COUNTRY DIAGNOSTIC STUDY ON LONG-TERM CARE IN MONGOLIA

NOVEMBER 2020

ASIAN DEVELOPMENT BANK

ADB

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Notes:
In this publication, "$" refers to United States dollars and "MNT" refers to togrog.

On the cover: With increasing numbers of older persons, life expectancy and pressure on traditional forms of familial care, providing effective care for older persons in Mongolia is an emerging challenge (photos from ADB Photo Library).

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FOREWORD

Rapid aging in Asia and the Pacific has put the region at the forefront of one of the most important global trends. The demographic shift is largely the result of both increased longevity and decreased fertility rates, which are both examples of development success. The change is happening at an unprecedented pace: in 2020, 13% of the population in the Asia and Pacific region is aged 60 or above, and by 2050, it is expected to increase to 24%, or roughly 1.3 billion people. At the same time, traditional family support systems are weakening due to increased migration, urbanization, decreasing family sizes, and expanding female labor market participation. Even when family care support is available, people with complex care needs and their caregivers require additional support.

The demographic, economic, and social trends are resulting in a growing need to establish and finance long-term care (LTC) services and develop the enabling environments to support older people to age well and help families and communities to care for their older citizens. The development of models of care that are affordable, sustainable, accessible, efficacious, and adapted to local contexts is sorely needed.

The window of opportunity to plan for, prepare, and adapt to the needs of aging populations is now. There is great diversity among countries in the region. Some are aging at a fast rate and need to adapt quickly, others will age slower, but will end up with very large older populations. What is common, however, is that countries in the region will see change in the coming years and need to prepare for it. The coronavirus disease (COVID-19) pandemic and its disproportionate impacts on older persons and on existing care systems have illustrated how important it is to strengthen existing systems and develop new capacities.

The Asian Development Bank (ADB) has a growing portfolio on LTC, and is working to capitalize on opportunities of increased population longevity and help mitigate the social and fiscal risks of population aging. In May 2016, ADB approved the regional capacity development technical assistance for the Strengthening Developing Member Countries' Capacity in Elderly Care project, to help increase the capacity of developing member countries to design policies and plans for the improvement of their LTC services. The six diverse countries included in this regional technical assistance are Indonesia, Mongolia, Sri Lanka, Thailand, Tonga, and Viet Nam.

The technical assistance aims to (i) build a knowledge base in the region for the development of LTC systems and services; (ii) improve the capacity of officials and other stakeholders in these countries to design and implement strategic LTC plans; and (iii) create a network for disseminating knowledge, good practices, and expertise.

This country diagnostic study aims to help strengthen the knowledge base on emerging LTC policies, programs, and systems in Mongolia. The study outlines findings on the current situation of LTC with regard to the need for care and the supply of care, regulatory and policy frameworks, service provision, quality management, human resources, and financing. Analysis, conclusions, and recommendations concerning LTC system development are also included and have been informed by an in-country consultative process.

Population aging is a key megatrend of the 21st century, and how the Asia and Pacific region adapts to this trend will be an important factor in the continued development of the region. ADB is committed to working with our members on this journey.

Woochong Um
Director General, Sustainable Development and Climate Change Department
Asian Development Bank

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ABBREVIATIONS

ADB	Asian Development Bank
ADL	activities of daily living
CDS	country diagnostic study
CSO	civil society organization
GDP	gross domestic product
GOSWS	General Office for Social Welfare Services
IADL	instrumental activities of daily living
ILO	International Labour Organization
LTC	long-term care
MAEP	Mongolian Association of Elderly People
MECS	Ministry of Education, Culture and Science
MLSP	Ministry of Labor and Social Protection
MNUMS	Mongolian National University of Medical Sciences
MOH	Ministry of Health
NGO	nongovernment organization
NRC	National Rehabilitation Center
NSO	National Statistics Office
OECD	Organisation for Economic Co-operation and Development
PWD	person with disabilities
TFR	total fertility rate
UNSPWG	United Nations Social Protection Working Group
WHO	World Health Organization

MONGOLIAN ADMINISTRATIVE DIVISIONS

aimag	province
soum	provincial district
bagh	hamlet
düüreg	Ulaanbaatar municipal district
khoroo	Ulaanbaatar subdistrict
kheseg	Ulaanbaatar micro-district

EXECUTIVE SUMMARY

The objective of this country diagnostic study is to contribute to the building of an in-depth knowledge base on emerging long-term care (LTC) policies, programs, and systems in Mongolia. The country diagnostic study covers demography, the needs of older persons, the supply of care, policy and regulatory frameworks, institutional arrangements and capacity, human resources, and financing.

Since 1990, Mongolia has exhibited the trends of a decreasing total fertility rate, increasing life expectancy, decreasing death rate, decreasing infant mortality rate, and of high rate of rural-to-urban migration in the context of an extremely low population density. Indeed, Mongolia has one of the lowest population densities in the world, with 3.2 million people in a land area of 1,565,000 square kilometers. The population dynamics of Mongolia are similar to those of most other developing countries in the region, with a population growth rate of 2.0% in 2016 and 1.3%–1.4% expected growth rates per year through 2040. **Mongolia's age pyramid has not yet reached the "coffin-shape" that populations in the developed countries have attained, but the process is underway. Mongolia's population is expected to increase by at least 1.4 million people by 2040, compared with 2010.** The proportion of older persons in the population is growing particularly rapidly, from 5.2% in 2000 to an expected 16.7% by 2040.

