

## Cost Containment in Comparative Health Systems: A Comparative Descriptive Analysis and Document Review of the United States, Germany, Japan, South Korea, and Mongolia

Amarzaya Batchimed <sup>1\*</sup>, Khongorzul Altangerel <sup>2</sup>, Buyantogtokh Batsukh <sup>1,3</sup>, Ganzorig Batbaatar <sup>1,4</sup>

<sup>1</sup> Graduate School, University of Finance and Economics, Ulaanbaatar, Mongolia

<sup>2</sup> Health Department of Orkhon Province, Erdenet, Mongolia

<sup>3</sup> Advisor, Secretariat of the State Great Khural (Parliament of Mongolia), Ulaanbaatar, Mongolia

<sup>4</sup> National Center for Pathology, Ulaanbaatar, Mongolia

\*Corresponding author: Amarzaya Batchimed E-mail: [amarzayabatchimed@gmail.com](mailto:amarzayabatchimed@gmail.com)

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**Abstract:** Containing healthcare costs while preserving quality and access remains a central challenge in health policy. Rising expenditures – driven by population ageing, technological change, wage growth, and expanded coverage – pose increasing risks to fiscal sustainability. In Mongolia, ongoing health financing reforms highlight the need for clearer evidence on effective and context-appropriate cost-containment strategies. **Objective:** This study compares cost-containment strategies across the health systems of the United States, Germany, Japan, South Korea, and Mongolia, and identifies specific policy options tailored to Mongolia. **Methods:** A sequential explanatory comparative design was applied. Quantitative analysis used the most recent available data (2019-2024) from OECD Health at a Glance 2025, the World Bank, WHO Global Health Expenditure Database, and national Health Accounts to compare expenditure patterns and system indicators. This was followed by a structured document review and thematic policy analysis of national policies, institutional reports, and peer-reviewed literature. A deductive-inductive coding framework identified key cost-containment mechanisms and their empirically documented outcomes. **Results:** Health expenditure as a share of GDP ranged from 17.2% in the United States to 8.4% in South Korea, with substantial variation in per capita spending. Countries with stronger centralized price regulation, coordinated purchasing, and pharmaceutical cost control, particularly Japan and South Korea, achieved more effective cost containment while maintaining favorable health outcomes. Germany demonstrated stable expenditure growth through negotiated pricing and corporatist governance. In contrast, the United States exhibited high expenditure with limited cost control. Mongolia showed constrained strategic purchasing capacity, limited provider incentives, and hospital-centered resource allocation. **Conclusion:** Effective cost containment depends on payment design, purchasing capacity, and regulatory coherence. For Mongolia, evidence supports adopting a blended payment model combining expanded DRG-based hospital payments with capitation-based primary care financing and 20-30% performance incentives, alongside increasing primary care expenditure to 30-35% of total health spending and strengthening pharmaceutical pricing and regulatory mechanisms.

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**I. INTRODUCTION**

A key objective of global health policy is to contain rising healthcare costs, as unchecked spending growth poses significant risks to fiscal sustainability. Cost containment remains a persistent policy challenge globally as health expenditures continue to grow faster than national incomes. Healthcare expenditure as a share of gross domestic product (GDP) has risen worldwide, placing pressure on public budgets and insurer finances. Contemporary cost-containment strategies are evaluated not only on spending outcomes but also on their effects on quality and access. The Organisation for Economic Co-operation and Development (OECD) emphasises that policies must balance quality with cost containment to ensure sustainable healthcare financing without compromising outcomes (OECD, 2025). Key drivers of rising costs include population ageing, technological advancements, changing consumer preferences, and higher wages associated with slower productivity growth and expanded service coverage (Stadhouders et al., 2019). Failure to address these pressures may undermine governments' fiscal capacity to fund healthcare sustainably and threaten broader economic stability.

Expenditure on global health varies widely across regions and income levels. In 2022, health spending as a percentage of GDP ranged from 1.82 percent in Brunei Darussalam to 23.09 percent in Afghanistan (World Bank, 2025). By 2024, OECD nations dedicated approximately 9.3 percent of their GDP to healthcare. This metric is key to assessing health equity, as lower public spending relative to GDP often results in higher out-of-pocket costs for individuals (OECD, 2025). Percentage-based metrics can obscure the actual fiscal resources available per individual. In 2022, global average health spending per person was 1,240 USD, but disparities between high- and low-income countries were substantial, ranging from 12,430 USD in the United States to 15.35 USD in Somalia. Mongolia exemplifies this disparity: although its health expenditure as a percentage of GDP (8.85 percent) aligns with OECD averages, its nominal per capita spending of 448.24 USD indicates a significant shortfall in purchasing capacity compared to international peers (World Bank, 2025).

