Social Protection in Action: Building social protection floors for all

Country Brief: Mongolia

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Extending Social Health Protection in Mongolia: Accelerating progress towards Universal Health Coverage

1. Introduction

A middle-income country with a population of just over 3 million, Mongolia has experienced significant economic growth since its transition to a market-oriented economy in 1990, with the country's GDP more than tripling since 1991. This growth has been accompanied by substantial improvements in the provision of public health care services. Specifically, the right to "health protection and to obtain medical financial protection provided. These challenges are particularly acute in remote regions and among the most vulnerable, including nomadic households who comprise around one quarter of the Mongolian population (Higara, Uochi, and Doyle 2020). In particular, herders, who make up 19.5 per cent the population and account for three in five of the rural poor depend solely on their livestock for income (Higara, Uochi, and Doyle 2020; National Statistical Office 2018). This places them at high risk of slipping into poverty due to catastrophic health expenditures. To address these challenges, the Government is pursing Universal Health Coverage (UHC) as a national priority, as reflected in both the State Policy on Health (2017–2026) and the Long-Term Strategy for the Development of Health Insurance (2013–2022).

2. Context

Prior to Mongolia's economic transition to a market economy in 1990, the country's health system was based on the Semashko model, characterized by a centralized publicly owned health system, which provided free essential health services to the population (Sheiman, Shishkin, and Shevsky 2018). However, the system's effective functioning stalled towards the 1990s with the withdrawal of Soviet Union funding. To address this, the Government introduced user fees for accessing health care, which contributed to decreased health service utilization and caused negative fluctuations in health indicators throughout the 1990s. In response, the Government began to decentralize the health care system, with increased emphasis on primary care (Asian Development Bank 2008). To generate additional resources for the

health sector, a compulsory SHI scheme was introduced in 1994, precipitating a transition from a fully-integrated model to a contracting model with a purchaser-provider split. At the time, the Government fully subsidized insurance contributions for low income and vulnerable population groups, but in the late 1990s, these subsidies were reduced to limit scheme's reliance on governmental funding (Bayarsaikhan, Kwon, and Chimeddagva 2016).

Following initial shocks to the health care system resulting from economic transition, in 2005, the Government adopted the landmark Health Sector Strategic Master Plan 2005–2015. The plan encompassed a commitment to "improve the health status of all the people of Mongolia, especially mothers and children, through implementing a sector wide approach and providing responsive and equitable pro-poor, client-centered and quality services" (Mongolia Ministry of Population Development and Social Protection 2013). As a result, Mongolia's Health financing landscape began to benefit from increased public funding, promoting the development of a more equitable and pro-poor health system.

In 2006, co-payments for primary health services were abolished, and the Government took sole responsibility for financing PHC in line with amendments to the Health Insurance Law. These services were removed from the SHI package, and became part of a range of cost-free services. Today, tax funded PHC services and SHI scheme are the two central mechanisms for providing social health protection (SHP) to the Mongolian population. The dual structure of the health protection mechanism is derived from the broader structure of the social security system in Mongolia, which comprises both contributory social insurance schemes and a social welfare scheme financed from government revenues.

3. Design of the social health protection system

- Financing

PHC services are provided to the entire population on a non-contributory basis and are fully funded by the government general revenue. Financing of SHI on the other hand comprises a combination of government subsidies, co-payments and salary contributions of affiliated employees and employers. In line with resolutions issued by the Health Insurance General Agency (HIGA),[1] contributing employers and employees each pay 2 per cent of the concerned employee's monthly salary, with the Government contributing as the employer for state employees. Contributions are also required from self-employed and unemployed persons, students, foreigners, and other categories of the population at a rate of at least 1 per cent of the average minimum wage. In 2011, the Government re-introduced SHI subsidies for vulnerable groups (Asian Development Bank 2013). According to HIGA resolutions, these categories include: children under the age of 18, pensioners, low-income citizens, parents caring for a child who is younger than 2 years of age (or 3 years of age in the case of twins), military personnel, and prisoners. Nomadic populations in Mongolia no longer benefit from these subsidies. It was estimated that in 2014, subsidized population categories accounted for about 60 per cent of all insured persons (Bayarsaikhan, Kwon, and Chimeddagva 2016).

