Health and safety regulations and its implementation

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The Mongolian health sector policy is determined by the Constitution of Mongolia, the Health Law and other related regulations, government polices on public health, other acts and documents developed by the Ministry of Health[6].

Values of health laws and regulations are the following:

- Right to health and well-being
- Equity
- Pro-poor[7]
- Client centered
- Gender sensitive.

1. General provisions

Let us see the goals and brief contents of main legal acts and policy documents that determine legal environment of the health sector.

1.1 Legal acts

The Constitution of Mongolia

The citizens of Mongolia are guaranteed to enjoy the following rights and freedoms[8] :

- The right to healthy and safe environment and to be protected against environmental pollution and ecological imbalance
- The right to material and financial assistance in old age, disability, childbirth and childcare and in other cases as provided by law
- The right to the protection of health and medical care. The procedures and conditions for free medical aid shall be determined by law.

Health Law of Mongolia

The purpose of the Health Law is to define the state policy and basic principles on health to regulate the relations raised in connection with the responsibilities of organisations, business entities and individuals in safeguarding the social health and the rights of the citizens and officials of this country to health protection and medical aid and service; to regulate the legal framework of activities of health organisations and employees thereof.

All citizens have a right to receive medical care and services from doctors and health organizations (Article 47). According to the Health law, the citizens of Mongolia shall obtain the following medical aid and services such as medical emergency and ambulance service, treatment of tuberculosis, cancer, mental or some diseases, which require long-term rehabilitation process, disinfection and outbreak management

[6] Health sector strategic master plan, 2007
[7] This concept describes the resource allocation and management processes that will guarantee that the poor and very poor are not prevented from accessing the required quality care thus ensuring vertical equity.
[8] The Constitution of Mongolia, Article 16, 1992

of infectious diseases and medical services for pregnant women free of charge regardless of whether he or she is covered by the health insurance.[9]

The Health Insurance Law

The Health Insurance Law determines the form of the health insurance, the health services it covers, the paying of its premiums and the relations between the health insurance and health institutions, state, citizens and legal entities connected with the assembling, distributing and utilizing the health insurance fund.[10]

Law on mental health

The purpose of this law is to protect and support mental health of population, to determine state policies and principles on preventing from mental disorders, to define responsibilities of economic entities and citizens to assure that a person with mental health problems can get medical, social and psychological care, to regulate legal framework of health facilities providing mental health care and services. [11]

The Drugs Act

The purpose of the Drugs Act is to regulate relations with regard to manufacturing, importing, storing, retailing, distributing, utilizing and monitoring of drugs and bio-preparations for humans and livestock.[12]

Sanitation law

The purpose of this Law is to govern relationships concerning maintaining of sanitary conditions, defining the general requirements for sanitation in order to ensure the right of an individual to healthy and safe working and living conditions, ensuring normal sanitary conditions, defining the rights and duties of individuals, business entities and organizations with this respect.[13]

Concept of national security

This law regulates ways and means of ensuring Mongolian national security.[14]

The Food Law

The purpose of this Law is to ensure food necessities of the population, food safety and to regulate relations that arise between the government, individuals and legal entities in connection with the food production and services.[15]

1.2 Policy documents

Health policies are composed from following sub-policies:

State Public health policy

This policy aims to protect and promote people's health by establishing a healthy and safe environment to live, work and study through improving the harmony between people, nature and society.

The public health policy aims to increase involvement and participation of Government and NGOs, family and community to encourage healthy behaviour and focus equally on health promotion, preventive and curative issues.

Drug policy

The purpose of this policy is to provide the population, hospitals and veterinary clinics with effective, safe and good quality registered

[9] Health Law, article 28, 1998
[10] Health Insurance Law, 1993
[11] Mental Health Law, 2004
[12] Drugs act, 1998
[13] Sanitation Law, 1998
[14] Concept of national security, 1992
[15] The Food Law of Mongolia, 1999

medicines and drugs, continually and with equal access.

Population development policy

The purpose of this policy is to create an environment for the population to live a long, healthy and creative life thus ensuring sustainable population growth.

Mongolian Traditional Medicine Development Policy

The purpose of this policy is to develop Mongolian Traditional Medicine on the basis of principles of disease prevention, treatment and rehabilitation by enriching it with modern scientific achievements.

Health sector Human Resource Development Policy

This is a policy paper, which provides the sector's human resource development directions for upcoming 10 years, in order to upgrade quality of public health and medical care and services they provide.