The healthcare sector contributes significantly beyond the treatment of illness, acting as a driver of economic growth, social prosperity, and population health security. Investment in the health workforce can generate multiple returns, including increased economic activity, improved health outcomes, and expanded employment opportunities, particularly for women, resulting in both social and economic benefits (World Health Organization, 2016). This perspective highlights that adequate financial allocation to healthcare represents a strategic investment with diverse returns. However, rising healthcare expenditures require the adoption of efficient cost-containment mechanisms to maintain fiscal sustainability. Despite the emphasis on service quality and access in policy discussions, there is limited empirical evidence regarding effective cost-containment strategies in Mongolia, indicating a critical gap in research and policy planning.

A systematic review of cost-containment policies in OECD health systems provides important but cautious evidence on the effectiveness of widely used expenditure control strategies. Based on a synthesis of 43 original studies and 18 reviews encompassing 341 individual studies, the authors report that although a broad range of cost-containment policies are implemented across countries, robust empirical evidence of effectiveness is lacking for more than half of the policy categories assessed. In addition, many studies suffer from methodological limitations and potential bias, which weakens the overall strength of the evidence base. Despite these constraints, the review identifies a consistent pattern indicating

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that no single policy instrument is sufficient to achieve sustained cost containment. Instead, the most reliable evidence supports a combination of complementary measures, including cost-sharing mechanisms, managed care competition, reference pricing systems, and generic drug substitution, as being effective in moderating healthcare expenditure growth. The findings further emphasize that cost containment is more successful when policies are implemented as integrated packages rather than isolated interventions. The authors also highlight the importance of strengthening post-implementation evaluation and monitoring systems to better assess policy effectiveness in real-world settings and to inform adaptive policy design. Overall, the evidence suggests that sustainable healthcare cost containment depends on multi-policy approaches supported by rigorous evaluation frameworks rather than reliance on any single reform instrument (Stadhouders et al., 2019).

Improving the efficiency of Mongolia's healthcare system necessitates addressing the financial management challenges encountered by hospital managers during the transition to the Single Purchaser Model under the Health Insurance General Office. The move away from the Semashko model, which utilized line-item budgeting, has revealed deficiencies in hospital managers' experience with strategic purchasing mechanisms (Asian Development Bank, 2023). Under the previous financing approach, managers had limited authority over financial decision-making and resource allocation, restricting their capacity to enhance hospital efficiency. Amid ongoing health sector reforms, hospital management has shown limited responsiveness to the changing fiscal and structural environment. Such inertia may impede the effective implementation of reform initiatives intended to improve efficiency and sustainability. Accordingly, this study aims to explore cost-containment strategies that are suitable for the Mongolian healthcare system. The findings are intended to inform evidence-based policy discussions and support efforts to enhance operational efficiency within the broader national reform agenda.

***Definitions***

Cost containment focuses on sustainable healthcare financing while preserving quality and access, rather than simply reducing budgets.

Current health expenditure per capital is the average total spending on health per person, including both public and private funds, expressed in USD. It covers curative or preventive services, family planning, and emergency aid, but excludes water and sanitation, and is standardized to facilitate international comparisons.

***Theoretical framework***

The theoretical framework underlying healthcare cost containment is complex and draws established economic principles to elucidate the intricacies of healthcare markets and stakeholder behavior. Key frameworks include the Iron Triangle of healthcare, Neoclassical Health Economics with a focus on information asymmetry and principal-agent theory, and broader cost-containment models that incorporate these concepts into policy (Arrow, 1963; Carroll, 2012; Obermann & Thielscher, 2023). Collectively, these theories clarify the challenges of managing healthcare expenditures while preserving quality and access, which is essential for the healthcare system.