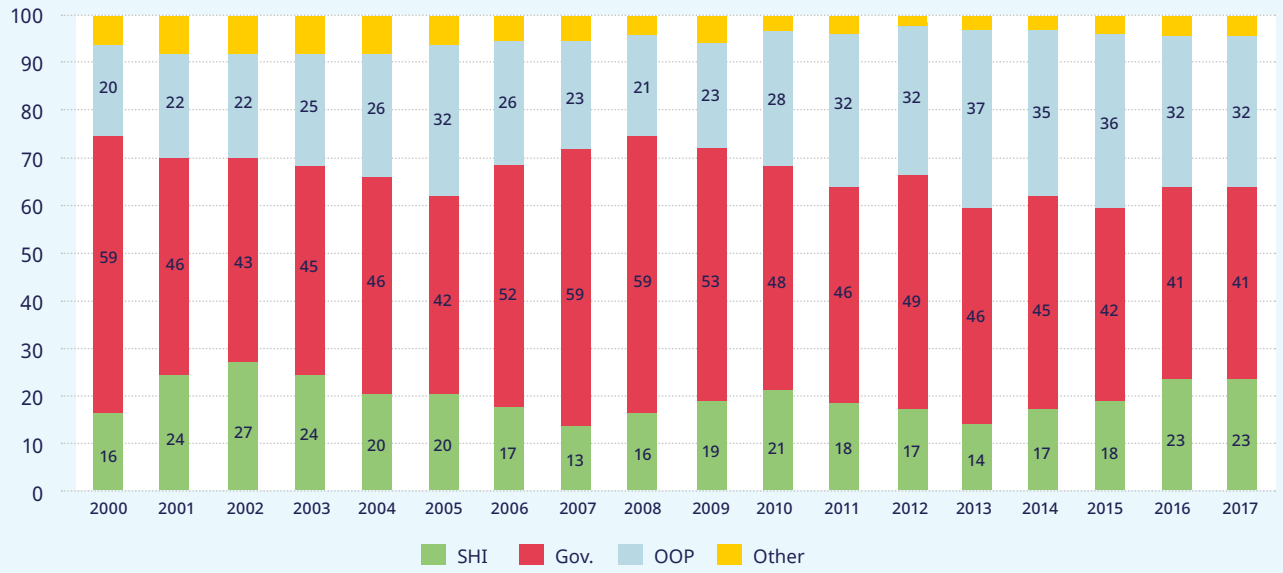
It is the responsibility of employers in the formal sector to pay and transfer SHI contributions (along with other social insurance contributions) from their employees' monthly salaries to the State Social Security General Office (SSIGO). SSIGO performs the collection function, and is then split into different social insurance funds, implemented through the Health Insurance General Agency (HIGA) in the case of Health Insurance. For self-employed persons, the frequency of payments may vary and for workers in the informal economy, such as

[1] HIGA issued a number of resolutions related to financing of SHI following legal amendments introduced in 2020. The series of resolutions, together with other HIGA resolutions from 2019-2021, can be found (in Mongolian) on the official HIGA website, available at: http://www.emd.gov.mn/%d1%8d%d1%80%d1%85-%d0%b7%d2%af%d0%b9%d0%bd-%d0%b0%d0%ba%d1%82/eronhii-gazriin-dargiin-tushaal/

nomads, payments are made on a quarterly or yearly basis based on their seasonal income and the nature of their employment, in line with individual payment agreements made at HIGA branch offices.

