Health Care in Mongolia

Field Notes from *Batnorov*

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Introduction

Once familiar to me only as the birth land of the great Genghis Khan (and as a place where babies learn to ride horses before they walk), Mongolia struck me with a kind of surreal beauty. Tall, dry grass covered the expansive plains that steeped into gently rolling hills. Overhead, cartoon-shaped clouds bobbed along peacefully, hanging so low it seemed that if I reached out my hand and jumped, I could touch them. Spread out on the plains like drops of paint were flimsy wooden houses and *gehrs*, the traditional lodging of Mongolians. The scenery was so picturesque that when I first arrived in Batnorov this past August, I almost forgot why I had come to Mongolia in the first place.

I was accompanying the Korean Open Doctors Society as a student volunteer on their annual trip to Mongolia. Korean Open Doctors Society is a secular, non-governmental organization committed to providing health care both in Korea and abroad. Since its modest inception in 1997, the humanitarian-based organization has made over 140 international and countless domestic medical aid trips. Although its countries of target are numerous, Open Doctors has a special connection to Mongolia in that the organization first started from an informal volunteer trip made to Mongolia by its founding members. Since then, they have returned every year—often more than once to different parts of the country—and have built a strong connection with the local population. This particular trip to the Batnorov district was their 25th Mongolian mission.

In a village of dirt roads and no running water, where the grandest building resembled a run-down convenience store from rural Alabama in the 1940s, there was one structure that was rather sturdy and seemingly permanent—the Batnorov *sum* Hospital. Set off from the rest of the village by white fences and topped with a bright cherry red roof, the hospital stood towering over all other buildings (although "towering" is a relative term–it only had two floors). The interior of the hospital was even more impressive: clean, white floors with freshly painted walls and fluorescent ceiling lights that screamed "STERILE." However, the impressive exterior belied the truth, for the hospital was barren—quite literally, empty. No beds, no equipment, no furniture, not even a medicine cabinet.

The Batnorov *sum* Hospital is not very different from other hospitals in poor *sums* (translated as rural districts in Mongolian). A *sum* is the second level administrative subdivision of Mongolia after *aimag*, the first level division. The nation of Mongolia is divided into 21 *aimags,* which are subsequently divided into 329 *sums*. A *sum* has 4,200 km^2 of territory on average and is home to about 5000 inhabitants, mostly nomadic herders.

Since the discontinuation of aid from the former Soviet Union in the 1990s, a lack of funding has resulted in a shortage of medical supplies, fuel and other resources in Mongolia (Manaseki, 1993). However, as the edifice of the Batnorov hospital suggests, Mongolia should in no way be simply written off as another destitute Third World country. Being a centrally-planned economy that was suddenly plunged into a market economy without guidance, Mongolia has struggled with complex issues of "Soviet-ized" health care infrastructure and is currently still in transition.

History of Health Care in Mongolia

After Genghis Khan's legendary Eurasian empire disintegrated in the 14th century, Mongolians gradually retreated to their original homeland, which closely coincides with the current national territory. They came under the rule of the neighboring Chinese in the 17th century. However, in 1920, the Russian Civil War spilled over the national border into Mongolia and subsequently drove out the Chinese forces that then occupied Ulanbaatar. This event catalyzed Mongolia's close alignment with the Soviet Union over the next 70 or so years, and with the USSR's help, Mongolia gained independence in 1921 and established the Mongolian People's Republic (Central Intelligence Agency [CIA], 2011).

Mongolia, as a communist nation, accepted public sector responsibility for the health of the nation's population at the time of its independence. Public health in Mongolia therefore saw its birth in the early 1920s, and after the launching of the first civil hospital in 1925, various specialized hospitals soon emerged. Provincial and rural facilities followed between 1925 and 1930. In the next ten years, Soviet medical care research and development teams were sent to Mongolia to provide medical services and guide the country in establishing a public health network. Such expeditions introduced Western medical knowledge extensively to the impoverished country (Korea Foundation for International Healthcare [KOFIH], 2011). Projects in the field of health care flourished, and by 1960, almost 25% of *sum* districts had medical facilities. In 1978, a national health law, designed to further improve the nationwide system of standardized services established between 1940 and 1960, was passed (Neupert, 1995). Under Soviet administrative support, this law provided the stepping stone for the current

referral health care system: the patient is referred from rural posts to *sum, inter-sum,* provincial and finally national hospitals (Neupert, 1995).