1. The Iron Triangle of Healthcare, a foundational concept, posits that healthcare systems inherently struggle to achieve three desirable goals simultaneously: cost containment,

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access, and quality. Improvements in one area often come at the expense of the others. For instance, aggressive cost-containment measures might restrict access to certain services or compromise the quality of care. Conversely, expanding access or enhancing quality can lead to increased costs. This framework highlights the trade-offs inherent in healthcare policy decisions, suggesting that policymakers must prioritize or develop innovative solutions to optimize across these three dimensions rather than expecting to maximize all of them simultaneously (Carroll, 2012).

2. Neoclassical Health Economics, particularly its focus on information asymmetry and principal-agent theory, provides a robust lens for understanding inefficiencies and cost escalation in healthcare. Unlike conventional markets, healthcare markets are characterized by significant information imbalances. Patients (the principals) often lack the medical knowledge possessed by healthcare providers (the agents), making it difficult for them to evaluate the necessity or appropriateness of services (Arrow, 1963; Obermann & Thielscher, 2023). This information asymmetry can lead to several market failures:
  - **Supplier-Induced Demand:** Providers, who possess superior information, may recommend more services than are strictly necessary, thereby increasing utilisation and costs. This is particularly relevant in systems where fee-for-service models dominate, potentially driving up inpatient costs for non-communicable diseases (NCDs) due to inappropriate referrals.
  - **Moral Hazard:** Both patients and providers can exhibit moral hazard. For patients, comprehensive insurance coverage might reduce their incentive to seek less costly care or engage in preventive behaviors. For providers, third-party payment systems can reduce their incentive to be cost-efficient (Arrow, 1963).
  - **Adverse Selection:** Individuals with higher health risks are more likely to seek comprehensive insurance, while healthier individuals may opt for less coverage, leading to higher premiums for the insured pool and potentially undermining the financial stability of insurance schemes (Obermann & Thielscher, 2023).
3. The principal-agent theory further elaborates on these dynamics by examining the relationship between principals (e.g., patients, insurers) and agents (e.g., physicians, hospitals). The theory posits that agents may act in their own self-interest rather than solely in the principal's best interest, especially when their incentives are misaligned. For example, if providers are reimbursed on a fee-for-service basis, they have a financial incentive to provide more services. Cost containment strategies, such as Diagnosis-Related Group (DRG)-based prospective payment systems, aim to realign these incentives by shifting financial risk to providers, encouraging them to manage care more efficiently and reduce unnecessary procedures (Ludwig et al., 2010).
4. A comprehensive cost containment framework integrates these theoretical underpinnings with practical policy interventions. This framework recognizes that effective cost containment requires a multi-pronged approach that addresses both supply-side (e.g., provider behavior, technology adoption) and demand-side (e.g., patient utilization, health-seeking behaviors) factors. It also emphasizes the importance of robust governance, regulatory mechanisms, and strategic purchasing to ensure efficient resource allocation (Stadhouders et al., 2019; World Health Organization, 2023). Such a framework considers:

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- Payment Reforms: Shifting from fee-for-service to value-based payment models, such as DRGs or bundled payments, to incentivize efficiency and quality (Stadhouders et al., 2019).
- Supply-Side Management: Regulating the supply of healthcare facilities, technology, and personnel to match demand more appropriately. This includes measures like Health Technology Assessment (HTA) to evaluate the cost-effectiveness of new interventions, ensuring that investments yield clinical and economic benefits (World Health Organization, 2023).
- Demand-Side Management: Promoting preventive care, patient education, and appropriate utilization of services, often through robust primary care systems that act as gatekeepers to more expensive specialized care (Stadhouders et al., 2019).
- Pharmaceutical Cost Control: Implementing strict price negotiations, reference pricing, and generic drug promotion to manage drug expenditures (Stadhouders et al., 2019).
- Administrative Efficiency: Streamlining administrative processes, improving claims auditing, and integrating fragmented health insurance funds to reduce waste and fraud (World Health Organization, 2023).

**Research objectives**

This research analyzes cost-containment strategies across various health systems, integrating quantitative and qualitative methodologies to examine financing design and cost-containment approaches. The study has two primary objectives: first, to conduct a comparative analysis of each country's healthcare system, financing, and cost-containment strategies; and second, to identify potential improvements to Mongolia's current healthcare cost-containment mechanisms.

**II. METHODS**

This study employed a sequential explanatory comparative research design, integrating quantitative cross-country analysis with qualitative policy interpretation to examine cost-containment strategies in health system.