Overall, financial resources dedicated to health care have remained at around 4 per cent of GDP during the majority of the past decade. The Government has consistently committed between 6 to 8 per cent of its total spending to the health system since 2010, and government health expenditure per capita grew steadily from 2000 to 2012, reaching US$102.3 per capita. However, between 2012 and 2017, this figure declined by 9.8 per cent (WHO n.d. a). Notably, the share of state funding allocated to PHC has decreased from nearly 25 per cent of the total government health expenditure in 2005 to under 16 per cent in 2016 (WHO 2017). Today, the main sources of funds for the health system include government funds, SHI revenues, and direct out-of-pocket (OOP) payments.

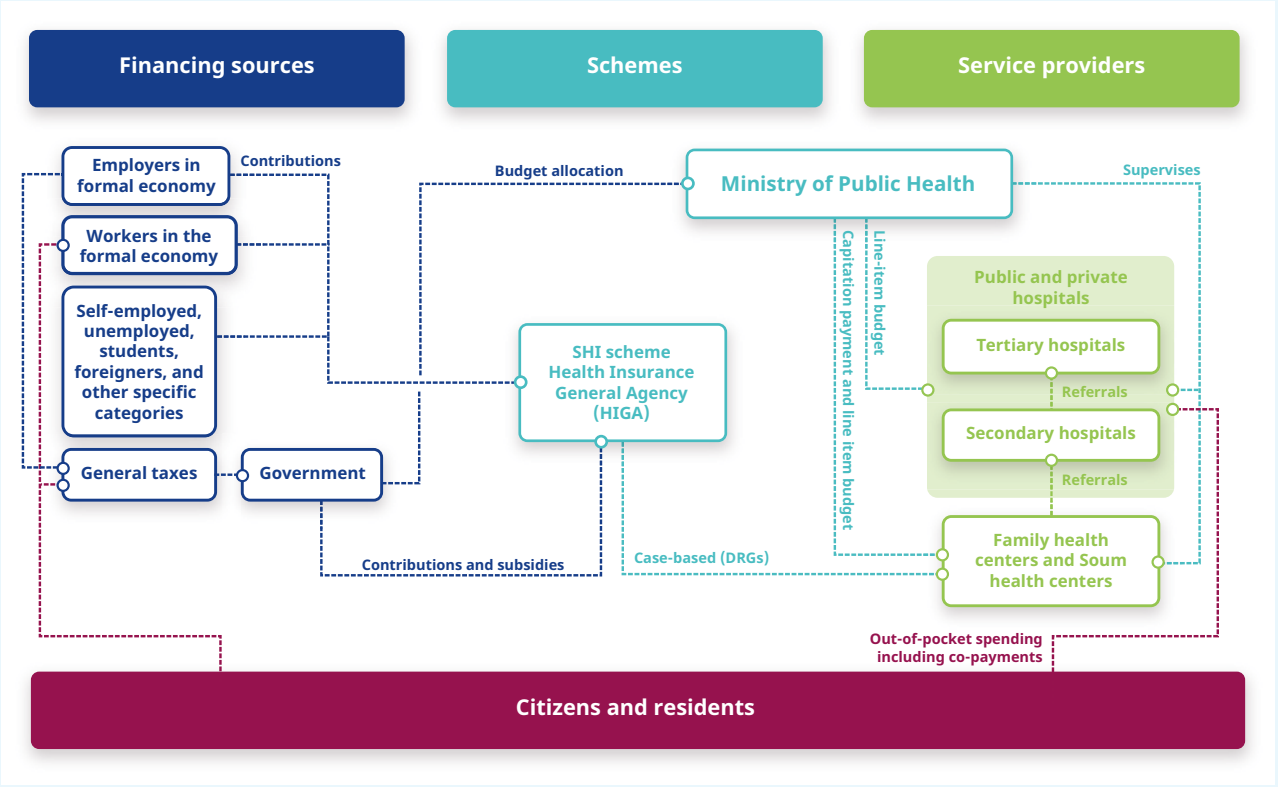
▶ Figure 1. Evolution of the share of the different financing sources in the composition of the current health expenditure



Source: Adapted from WHO Global Health Expenditure Database.