The advancement of Western medicine in Mongolia ran parallel with the decline of the practice of traditional Mongolian medicine. As the country became more Westernized, traditional medicine was inevitably rejected as part of the pre-modern past. Until 1921, traditional Buddhist-Tibetan medicine had been the sole basis for health care. The indigenous traditional medicine had been incorporated under the overarching framework of Tibetan Buddhism and was mainly practiced by Buddhist monks. Thus, it met its end when Stalinist purges of Mongolian religions took place in the 1930s (Baabar, 1999).

The socialist regime was entirely responsible for the country's health budget and directly provided public health service, leading to a centralized, bureaucratic public health sector (KOFIH, 2011). More importantly, the Soviet Union made an indispensable financial contribution to Mongolia's health care (Soviet assistance at its height was one-third of Mongolia's GDP). The USSR's decline in 1990 resulted in an abrupt cessation of financial assistance, and Mongolia was thrown into a deep and long economic recession over the next decade, under which the health sector suffered. After the break from the Soviet Union, Mongolia turned abruptly toward a free-market economy and extensive privatization. The country continues to struggle as a result of this sudden change from a formerly state-run economy (CIA, 2011).

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The Current Situation

There are two issues at hand with the current Mongolian health care system: a lack of funding and marginal preventive medicine. While the USSR provided aid, Mongolia never reached a level of socioeconomic development high enough to sustain a health care system modeled after those of modern Western countries (Neupert, 1995). Although not hopelessly destitute, Mongolia remains far from standing on its own feet. According to the Organization for Economic Co-operation and Development (OECD), Mongolia is one of the countries receiving official development assistance (OECD, 2011). With a GDP per capita of $3,522 (2009), Mongolia is classified as a Lower Middle Income Country/Territory. Its total expenditure on health was 4.7% of GDP as of 2009, compared to the United States' 16.2% (World Health Organization, 2009). As the United States' GDP per capita equaled $45,989 (2009), roughly 13 times that of Mongolia, it is quite easy to see that the health care available to Mongolians is incomparable to what we take for granted.

To make matters worse, the abrupt induction into capitalism in 1990 meant that the health sector became market-based as well. Health care service previously available to Mongolian citizens—all expenses paid by the government—has become, in large part, "off limits" to the poor. The few resources Mongolian hospitals do manage to procure, such as drugs, equipment, ambulances, instruments and personnel, are accessible only to those with the means to pay for them, and, oftentimes, "unofficially" to the hospital faculty (KOFIH, 2011). The country's health system continues to struggle with structural transformations necessitated by the policies and realities of a capitalist economy (O'Rourke & Hindle, 2001).

Another issue is that the current health delivery system emphasizes clinical treatment but significantly neglects preventive medicine. As mentioned above, the Mongolian system is fundamentally rooted in the Soviet model, and while Soviet influence has had a largely positive impact in centralizing and modernizing the system, its major shortcoming—the neglect of preventive medicine—has also carried over. In fact, the concept of preventive medicine has not firmly settled into public awareness (KOFIH, 2011). The dominant preventive medical approach adopted in modern Mongolia has been mandatory examinations by mobile medical teams. This medical "policing" system, which imposes health care on the population, has hindered public awareness of the fact that health care is a responsibility that applies at the individual and community level. As a consequence, primary health care initiatives including "hygiene and nutrition education [and] improvement of local sanitation and environments" have historically been underdeveloped (McMurray & Smith, 2001). Today, although some basic interventions such as vaccinations are carried out, campaigns or programs to expand the population's overall knowledge in primary care are severely deficient and inadequate.

Furthermore, with the loss of traditional medicine in the 1930s, Mongolia eradicated two thousand years' worth of accumulated self-care knowledge. Traditional Mongolian medicine centers on a biopsychosocial balance, which fosters self-care and helps keep ailments at bay through changes in behavior and lifestyle in conjunction with herbal infusions and other treatments. Although Western society has questioned the scientific basis of some aspects of indigenous medicine (e.g. religious prayers and rituals), preventive traditional medicine is authentic to the extent that practitioners instill appropriate long-term behavior patterns in response to compromising environmental factors. For instance, people with obsessive personalities who tend to be restless and thin are "generally taught to avoid running, exposure and distracting stimuli, especially in cold, clear and dry seasons or climates, because these make them prone to disorders…like arthritis or insomnia" (Loizzo et al., 2009). It is thus probable that a public health care model structurally lacking in preventive medicine coupled with the loss of traditional self-care knowledge may have increased Mongolians' susceptibility to illnesses (Neupert, 1995).