Concept of Mongolian national security:

Chapter 9 of this concept determines the means to secure population health, its gene pool maintenance, sustained growth and protection from external and internal factors, which may adversely affect the endurance of the safety of population.[16]

2. Capacity to implement laws

Among many of short and long term issues faced by health sector, financing, equity, care, and responsiveness are the priority ones. These issues are shown in Table 1 in accordance to sector areas of work. Table 1 summarises the priority issues.

Table 1. Key Area of Priority Issues

Key area	Priority issues
Health Services Delivery	• MMR and IMR have been showing steady decline but are still high. • Low utilization of the health services by the poor and the vulnerable groups • Existing referral system is not functioning well • Gate-keeping function of the FGPs and the soum hospitals in very inadequate • Curative based hospital centred approach contributes to the over-capacity of hospital beds at the secondary and tertiary levels especially in Ulaanbaatar • Community participation in the planning, implementation, monitoring and evaluation of the health services is very limited • Hospital services are not appropriate for the corresponding level of care • Costly and wasteful services predominate • Ambulatory services and day, home and palliative care are inadequate • Technological developments are not introduced into the health services in a timely manner. • No continual decline in the incidence of communicable diseases coupled with a corresponding increase in non-communicable diseases

[16] Concept of national security , session 9, (*www.mfa.*)

Pharmaceutical & Support Services	• Availability of essential drugs is still problematic especially in rural areas • Logistic management with particular reference to drugs, medical supplies, commodities and equipment is fragmented and there is no integrated Logistics Management Information System (LMIS) covering procurement, inventory, warehousing and distribution. • Low and counterfeit quality drugs are commonly available and used because of poor quality assurance and control. • There is widespread poly-pharmacy and irrational drug use by prescribers. • Widespread self medication including an indiscriminate and excessive antibiotic usage and a high injection rate per person are very common in the community • Outdated equipment and technology and their being in a state of poor repair • Hospital buildings and transportation in terms of the premises and vehicles being unsuitable and also in a state poor state of repair. • No suitable diagnostic standards and guidelines for laboratories at the various levels of care. • Diagnostic capacity is generally poor throughout the system.
Behavioural Change & Communication	• Sedentary lifestyles especially of the urban and peri-urban dwellers • Unhealthy lifestyles associated with increasing smoking, alcohol consumption, high calorie fatty diets and reduced consumption of micronutrients • Increase in unsafe sexual behaviour especially among the young people • Other risk-taking behaviours especially on the road resulting in higher incidence of fatal road traffic accidents • Poor sanitation, improper latrine use, poor waste management and personnel hygiene at household level and the lack of availability of safe water • Biological and chemical contaminants, such as Arsenic, in the environment because of industrial and other pollution and inadequate disposal of garbage and waste. • IEC activities are fragmented, often duplicated, inappropriately targeted and not effectively monitored and evaluated to determine their impact. • Service providers frequently exhibit negative and judgmental attitudes and lack appropriate communication and counseling skills • Services currently provided in the health sector are not client-friendly in terms of the providers' attitudes, health setting environments and access to information about health promotion, clinical services and skilled personnel. • Lack of initiative and willingness to exercise among the general population reinforced by a very underdeveloped community fitness infrastructure
Quality of Care	• Current quality management system is not well developed and there is no culture of quality because of lack of knowledge and methods. • Absence of a sector-wide national programme for continuous quality improvement • No award or incentive mechanisms for good and improved quality • Standards are inadequate for different levels of health care and services • Few evidence based quality standards and related application guidelines, training programs and materials • Professional associations are currently not involved in quality of care management • Unsatisfactory use of quality indicators in the evaluation of the services

Human Resource Development	• Shortage of health workers in the rural areas and overstaffing in Ulaanbaatar city • Lack of interpersonal communication skills and poor ethics among health workers • I nappropriate pre-service, limited continuing education and in-service training combined with a strong over-emphasis on specialisation. • Insufficient and inappropriate continuing education for midlevel health workers. • Poor clinical and management competence of staff in health facilities • Rapid staff turnover in the rural areas • Low salaries (lowest salaries in the social sector) of the health workers combined with insufficient incentives, inadequate social protection and a poor working environment • No career pathways or incentives, especially for the mid level health workers • Excessive workload on the soum doctors leads to the neglect of the provision of public health services • Weak professional associations resulting in a poorly organized and managed health workforce. • The production of human resources not linked to policies and planning in the health sector
Health Financing	• Fragmented health financing and inefficient financial management • Lack of capacity to understand and implement the PSFML and the related international accounting practices at all levels. • Budgeting practices vary widely between different health facilities and levels because the implementation of the PSFML is not uniform. • Financial deficits incurred by hospitals are written off by the government encouraging fiscal and managerial irresponsibility. • Health insurance financing is not linked with the performance or reduction in costs • HIF co-payments and related user charges are a significant barrier for the poor and vulnerable to accessing health care especially at the secondary and tertiary care levels. • The ownership of the HIF and the control over its operations is split between the MoSWL and MoH and this makes management and use of HIF funds cumbersome.