Since 2008, a decline in the government share of Current Health Expenditure is apparent, compensated for by an increase of OOP expenditures and pooled resources under the SHI scheme. As a result, Mongolia has a considerably high level of OOP health expenditure, which currently exceeds the average in the East Asia and Pacific region by nearly 23 per cent, although it remains lower than the average among lower-middle income countries globally. Figure 2 below indicates the funding flows for the health protection system.

▶ **Figure 2. Overview of main financial flows of the social health protection system in Mongolia**



Source: Authors.

- Governance

The social health protection (SHP) system in Mongolia is based on a well-established legal framework. The provision of PHC is mandated by the Law on Health of 2011, which defines the types of medical care to be financed from the government budget through article 24.6; and the Law on Medical Care and Services of 2016, which outlines expenses for these services. The Ministry of Health (MOH) is tasked with developing national-level policies and guidelines and overviewing implementation by provincial ("Aimag") and capital city health departments and facilities (WHO 2017). Article 11.2.3 of the Law on Health empowers local level governors "to organize the involvement of business entities, organizations, and citizens in public activities in the field of protection and promotion of health". In addition, it gives the power to citizen representatives at Aimag, district (Soum), and lower levels to "ensure joint participation of governmental and non-governmental organizations and citizens in measures to protect and promote the health of the population of the territory under their jurisdiction and coordinate their activities" (Article 10.1.4).

The SHI scheme is implemented under the governance of the Law on Health Insurance of 1994 and its subsequent amendments. The law defines the principles and scope of the health insurance policy, while also regulating interactions between the state, service providers, and citizens. SHI is centrally regulated, with the MOH functioning as the standard-setting agency, under which the government implementing agency, HIGA, is responsible for managing the scheme. HIGA is supervised by the National Health Insurance Council (NHIC) — a tripartite body that reports to the Parliament of Mongolia and is in charge of regulating payment methods, collecting contributions, defining contract guidelines and cost-sharing rules, and managing the Health

Insurance Fund (IRIM and Conseil Santé 2018). HIGA selects, signs purchasing contracts and pays public and private service providers, which helps to ensure a purchaser-provider split (IRIM and Conseil Santé 2018).

- Legal coverage and eligibility

By law, all citizens are entitled to free PHC services. The State Policy on Health stipulates universality and non-discrimination as integral components of its guiding principles by specifically stating that health care services should be provided in an "equitable and inclusive manner regardless of the citizen's health status, type of disease, place of residence, age, gender, education, sexual orientation, origin, language and cultural difference". [2]

SHI is an inclusive scheme that aims to cover all of the Mongolian population. According to articles 4.2–4.3 of the Law on Health Insurance of 1994, SHI coverage is mandatory for all citizens and stateless persons whether they are employed in the formal or informal sector, unemployed or self-employed. For foreigners, enrolment to the scheme is voluntary.

- Benefits

Tax-funded primary health services are defined based on a positive list under the Law on Medical Care and Services 2016 (article 17). These services are available to all citizens seeking care at Family Health Centres (FHCs), which are based in urban areas, and Soum Health Centres (SHCs) which are concentrated in rural areas. Available services include public health services; emergency medical care and ambulance services; obstetric and maternal care and health care during disasters and communicable disease outbreaks. PHC services available in rural areas tend to be slightly broader than in urban areas, as they need to accommodate for health care needs in areas where no secondary and tertiary health facilities are available. In general, the package corresponds to PHC as defined under the Alma-Ata Declaration of 1978, including immunization (WHO 2017). The cost of medicines is fully borne by patients, [3] unless they are covered by SHI.