Batnorov

My observations will perhaps elucidate the stark reality of health care in Mongolia., although they are only a snapshot of the myriad challenges that the country currently faces. During our five days in Batnorov, an average of 430 locals per day came to be examined and treated. Many traveled from distant villages, and fights broke out among villagers pushing each

other to obtain patient number tags. For many of them, the annual or biannual trips the Korean Open Doctors Society made were their only exposure to proper modern medicine.

Villagers came from far and wide to have their immediate injuries and aches cured, but an observation of their diet, lifestyle and housing showed that any treatment would provide only temporary relief; most villagers had neither the concept of nor the access to basic natural resources needed for healthy nutrition and hygiene. The dry climate and terrain contribute to the lack of vegetation in the villages; thus, vegetables and fruits are extremely limited in the daily diet. Instead, a typical diet consists of red meat, animal fat and dairy products. As for personal hygiene, locals live in communal outhouses (often just one for many families) and toilets are fashioned simply from wooden planks placed side-by-side with a gap in the middle over a deep hole. The arid climate brings little rain, and the lack of plumbing means that most locals have no running water. Washing frequently, or even regularly, is not an affordable option.

The Future

Mongolia faces a difficult challenge in improving its medical system. Overall, the country is economically underdeveloped, which limits resources and the ability to provide quality medical services and coverage to the poor. The low socioeconomic status also makes it difficult for the country to solidify its health care infrastructure. These financial problems are long-term issues that Mongolian officials must address. Although these problems are extremely pervasive, there are short-term goals that can be met.

The second issue may have a more achievable short-term solution: the limited-to-nonexistent knowledge of the Mongolian population regarding preventive and promotional health. This problem can be alleviated by simple efforts to increase public awareness. While attempting to reform the larger health care system, a revival of traditional medicine should also be incorporated as part of a broader effort to entrench preventive care into the Mongolian health care system. Such projects are in progress. For example, in 2004, the Nippon Method was implemented in Mongolia, the purpose of which was to enhance primary health care. The project supplied participating families with a family pharmacy kit of traditional medicines and gave an accompanying health education. The Mongolian people and physicians who had forgotten the use of traditional medicines were trained via broadcast on national television, which also proved to be an effective general health promotion strategy. The results showed that 64% of the participants noticed a general improvement in their health, and an increased understanding and use of traditional medicine enhanced the confidence of Mongolian physicians (WHO, 2007).

Traditional medicine, which actually only began to be revitalized in the 1990s after the break from the Soviet Union, represents not only a wealth of self-care knowledge but also a wealth of Mongolian culture. Its foundation in Tibetan Buddhism has ensured a firm place in the cultural realm, and its incorporation into public health care would benefit the country both in terms of optimal use of available resources and in preserving its national identity. In moving forward, global health experts should focus on improving Mongolians' quality of life by disseminating modern Western medical practices. However, in doing so, they should pay careful attention to respecting and reemphasizing the traditional culture.

The image of the Batnorov *sum* hospital serves as a symbol for the critical issues at hand. Initially built during the time of Soviet aid, its aim was to provide continuing Western medical care to the locals. However, a severe lack of funding following Soviet decline left its medical faculty with bare minimum supplies and resources. The excessively high number of patients with festering sores, illnesses and cavities that could have been moderated by basic self-care suggests a lack of preventive medicine—or at the very least, a lack of public health awareness.

Health care service previously available to Mongolian citizens had become "off limits" to the poor.

Watching the most beautiful sunrise over endless plains of gold from the hospital and turning around only to come face-to-face with twiglike, thinly clothed children smiling at me with blackened teeth was tragically ironic to the point of physical agony. I hope and pray that in the near future, those same children will be relieved of all their pain and be granted the physical and psychological health that would allow them to appreciate simple things like the sun rising over their village.

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