Institutional Development and Sector-wide Management	• weak management capacity at all levels and inappropriate organizational structure, • dominant project based management not integrated with the various health policies, • weak integration and coordination of programs and projects implemented by international partners, • absence of sector wide approach • poor preparedness and response to and fragmented management of natural disasters and emerging public health problems • inefficient budgetary planning and resource allocation, (PSFML) • weak system of accountability and lack of transparency • lack of continuous and sustainable development of local and top level managers through in-service training and continuous education • transfer of many activities, duties and responsibilities to local governments without adequate capacity building, • no integrated policy on privatisation • no appropriate regulations and guidelines to monitor the • poor quality of information, • weak capacity to use information for decision making • the lack of an integrated health research system • weak routine monitoring and participatory evaluation of performance

Source: Government of Mongolia, MOH. Health Sector Strategic Master Plan 2006-2015, Ministry of Health, pp. 40-43.

3. Health sector relations left without regulation

1. Essential and complimentary package of health services and national programs lack financial mechanisms to support sustainable, continious health services at bagh and soum levels, ger districts.
2. Unclear position and status in the medical and professional hierarchy, responsibilities and financing of FGPs, which provide emergency care and services.
3. A sector-wide referral system (level of competence of the staff at all the levels, criteria for the hospital admission, criteria for the patient referral to higher referral level, based on diagnostic-treatment standards, list of services to be provided on each level, instructions, guidelines, forms, referral related incentives and penalties) is not established.
4. Lack of standard instructions and guidelines to monitor laboratory quality assurance and accreditation system all levels.
5. Lack of policy to coherence Law on health insurance goals, activities, state budget, Law on financing of government organisations, health state accounts with another financial and managerial structures.

The first Mongolian Food Law, which was adopted in 1995, based on international organisation's definition, stated that "food safety means a condition when adequate supply and availability of food, appropriate norms of food hygiene and quality are satisfied". However, in its 1999 Ammendment, the availability and supply issues were left out and now it states that "food safety means a condition when appropriate norms of food hygiene and quality are satisfied."[17]

[17] Rural development: rdmorgolia.blogspot.com

4. Evaluation and conclusions of researchers on implementation of laws and regulations

Here is a short summary of health related laws and regulations:

Health care services:

- A client-freindly, standartised service structure has not been established yet.
- Essential and complimentary package of health services and national programs lack financial mechanisms to support sustainable, continious health services at bagh and soum levels, ger districts .
- Hospitals, health centres, health facilities lack follow-up mechanisms to assess and evaluate service provider's attitudes and communication skills.

Pharmaceutical and support services:

- Lack of standards and methodologies to calculate drug needs, in order to make drug supply and procurement real and appropriate.
- Poor adherence of local pharmaceuticals manufacturers to GMP .
- Slow work of reconciling techical standards and guidelines to be used for accreditation and monitoring of quality assurance of laboratories to the national standards.

Quality of care:

- Without health care and services provider's communication skills included as a part of performance evaluation of health care providers, complaints related to provider's
- attitude and communication will not stop.
- Lack of integrated management and a mechanism for improvement of quality of care, and decentralisation.
- In the countryside, work to monitor and conform the health facility structure, diagnostic and treatment standards, criteria and indicators according to international standards is backward, thus making differences in techiques and technological development bigger.
- Poor involvement of community, NGOs, local government in planning, implementing, monitoring and evaluating health services and care. There is a need to establish a suitable mechanism to support this involvement.

Sector capacity:

- No work is done to review and upgrade the legal framework and the human resources development policy to establish high level body to regulate training, recruitment, deployment and career development of health personnel sector-wide.
- There is a need to renew financing guidelines and procedures according to the market relations, in order to coordinate interactions between the aimag, city, local government and the Governmental fund to ensure sustainable timeliness and volume of the funds from the state budget to health services.

Health financing:

- There is no linkage between the Health insurance goals, its state fund, Law on government organisation management and financing, the State health account with other financial and management information system Therefore, there is a need to revise and renew the current health insurance legal framework, and its principles