The SHI benefit package complements tax funded PCH services. Services available to insured persons are the same for all members, regardless of the contribution amount paid. General categories of secondary and tertiary services covered by the SHI scheme are defined positively in accordance with the Law on Health Insurance (Article 9.1) and include the following:

- Inpatient services;
- Outpatient/ambulatory services, follow up, diagnostics and treatment;
- Palliative care for cancer and other illnesses;
- Traditional care, rehabilitative and sanatorium services;
- Some high-cost medical services and required medical tools;
- Pharmaceuticals (included in the essential drug list approved by the NHIC) prescribed by medical doctors at FHCs, SHCs, Aimag and district clinics, and other medicines available and subsidized prices;
- Certain kinds of artificial tubes, prosthetics and orthopaedic implants for rehabilitative care;
- Some rehabilitative, home and day care services provided by FHCs, SHCs and village health centres, and diagnostic tests;
- Day care for cancer chemotherapy and radiotherapy;
- Treatment of associated diseases preceding the 37th week of pregnancy and post-natal period;
- Prevention, early detection and routine diagnostic tests defined by the NHIC.

According to HIGA resolutions issued in 2020,[4] the ceiling on the benefit amount that an insured person can receive under SHI is set at around 2,000,000 Mongolian tögrög (MNT) per year, which is equivalent to around US$710. However, individuals may transfer their own benefit to another family member (Bayarsaikhan, Kwon, and Chimeddagva 2016).

[2] Resolution of the Government of Mongolia, 2017 (No. 24).
[3] Except for "drugs for diseases that require lengthy treatment and palliative care" and "drugs for children with disabilities under 16 years of age", in which case costs will be paid by the Government (article 24.6).
[4] Available (in Mongolian) at: http://www.emd.gov.mn/%d1%8d%d1%80%d1%85-%d0%b7%d2%af%d0%b9%d0%bd-%d0%b0%d0%ba%d1%82/eronhii-gazriin-dargiin-tushaal/

- Provision of benefits and services

As noted above, PHC in urban areas is provided by FHCs — private organizations fully funded by the Government budget (Dorjdagva et al. 2017), and in rural areas, PHC is delivered at SHCs, which are owned by local governments (Audibert, Guillon, and Mathonnat 2018). No co-payments are required to access PHC services. FHCs and SHCs are intended to perform a gate-keeping role by referring patients to secondary and tertiary facilities, which include both public and private facilities, though the latter predominate. [5] Secondary and tertiary health care providers in Mongolia are concentrated at district and city levels, comprising district health centres, general hospitals, city-level specialised centres, aimag general hospitals, regional treatment centres, specialized centres, and state hospitals (IRIM and Conseil Santé 2018). To access secondary and tertiary care services and apply for SHI benefits, individuals typically have to be referred by primary health care practitioners though self-referrals, meaning that high rates of inappropriate admissions within hospitals at this level are commonplace (Jigjidsuren et al. 2019). Upon accessing SHI benefits, affiliated patients are required to make co-payments that are charged at a flat rate of 10 —15 per cent depending on the level of the facility at which the services are provided (Dorjdagva et al. 2016). Insured persons are provided with magnetic insurance cards (Bayarsaikhan, Kwon, and Chimeddagva 2016).

Line-item budgets, case-based hospital payments and fee-for-service for direct payments are the three types of payment methods currently being used in Mongolia. This mix of payment systems applies with large variation at each level of the health care system, including at the individual provider level. At least 50 per cent of all revenue for the majority of public providers is allocated through a line-item budget payment system, although this system represents only 12 per cent of total revenue for some tertiary providers. On average, DRG payments represent around 30 per cent of revenues received by both public and private hospitals, and fee-for-service comprises a fairly minimal share of total revenue for all public providers, usually accounting for less than 5 per cent to a maximum of 10 per cent of revenue for a single provider. At PHC level, FHCs receive 100 per cent of their revenue through such payments, SHCs are paid through a mix of mechanisms, while SHI resorts to case-based payment using Diagnosis Related Groups (DRGs) (Joint Learning Network et al. 2015). The Health Insurance Fund acts as third party payer and reimburses pharmacies for discounted sales of essential medicines to insured persons when prescribed by SHC and FHC physicians (WHO 2017).