The quantitative phase involved a comparative descriptive analysis of health system performance and financing indicators across five countries: the United States, Germany, Japan, South Korea, and Mongolia. Data source included are OECD Health at a Glance 2025, WHO Global Health Expenditure Database, and National Health Accounts of Mongolia. The following indicators were analyzed: Total health expenditure as a percentage of GDP, Per capita health expenditure (USD), Financial protection (share of prepayment of financing), and Health system structural indicators (service capacity and resource distribution). Descriptive statistical comparison was used to identify cross-country variation in expenditure levels, financing structures, and system outcomes.

The qualitative phase consisted of a structured document review and thematic policy analysis to explain the observed quantitative differences. Data sources for the qualitative component included national health policy documents, OECD and WHO policy reports, and peer-reviewed academic literature. A structured document review approach was applied to ensure systematic identification of relevant policy content across countries. A combined deductive-inductive coding framework was used to guide the analysis. In the deductive phase, coding was theory-driven and based on established health financing and cost-containment

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concepts, including provider payment mechanisms, strategic purchasing arrangements, price regulation, pharmaceutical cost control, and utilization management. In the inductive phase, additional themes were generated directly from the data to capture context-specific and emerging factors, including governance capacity, provider incentive structures, and institutional coordination constraints.

Data integration: Findings from both phases were integrated through comparative case synthesis, allowing interpretation of how institutional design and policy instruments influence cost-containment outcomes across different health system models.

### III. RESULTS

The five countries examined in this comparative analysis—the United States, Germany, Japan, South Korea, and Mongolia—exemplify a range of health system governance models, economic development levels, and institutional arrangements. These structural distinctions manifest in differences in health system organization, financing mechanisms, service coverage, and population health outcomes.

**Table 1.** Health system overview and the core resources

| Countries     | Health system overview                              | Doctors –<br>practicing<br>physicians per 1000<br>population | Nurses –<br>Practicing<br>nurses per 1000<br>population | Hospital<br>beds per<br>1000<br>population |
|---------------|-----------------------------------------------------|--------------------------------------------------------------|---------------------------------------------------------|--------------------------------------------|
| United States | Market-based, fragmented,<br>mixed public-private   | 2.7                                                          | 12.7                                                    | 2.8                                        |
| Germany       | Social health insurance,<br>regulated corporatist   | 4.7                                                          | 12.2                                                    | 7.7                                        |
| Japan         | Universal statutory<br>insurance, tightly regulated | 2.6                                                          | 12.2                                                    | 12.5                                       |
| South Korea   | Single-payer national<br>health insurance system    | 2.7                                                          | 9.5                                                     | 12.6                                       |
| Mongolia      | Tax-funded, social<br>insurance hybrid system       | 4.6*                                                         | 4.4*                                                    | 8.4*                                       |

Source: OECD, 2024, \*- Health Indicators, 2024

The United States maintains a predominantly market-oriented healthcare system, marked by fragmented governance and a combination of public and private financing mechanisms. Public programs such as Medicare and Medicaid operate alongside employer-sponsored insurance and the individual private market. Although the United States has the highest healthcare expenditure among OECD countries, its population health outcomes are comparatively weaker than its spending levels would suggest. Healthcare expenditure accounts for 17.2% of GDP, a proportion significantly higher than in other high-income countries, while life expectancy remains below the OECD average (Anderson et al., 2019; Rice et al., 2024).

Germany utilizes a social health insurance system based on statutory health insurance (SHI), governed through a corporatist structure that includes sickness funds, healthcare providers, and government regulation. This system ensures near-universal population coverage through



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mandatory insurance contributions and regulated benefit packages. Germany allocates 12.3% of GDP to healthcare, maintaining relatively high life expectancy and robust service coverage indicators (Busse et al., 2017; OECD, 2025).

Japan implements a universal social health insurance system characterized by stringent government regulation of healthcare prices and benefits. While multiple insurance plans are available, a nationally uniform fee schedule determines provider reimbursement rates. This centralized pricing approach has enabled Japan to sustain moderate healthcare expenditure levels while achieving the highest life expectancy among OECD countries (Ikegami et al., 2011).

