declaration of Alma-Ata sought the commitment of World Health Organisation (WHO) member countries to a strategy of primary health care, an important element of which was the promotion of greater and more effective community participation in planning and provision of health services (WHO 1979). Ladbury (1997) notes the worldwide trend towards empowerment of the patient with citizens demanding more client and community approaches to health care.

Community involvement in health derives its conceptual strength from the trend towards people's participation in the 1970s and 1980s. The WHO promoted this idea and, in 1985, first used the term "community involvement in health" to describe community participation in the planning, implementation and monitoring of health care and promotion (Oakley 1989).

Kahssay and Oakley (1999) identified several factors that influence the implementation of community involvement including political commitment to secure a participatory platform, and the reorientation of formal health and other development organisations to devolve bureaucratic authority to the levels at which community participation can operate. In essence, community involvement emphasises accountability of health systems to the public, encourages individual and community responsibility for wellness, and values openness about directions to be taken in health policy and direction (Burkey, 1993; Midgely, 1986; Rahman, 1985). Walt and Gilson (1994) have argued that policies directed towards change need to be consistent with societal values and should reflect the interests of the community and key stakeholders. In the context of Central Asia, Savas and Gedik (1999) argue that a comprehensive and participatory process can contribute overall to the development of a democratic culture. These basic ideas have strongly influenced the development of community participation models in Mongolia.

Establishment of hospital boards in Mongolia

The Mongolian Ministry of Health (MoH) established hospital boards in 1998. They were the first attempt simultaneously to involve consumers (the community) in health management and decision-making and to provide a strategic management capacity to achieve the hospital's aims and objectives. Boards were empowered to nominate the hospital's Executive Director, direct strategic management including goal-setting and planning, approve the hospital's organisational structure and number of staff, set budgets to control income and expenditure, promote improvements in the quality of clinical services, and assess community needs and expectations. Boards were established for each of the 11 major clinical and specialised hospitals (mostly in Ulaanbaatar, the capital city), and the 21 aimag (provincial) hospitals.

Several problems emerged almost immediately. First, tensions were created between the board and the hospital's Executive Director. The board's powers were significant, and it was not unusual that its members chose to intervene in the day-to-day operations of the hospital.

Second, consumers were under-represented: only one of the seven board members was to be a community representative. The board was dominated by people with vested interests such as doctors, nurses, health insurers, and medical educators.

Several other weaknesses became apparent. The creation of the hospital board did little to encourage links with community-based services such as district nursing and family group practice. Nor was there any encouragement of collaboration between hospitals in spite of the importance of the referral system in a country as sparsely populated and poor as Mongolia. There were also obvious disadvantages in having eleven boards in Ulaanbaatar, which has a population of only 700,000 and obvious needs for hospital networking and rationalisation.

Refinement of the hospital board model in 2000

The Mongolian government was quick to respond to the design weaknesses. Revised regulations were issued in 2000 that resulted in four main changes.

First, provincial health service boards were established, which were empowered to manage all the health care facilities within the province. Given that most responsibilities for health services have been devolved to provincial level since 1996, this has provided a significant opportunity to address matters of collaboration and integration.

Second, the number of community representatives was increased. They now comprise 5 out of 11 members for general tertiary hospitals, 4 out of 9 for specialised tertiary hospitals, 4 out of 11 for provincial hospitals, and 4 out of 10 for urban district hospitals. The other members are now more widely representative of special interests in that there are requirements to include nominations from health sector employees, general practice, and local government.

Third, the roles of the boards have been redefined to emphasise community accountability, strategic planning, and community needs assessment. Their opportunities to intervene in operational management have been significantly reduced.

Fourth, the method of appointment of board members has been revised. In general, members are appointed by the Director of Health in each region, after an appreciable degree of consultation. The steps comprise public invitation for nominations, assessment of suitability based on experience, contribution to community development, and formal appointment for a period of three years.

Thus the Mongolian process closely resembles that commonly used in the United Kingdom (for example, for NHS Trusts), Australia (Area Health Services in several states) and New Zealand District Health Boards, which have recently moved towards an elected board member basis (Gauld 2002). One common factor is representativeness of the communities being served.

In Mongolia, board members receive a director's fee plus attendance allowances for each board meeting. The payments are deliberately intended to stimulate community interest and participation.

The boards, with their strengthened community representation, may be an important step towards democratisation. They facilitate transparency and accountability in the management of public resources, and increase involvement of the community in setting direction for the type of care the community needs.

The government is committed to community involvement in the provision of services in other sectors besides health. It has indicated in its Good Governance Program that increased public representation on governing bodies will be a future priority (Mongol Messenger 2000). The commitment to increased participation is one of the reasons Mongolia's reforms have been more successful than many other transitional countries influenced by the Soviet model.

Other areas of community involvement

Several other activities are under way that are intended to promote community participation. Five are noted below.

First, there is the Family Group Practice (FGP) model (Hindle et al, 1999). In brief, family doctors are losing their salaried government positions and being given assistance in establishing themselves in private group practices, with guarantees of income through risk-adjusted capitation payments from the government. FGPs are expected to employ nursing staff, and to provide outreach (home) services as well as clinic-based primary care. All citizens are entitled to register with the GP of their choice, and the FGPs receive income accordingly. By 2002, 56% of the population was covered by this new model, and it is intended that all of Mongolia will be covered by a primary health care network by 2004 (Orgil, Hindle et al 2002).

The FGP model directly promotes community involvement in several ways. One is by use of patient satisfaction survey instruments – a novelty for Mongolia (HSDP 2000). Another is the registration process itself, in that choice of care provider is also new in many respects. Mongolians are able to choose their own practitioner, unlike in Kyrgyzstan, Uzbekistan and Turkmenistan where defined catchment areas dictate which doctors can be selected (Savas and Gedik 1999). In Mongolia, major efforts were made to ensure people were aware of the program and their rights to access – and they were given details of the backgrounds and experience of Family Doctors in their area to help them to make their choices.