▶ 4. Results

- Coverage

Because all citizens are entitled to free PHC by law, legal coverage stands at around 99 per of the population, excluding international migrants (UN 2019). In 2014, a total of 218 FHCs provided PHC services for approximately two million individuals in urban areas (Dorjdagva et al. 2017), and currently, there are over 330 SHCs providing services for their areas of operation in rural areas (Jigjidsuren et al. 2019). Coverage for secondary and tertiary care provided through the SHI scheme is lower. Directly after its introduction in 1994, the scheme achieved a high affiliation rate. However, after subsidies were reduced in the late 1990s, the affiliation rate substantially declined (Bayarsaikhan, Kwon, and Chimeddagva 2016), which was further compounded by increasingly prevalent rural to urban migration. This trend led to an increase in the number of poor and unregistered people in cities facing challenges in accessing in health care due to a lack of civil residential status. SHI membership peaked again from 2011—2014, reaching over 90 per cent after the government launched mass enrolment campaigns (Bayarsaikhan, Kwon, and Chimeddagva 2016). Unfortunately, the government has struggled to maintain this progress in subsequent years. Based on the latest data available from 2016, SHI coverage in Mongolia stands at around 76 per cent (IRIM and Conseil Santé 2018). This decline can be attributed in part to challenges in maintaining adequate coverage among the self-employed, unemployed persons and remote and disadvantaged populations, due to dropouts, insufficient administrative support, and internal migration. Very low population density further

[5] Based on data from 2014, there were 869 public and private providers contracted through SHI – 100 public and 769 private (Bayarsaikhan, Kwon, and Chimeddagva 2016).

complicates the coverage of herders who live in remote rural areas of the country (Dorjdagva et al. 2017).

- Adequacy of benefits

The provision of tax funded PHC and the expansion of SHI have significantly improved the financial protection of the population against catastrophic and impoverishing health expenditures. Nonetheless, there are limits to which the existing system is able to shield its users from financial risks. Although no co-payments are required when accessing primary health services, the cost of medicines is fully borne by patients unless they are covered by the SHI, which can result in a high degree of financial vulnerability. Even when subsidized through SHI, the price of medication can be prohibitive for many population groups. Moreover, the practice of self-medication is quite prevalent in Mongolia (IRIM and Conseil Santé 2018), which means that people often seek to purchase drugs from pharmacies without prescriptions, thus forgoing the benefit of subsidised prices and incurring greater health care costs. Estimates from 2011 indicate that pharmaceuticals represented 94 per cent of OOP payments among the very poor in Mongolia (Tsilaajav et al. 2017).

Comprising 32 per cent of total national health expenditures in 2017, OOP payments pose a significant challenge, with estimates suggesting that approximately 20,000 people in Mongolia are forced into poverty due to health care expenditures (Dorjdagva et al. 2016). In addition to pharmaceutical costs, Mongolia's relatively high OOP expenditure rate can be attributed to co-payments for accessing tertiary and secondary health services under SHI. Because co-payment rates are flat for all population groups (between 10—15 per cent), including vulnerable populations, this creates inequalities in access and negatively impacts health care utilization; it has also been noted that the contribution rate of 1 per cent of the average minimum wage for the self-employed is likely too high for many categories among this group (IRIM and Conseil Santé 2018).

- Responsiveness to population needs

  - Availability and accessibility

The introduction of state-funded PHC has yielded some positive results in improving access to health among the poor and the vulnerable in Mongolia. Studies show that low-income groups are much more likely to use PHC, regardless of their health care needs, while higher income groups access secondary and tertiary health care more frequently (Dorjdagva et al. 2016). In particular, in urban areas, FHCs often serve as the major (and often the only accessible) health care provider for low income households (Dorjdagva et al. 2017). However, in the case of SHCs in rural regions, some patients have to travel long distances (50 kilometres and more) in order to access PHC services. Because secondary and tertiary health care providers in Mongolia are concentrated primarily at district and city levels, this compounds limited service availability for many rural population groups, which leads to indirect financial costs, resulting from transportation and accommodation expenses, and time spent on travel. It is worth noting that a large share of the rural population in Mongolia are herders, who move every season and settle for prolonged periods in remote areas where no infrastructure is available.