South Korea employs a single-payer National Health Insurance (NHI) system, which achieved universal coverage after consolidating multiple insurance societies in 2000. The National Health Insurance Service centrally manages financing and reimbursement mechanisms. In recent decades, South Korea has realized significant improvements in population health outcomes while maintaining moderate healthcare expenditure levels compared to other OECD countries (Ikegami et al., 2011; Kwon, 2018; OECD, 2025).

Mongolia uses a mixed healthcare financing model that combines tax-funded public health services with social health insurance. The Ministry of Health offers policy leadership, while the Health Insurance General Office oversees service financing and purchasing. Despite expanded insurance coverage and improvements in several health indicators in recent decades, Mongolia's life expectancy and service coverage indicators remain below those of high-income comparator countries, reflecting ongoing structural challenges in health system capacity and socioeconomic determinants of health (Asian Development Bank, 2023; World Health Organization, 2023).

**Table 2.** Health Expenditure and Population Health Outcomes Across Selected Countries

| Countries     | Health Spending % of GDP | Health spending per capita (USD) | Financial protection (expenditure covered by compulsory prepayment) | Life expectancy | Population coverage – population eligible for core services (% of services) |
|---------------|--------------------------|----------------------------------|---------------------------------------------------------------------|-----------------|-----------------------------------------------------------------------------|
| United States | 17.2                     | 14 885                           | N/A                                                                 | 78.4            | 93                                                                          |
| Germany       | 12.3                     | 9365                             | 85.9                                                                | 81.1            | 100                                                                         |
| Japan         | 10.6                     | 5790                             | 84.8                                                                | 84.1            | 100                                                                         |
| South Korea   | 8.4                      | 4797                             | 60.4                                                                | 83.5            | 100                                                                         |
| Mongolia      | 8.85*                    | 448.24                           | 56.7**                                                              | 71.8***         | 98                                                                          |

Source: OECD, 2024, \*- World Bank, 2022; \*\*- World Global Health Expenditure Database, 2019; Health Indicators, 2024

### Cost containment strategies

The five countries employ a range of policy instruments to control healthcare expenditures. These strategies generally focus on four key areas: provider payment reforms, price regulation, pharmaceutical expenditure management, and utilization control.

In the United States, cost-containment policies largely rely on market-oriented mechanisms and payment reforms. Initiatives such as value-based purchasing, accountable care organizations (ACOs), and bundled payments aim to improve efficiency and reduce unnecessary healthcare utilization.

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However, the fragmented nature of financing and the limited use of centralized price regulation have limited the overall impact of these reforms on national healthcare expenditure growth (Anderson et al., 2019).

Germany employs coordinated cost-containment mechanisms within its statutory health insurance system. These include negotiated provider payment rates, diagnosis-related group (DRG) payment systems for hospital services, and pharmaceutical reference pricing mechanisms. In addition, health technology assessment is used to regulate reimbursement decisions for pharmaceuticals and medical technologies (Busse et al., 2017). Japan relies heavily on centralized price regulation as its primary cost-containment strategy. The government revises the national fee schedule for healthcare services every two years to control expenditure growth. Pharmaceutical prices are also periodically reduced through regulatory price revisions, allowing the government to directly influence overall healthcare spending (Ikegami et al., 2011).

South Korea utilizes several regulatory mechanisms including fee schedule adjustments, pharmaceutical price negotiations, and health technology assessment, to determine reimbursement eligibility. The gradual introduction of DRG-based payment systems for selected medical procedures also aims to reduce unnecessary hospital utilization and improve efficiency (Kwon, 2018).

Mongolia has introduced several policy reforms to improve the efficiency of the health system. These reforms include strengthening strategic purchasing mechanisms within the social health insurance system, implementing case-based payment methods for hospitals, and expanding primary healthcare services to reduce avoidable hospital admissions (Asian Development Bank, 2023).

**Table 3:** Cost-Containment policy mechanisms across countries

| Country       | Price Regulation                 | Provider Payment Reform                | Pharmaceutical Cost Control                        | Utilization Management                     |
|---------------|----------------------------------|----------------------------------------|----------------------------------------------------|--------------------------------------------|
| United States | Limited centralized regulation   | Value-based payments, bundled payments | Negotiated drug prices (limited federal authority) | Managed care, utilization review           |
| Germany       | Negotiated fee schedules         | DRG hospital payment                   | Reference pricing and HTA                          | Budget caps and negotiated service volumes |
| Japan         | National fee schedule            | Fee-for-service with regulated prices  | Periodic pharmaceutical price reductions           | Strict reimbursement rules                 |
| South Korea   | National fee schedule regulation | DRG payment (selected procedures)      | Drug price negotiation and HTA                     | Claims review and utilization monitoring   |
| Mongolia      | Government price regulation      | Case-based hospital payments           | Essential medicines regulation                     | Primary healthcare strengthening           |

### ***Outcomes of cost containment strategies***

The comparative analysis indicates substantial variation in the effectiveness of cost-containment policies across the five countries. Outcomes appear closely associated with governance structures, regulatory capacity, and the degree of centralized control over healthcare prices.