Second, community participation is being encouraged through Revolving Drug Funds (RDFs), which have been established in approximately 100 local areas by the MoH in collaboration with the United Nations Children's Fund (UNICEF). The idea is simple: local communities are given a start-up stock of cost-effective drugs, which they are allowed to sell to generate funds for the next set of purchases. Each Fund is managed by elected volunteers within a management committee, and any profits may be applied by the committee to other health-promoting activities in their community. There are other ways of achieving the same objectives – of access to reasonably priced drugs under some form of social pooling arrangement – but the RDF approach has the distinctive attribute of developing a strong sense of local control.

Ensor and Thompson (1998) have stressed the significance of health insurance as a vehicle for wider reform in health, with community involvement and engagement important aspects. A third area of community involvement in Mongolia is Health Insurance Councils, which are primarily concerned with the operation of the national government-operated compulsory health insurance scheme (Hindle, Van Langendonck & Tsolmongerel 2002). The Councils, which operate at national and regional level, include community representatives nominated by consumer non-government organisations and are involved in determination of insurance rates for population groups and in extending population coverage. They have given particular attention to the monitoring of access of services by poor and vulnerable groups.

Fourth, there are the Community Health Volunteer networks – volunteers organised at the local government level for a variety of purposes including assistance with primary care (and FGP activities in particular). Volunteers are associated with and trained by Family Doctors (using a 21-day curriculum with specially designed materials). They work with groups of families at village level on such tasks as reporting diseases, monitoring pregnancies, advising on infant care (including breast feeding and weaning), weighing children, assisting with immunisations and their follow-up, and family planning activities. This program has been well received, and provides a strong community participation focus at the local level. This is particularly encouraging, given that Mongolia, like most of the central Asian countries, has had no significant history of voluntary work.

Fifth, there have been efforts to inform the community at large about health, health care, and consumers' rights. Again, Mongolia has much more success in this regard than similar countries. For example, Gedik et al (2002) note that information and communication activities in Central Asia have largely failed to involve local people in their design, thus failing to gain community confidence and participation.

An extensive Information and Awareness (social marketing) campaign was initiated at the commencement of the reform program. It involved electronic and print media, posters and brochure campaigns, focus group exercises to gauge public opinion, and question and answer sessions involving senior health personnel (including the Minister for Health) and the community via TV and radio programs and newspapers. The campaign described the reform process, so that the population had the opportunity to learn about changes and long-term benefits. In addition, the campaign sought community participation in the FGP model and in primary health care generally, by outlining community and individual roles in health promotion and disease prevention (BBC MPM 1999).

The Government is currently examining extensions of the community participation process as part of a technical assistance program supported by Asian Development Bank, which is directed at strengthening provincial health services. Several ideas are being developed including the establishment of a National Public Health Committee responsible for coordination and organisation of public health programs at national level and ensuring representation from non-health sectors and the community, Community Advisory Groups to work with local health authorities on health issues, training for local government staff on participatory mechanisms and practical approaches to engage local communities, increased training for Health Volunteers, and introducing community health issues into training curricula for health professionals including doctors (ADB 2002).

Discussion

Before independence, the health care system was driven by inputs and by the providers of treatment, with patients regarded as compliant users. As in other similar countries, coverage and access to health care were good, but choice of care or provider was limited for patients, and complaints were not encouraged (ZdravReform 1999). This lack of choice permeated all aspects of health care, reflecting the essentially weak role of the patient as a consumer.

Hospital boards are a vital first step in the Mongolian government's aim of increasing community participation. Already in the first years of operation, the boards have provided a platform for public involvement in health services and for accountability back to the community. A recent examination of hospital board functions as part of a broader review of the health reforms (HSDP 2000) indicated some very positive aspects of hospital board and community interactions including reports of hospital board meetings in local newspapers, patient and community surveys undertaken by the hospital board to assess satisfaction and need for new services, local press attending board meetings, employees' surveys to gauge staff concerns, regular inspections and visits to hospitals and clinics, and development of performance indicators and targets to be achieved in hospitals.

There appear to be several reasons why Mongolia has been relatively successful thus far. First, there is the pace of change in committing to openness and community engagement. Healy et al (2002) note that the success or failure of health reform depends to a large part on the political and social environment, and that progress will remain slow in the absence of wider political and community participation. Some Central Asian countries, such as Kazakhstan (Economist 2002; Olcott 1998) and Uzbekistan (Ilkhamov and Jacubowski 2000), have failed to embrace community participation or openness and basic democratic processes have stalled as a result. In contrast, Mongolia has fully accepted the idea of community involvement as a partnership between Government and local communities. This reflects Mongolia's overall commitment to democracy. Since the transition in the early 1990s, Mongolia has had three general elections and the government has changed twice.

Second, Mongolia has shown a willingness to adopt new ideas on community involvement and, if necessary, to change the model if it is not working optimally – as in the case of the first phase of hospital boards. These factors have contributed significantly to the extent of community involvement in Mongolia.

One aspect of concern is the serious economic situation in Mongolia – the GDP has increased on average only 1% per annum over the last 3 years. According to a WHO Study Group (WHO 1991), community involvement requires a significant investment in resources (staff, logistics support, teaching materials, and so on) and these may be difficult to obtain in resource-poor countries. Continued efforts to strengthen community participation may be viewed as a luxury when budgets are under increased stress. The argument that it is a good investment in both economic and social terms has never been easy to promote, even in wealthy countries like Australia.

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