Mongolia has a comparatively high density of hospital beds, which is greater than the average among the lower-middle income countries, as well as the global average (WHO n.d. b). However, geographical distribution is uneven. Notably, a study from 2017 study calculated that the mean number of hospital beds per 1,000 km in rural regions was over 61 times less than the mean in suburban regions and nearly 304 times less than in Mongolia's capital (Erdenee et al. 2017). Even in areas where health infrastructure is plentiful, the civil registration requirement for individuals to benefit from state welfare benefits and health insurance prevents many unregistered individuals in urban areas from receiving essential health services (Asian Development Bank 2008; Gan-Yadam et al. 2013; Lhamsuren et al. 2012). Unregistered populations can constitute up to 20 per cent of city or district populations, which is driven by high levels of internal migration and complex registration procedures (Asian Development Bank 2008; Lhamsuren et al. 2012). These barriers, combined with the aforementioned requirement of co-payments to access tertiary and secondary care, result in inequality in service utilization which can lead to greater financial losses for vulnerable groups at a later stage (Dorjdagva et al. 2017).

  - Quality and acceptability

Although the quality and scope of health services provided by the health care system has

improved in recent decades (WHO 2017), PHC facilities in Mongolia face significant shortages of equipment and medicines, and have limited diagnostic capacity (Jigjidsuren et al. 2019). The capacity of FHCs in particular do not meet the demands of the increasing number of patients in these facilities, due to rising levels of rural-to-urban migration over the last decade. This intensifies pressure on FHC health care personnel, who tend to cater for over 2 times more patients than SHC personnel (WHO 2017). Secondary and tertiary level hospitals and clinics also experience shortages of equipment and medicines (Jigjidsuren et al. 2019), though there is currently little reliable information on the quality of the health services provided by the private sector (Bayarsaikhan, Kwon, and Chimeddagva 2016; IRIM and Conseil Santé 2018).

Overall, Mongolia has a comparatively large number of health workers. Latest WHO estimates indicate that there are nearly 2.9 physicians per 1,000 patients, which is greater than the average among lower-middle income countries (Higara, Uochi, and Doyle 2020). However, the number of nurses is quite low (Jigjidsuren et al. 2019). In rural regions in particular, SHC facilities face a weaker supply of qualified specialized medical personnel. These deficiencies stem primarily from insufficient PHC financing. In 2017, primary health facilities used over two thirds of their funding for salaries and operating costs, while only a small proportion remained for improving actual quality of care and services (IRIM and Conseil Santé 2018).

As such, public perceptions of the quality of primary care are generally negative, which has been cited as a major contributing factor to a high prevalence of self-medication and self-referrals within district and tertiary level hospitals in Mongolia (IRIM and Conseil Santé 2018; Jigjidsuren et al. 2019). This is a significant challenge, as it results in higher health care costs and increased OOP spending due to the fact that self-referred patients cannot benefit from SHI protection (Dorjdagva et al. 2016). There is also evidence that perceptions of the quality of tertiary level services are also relatively low. One survey conducted between 2014 and 2015 in three tertiary level state hospitals in Ulaanbaatar found the overall satisfaction with health services among patients to be just over 60 per cent (Batbaatar et al. 2016).

The MOH mandates client satisfaction surveys to be conducted on an annual basis, in line with Decree No.135 (4 May 2006) of the Minister of Health on the Approval of the Code of Ethics for Medical Staff and the Charter of Ethics committee, which emphasises respect for patient rights in health services. However, it has been found that the results of such surveys are inadequately used for substantive actions (WHO 2017). A 2018 technical report prepared by the Independent Research Institute of Mongolia and Conseil Santé concluded that, overall, the services provided in the health sector were "not client-friendly" in terms of the providers' attitudes and health-setting environments (IRIM and Conseil Santé 2018). Notably, one study observed a negative association between FHC visits and disability status (Dorjdagva et al. 2017).