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Japan and South Korea demonstrate comparatively effective cost control while maintaining strong health outcomes. Both countries combine universal health coverage with centralized price regulation, allowing governments to directly influence healthcare prices and expenditure growth. As a result, these countries achieve high life expectancy while spending a smaller proportion of GDP on healthcare compared with the United States (Asian Development Bank, 2023; Ikegami et al., 2011; Kwon, 2018; OECD, 2025).

Germany also demonstrates relatively stable expenditure growth while maintaining high levels of service coverage and quality. The corporatist governance model facilitates coordinated negotiation between insurers and healthcare providers, which supports effective cost containment without compromising access to care (Busse et al., 2017).

In contrast, the United States continues to experience significantly higher healthcare spending without proportional improvements in population health outcomes. Research indicates that higher prices for medical services and pharmaceuticals, combined with administrative complexity and fragmented financing structures, contribute to the country's elevated healthcare expenditure (Anderson et al., 2019; OECD, 2025).

In Mongolia, cost-containment policies have contributed to gradual improvements in health system efficiency and population health indicators. However, their impact remains constrained by structural factors, including limited financial resources, geographic barriers to service delivery, and workforce distribution challenges. Consequently, while reforms such as case-based payments and strategic purchasing have begun to improve efficiency, their effects on overall system performance remain limited (Asian Development Bank, 2023; World Health Organization, 2023). The key results are summarized in Table 4.

***Factors associated with policy implications***

The cross-country comparison identifies several factors associated with the effectiveness of cost-containment strategies. First, centralized price regulation and unified purchasing mechanisms appear strongly associated with successful expenditure control. Japan and South Korea demonstrate how national fee schedules and centralized insurance administration can effectively regulate healthcare prices and spending (Ikegami et al., 2011; Kwon, 2018). Second, institutional coordination between insurers, healthcare providers, and government regulators contributes to effective cost containment. Germany's corporatist governance structure allows for collective negotiation of healthcare prices and expenditure targets, facilitating coordinated policy implementation (Busse et al., 2017).

Third, fragmented financing systems and weak price regulation are associated with higher healthcare expenditure. The United States illustrates how decentralized governance structures and strong provider market power can limit the effectiveness of cost-control policies (Anderson et al., 2019).

Finally, health system capacity and socioeconomic context play a critical role in shaping policy outcomes in lower-resource settings. In Mongolia, structural constraints—including health workforce distribution, infrastructure limitations, and epidemiological transition toward non-communicable diseases—continue to influence the effectiveness of cost-containment reforms (Asian Development Bank, 2023; World Health Organization, 2023).

**IV. CONCLUSIONS**

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This study demonstrates that healthcare cost containment is determined less by total spending levels and more by the institutional design of financing, purchasing, and service delivery systems. The comparative analysis of the United States, Germany, Japan, South Korea, and Mongolia shows that countries achieving more sustainable expenditure control consistently combine strong price regulation, effective strategic purchasing, aligned provider payment incentives, pharmaceutical cost control, and a stronger emphasis on prevention and primary healthcare.

The findings indicate that higher health expenditure does not necessarily result in better efficiency or improved health system performance. Instead, the structure of financing and the alignment of provider incentives with system goals are the key determinants of cost-containment outcomes. Japan and South Korea demonstrate effective cost control through centralized or tightly regulated pricing systems, while Germany achieves stability through corporatist negotiation mechanisms. In contrast, the United States continues to experience high expenditure driven by price levels and fragmented financing structures.

Across all systems, prevention and primary care remain under prioritized despite strong evidence of their role in improving efficiency and reducing avoidable hospital admissions. Hospital-centric financing and excess inpatient capacity continue to contribute to cost pressures.