▶ 5. Way forward

Despite vast improvements to Mongolia's SHP system over the years, the aforementioned challenges impede progress towards sustainable, equitable and efficient health protection. In light of the impacts of the COVID-19 pandemic, ensuring equitable access to adequate quality health care has never been more important. To accelerate progress in this area, the State Policy on Health (2017–2026), adopted through the Resolution of the Government of Mongolia No. 24 of 2017, stipulates a commitment to improving availability, accessibility and quality of services, by setting a range of defined targets to be achieved by 2026. These targets include: a reduction of the share of OOP payments to 25 per cent of the total health expenditure; an increase of the share of health sector financing to 5 per cent of GDP; and an increase of the average life expectancy in Mongolia to 74 years.

In order to achieve these targets, health financing, health sector management, organization and transparency, as well as new technologies for information management have been identified as key priority areas to address (IRIM and Conseil Santé 2018). If fully implemented, this approach should help decrease the disparities between SHI financing sources. The digitization of health information and improvement of the relevant registries

could also help reduce the mis-targeting of government subsidies, which has previously been identified as a pressing challenge (Asian Development Bank 2013). The World Bank and the Government of Mongolia have already started working on establishing health information platforms throughout the country to facilitate the management and monitoring of health systems, in particular through the implementation of the E-Health Project 2015–2020 (World Bank and Mongolia Ministry of Health 2019). A broader effort to create integrated information platforms to easily and securely store, transfer, and combine individual civil and health data could yield a wide range of benefits to both patients and service providers.

In terms of governance, continuing decentralization efforts hold promise towards improving the system's resilience, as the delegation of power to local authorities may enable a more efficient use of resources (WHO 2018). These efforts may be reinforced by steps towards improving the participation of different stakeholders in the design of health policies and plans. For example, the Law on Development Policy and Planning has introduced a multi-stakeholder process for policy-making, which has the potential to create more opportunities for Mongolian society to better influence health care provision in accordance to its needs. More broadly, the ratification of the ILO Convention No. 102 on medical care, sickness, and maternity could be an important step towards improving the existing social health protection system, as it would help to harmonize national laws and practices with existing international standards and guidelines, thereby improving the system's performance.

To enhance coverage and sustainability of the SHI scheme, activities prescribed by the Long-Term Strategy for the Development of Health Insurance 2013–2022, if fully implemented, have the potential to stimulate necessary improvements. These include mobilizing additional resources for SHI funding; improving the government subsidy targeting mechanism; improving the efficiency and quality of the health services offered; and conducting continuous social marketing activities in order to increase understanding and knowledge of health insurance among the population. With regard to PHC specifically, the Government is currently making efforts to address the physical constraints related to accessing SHCs by introducing mobile health units. For example, two trains have been equipped to serve as "mobile hospitals" providing basic diagnostics and preventive care (Batchimeg 2019).

6. Main lessons learned

- The case of the Mongolian SHP system illustrates a successful combination of tax funded primary health care and coverage provided through SHI. The mix of financing mechanisms ensures continuity of coverage, and hence continuum of care, throughout the health system. The financial participation of the population through contributions makes SHP more affordable to the government, which can allocate its limited financial resources to provide quality primary health care and support the most vulnerable.
- In Mongolia, the fluctuation of policies on SHI contribution subsidies, including the introduction, removal and then reintroduction of subsidies, has impacted enrolment rates and in turn financial protection. This illustrates the crucial need for consistency in social health protection policies and continuity in government financial allocation in the form of SHI contribution subsidies to enable coverage of groups of the population with low contributory capacity.

  Mongolia is facing a triple challenge: not only is it the most sparsely populated country in the world, but the country has a large nomadic population spread over large areas. This makes the provision of public services expensive, and complicates the ability to reach out to populations in need. With only 40 per cent of Mongolian herders participating in the health insurance scheme (National Statistical Office 2018), specific strategies are needed. The government is endeavouring to adjust the health protection system to cover these groups through the provision of subsidies for low-income earners, and by enhancing the flexibility of contribution mechanisms in terms of timing and frequency of payments.

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