For Mongolia, the evidence strongly supports the following reforms:

- Adopt a blended provider payment system combining DRG-aligned case-based hospital payments, capitation-based primary care financing, and 20–30% performance-based incentives.
- Strengthen strategic purchasing capacity under the health insurance system to improve resource allocation efficiency.
- Increase primary healthcare financing to approximately 30–35% of total health expenditure to improve cost-effectiveness and reduce avoidable hospitalization.
- Reinforce pharmaceutical pricing regulation and claims auditing systems to improve fiscal discipline and reduce inefficiencies.
- Overall, effective cost containment requires coherent, system-wide reforms that improve efficiency while preserving equitable access and quality of care.

## V. DISCUSSION AND LIMITATIONS

### *Discussion*

This comparative policy analysis shows that cost containment is not simply a matter of reducing expenditure, but of improving financing design, payment mechanisms, and resource allocation while maintaining quality and access. The findings suggest that countries with stronger strategic purchasing, tighter payment regulation, pharmaceutical cost control, and greater emphasis on prevention and primary care are better able to manage spending growth more sustainably.

The country comparison also indicates that high spending does not necessarily lead to greater efficiency. While the United States spends the most, this does not automatically translate into better cost control. In contrast, Germany, Japan, and South Korea demonstrate that stronger regulation and more coordinated financing arrangements can support a more balanced relationship between cost, access, and quality. For Mongolia, the results highlight the

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importance of strengthening strategic purchasing, managerial capacity, claims auditing, and primary care investment under ongoing financing reforms.

***Limitations***

This study has several limitations. First, it includes only a small number of countries, which limits the generalizability of the findings. Second, the quantitative analysis relies mainly on macro-level indicators, such as health expenditure as a share of GDP and per capita spending, which cannot fully capture provider-level efficiency. Third, the qualitative findings are based on policy documents, reports, and published literature, which may introduce interpretation bias. Finally, the study identifies patterns and policy differences rather than establishing direct causal effects of specific cost-containment measures.

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Table 4. The summary of key results

| Country       | Governance Model                                          | Financing mechanism                 | Key cost-containment strategies                                                     | Empirically observed outcomes                                                                                      | Document side effects                                                                                                                                 | Key Evidence sources                                            |
|---------------|-----------------------------------------------------------|-------------------------------------|-------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| United States | Decentralized mixed governance                            | Multi-payer system                  | Managed care, value-based payment                                                   | Limited control of total health expenditure growth; persistent high per capita spending despite efficiency reforms | High administrative burden ( $\approx 25\text{--}30\%$ of health spending), provider consolidation leading to price increases and reduced competition | (Anderson et al., 2019; OECD, 2023, 2025; Rice et al., 2024)    |
| Germany       | Corporatist governance                                    | Social health insurance (SHI)       | DRG-based hospital payments, reference pricing, negotiated tariffs                  | Moderate and stable expenditure growth aligned with GDP; strong access and universal coverage maintained           | Pharmaceutical market distortions; delayed access to some innovations; high transaction costs in multi-stakeholder negotiations                       | (Busse et al., 2017; OECD, 2025)                                |
| Japan         | Centralized regulatory governance                         | Statutory universal insurance       | National fee schedule revisions (biennial), pharmaceutical price controls           | Strong long-term cost containment with high life expectancy and moderate expenditure levels                        | Pharmaceutical market distortions; delayed access to some innovations; high transaction costs in multi-stakeholder negotiations                       | (Ikegami et al., 2011; OECD, 2025)                              |
| South Korea   | Single-payer governance                                   | National Health Insurance (NHI)     | Fee schedule regulation, Health Technology Assessment (HTA), selective DRG adoption | Controlled expenditure growth with rapid expansion of universal coverage                                           | High out-of-pocket payments ( $\sim 30\text{--}35\%$ of total health spending); overutilization of outpatient services                                | (Kwon, 2018; OECD, 2023)                                        |
| Mongolia      | Centralized government stewardship (transitioning system) | Mixed tax-funded + social insurance | Strategic purchasing reforms, budget ceilings, case-based payments                  | Limited but improving fiscal predictability; early-stage efficiency gains under reform process                     | Resource constraints, workforce shortages, rural–urban quality gaps, persistent hospital-centered allocation                                          | (Asian Development Bank, 2023; World Health Organization, 2023) |

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