With a rising life expectancy, older persons are facing physical and health challenges that make them dependent on help from others. Health statistics show the following points:

- Among persons aged at least 60, 25% were moderately or severely dependent on others for basic daily living activities in 2016. Those severely dependent on others amounted to 7%.
- Older women were more likely than older men to need help with activities of daily living.
- Among older persons, 19% experienced some loss of independence, while 6% were fully dependent on others for instrumental activities of daily living.
- Among older persons, 5% had severe cognitive impairments.
- As for diet, 84% of older persons had a normal nutritional status, but 16% were at risk of malnutrition.
- Almost one in five older adults was either overweight or obese, which indicates a high risk of noncommunicable diseases, including hypertension. Older women were almost twice as likely as older men to be obese or overweight.

In Mongolia, most older persons live with their families, with the adult offspring or other relatives providing care when required. Generally, older persons are cared for at home, either in their own home, or in the home of the caregiver. According to the Mongolian patriarchal system, the oldest son is responsible for older parents, although their LTC needs are actually attended to by the son's wife and other female family members. Traditionally, parents have tended to rely on their children, but this pattern is likely to weaken over time with increasing urbanization and shrinking family size. If an older person does

not have a son to live with, there is now an increasing willingness to live with daughters or close relatives (mostly in rural areas) or to live alone close to relatives and neighbors.

A policy and legal framework to protect and care for older persons has been well developed in Mongolia, and covers various aspects of support, including social protection and welfare, health, and employment services. In 2017, the Law on the Elderly was approved by Parliament, and regulations for the implementation of the law are being developed. In cooperation with other stakeholders, the Ministry of Labor and Social Protection is working on a national program to support the implementation of the law, the National Program on the Development and Social Protection of Elderly People. This program will offer a comprehensive framework for the coordination of all partner inputs in the area of support and development for older persons in Mongolia. However, thorough consultations and a consensus are needed to integrate this program with other national programs and strategies, such as the National Strategy on Aging (2009–2030) and the National Program on Healthy Aging and the Health of Older Persons (2014–2020).

Nonetheless, Mongolia lacks an explicit policy or strategy on LTC, so there is no clear understanding of LTC among policymakers, and there is no coordination between the social and health sectors. Additionally, other important sectors needed for comprehensive LTC—such as infrastructure, transport, and housing—are often neglected.

The issue of care for older persons is a multi-stakeholder concern in Mongolia. Although the government is the main body for policymaking and implementation on aging, it lacks knowledge and institutional capacity, and faces challenges relating to policy continuity, so awareness of LTC for older persons should be strengthened to enable effective leadership and governance. The role of civil society has been concentrated on participation in policymaking and on some implementation activities. The private sector only provides very limited long-term residential care and health services, such as palliative care and sanatoriums.

In Mongolia, home-based family care is the most common form of LTC support. This aligns with cultural values in Mongolia, but it must be supplemented by other individualized and non-individualized services, so as to provide care for all. Other LTC services include residential care, day care, medical and geriatric care, nursing, rehabilitative care, mental care, palliative care, and assistive devices. Care for older persons in urban settings is different from that in sparsely populated areas; and existing services face challenges in terms of coverage, quality, and comprehensiveness. For example, residential care covers only 1.6% of the older persons in need of such care. Existing rehabilitation services are limited to sanatoriums and hospital physical therapy departments with outdated service models. Moreover, LTC in Mongolia is mostly medically driven, with a strong emphasis on curative and rehabilitative care, while other LTC services, such as social and psychosocial services, are poor or nonexistent. Many of these services rely on informal caregivers (such as family members), but more acute challenges will arise as the number of older persons increases with the population aging.

Quality management of LTC is not regulated uniformly, though related elements are managed by the Ministry of Labor and Social Protection and the Ministry of Health. The quality of health and social services is ensured using key tools and approaches, including professional licensing, accreditation and annual management agreements for performance, planned monitoring, and evaluation activities by government institutions. In addition, there are institutional service delivery standards, as well as guidelines and quality teams, in place in all institutions that provide health care. However, this does not mean that all these methods are developed and designed to meet the needs of people, especially older persons, nor that they are in line with an internationally recognized approach or even feasible for local implementation. An integrated approach to LTC with monitoring and quality management would allow for private sector and nonprofit providers, as well as government services, to provide care according to uniform standards. Assessment tools for identifying those in need of care support

have begun to be used but could also be strengthened and used more uniformly. **Human resources are key to ensuring good-quality and accessible LTC for older persons,** but in Mongolia these resources are over-medicalized, so only health-care services are available to older persons. Day caregivers, respite caregivers, and trained community-based service providers are almost nonexistent in Mongolia. Informal caregivers (mainly family caregivers) form the bulk of the LTC workforce, but they have generally not received any training in caregiving. Therefore, the training and recruitment of formal (frontline) and informal caregivers should be a priority. It is also important to train primary health-care workers, social workers, community-based volunteers, and nongovernment organization staff, as well as older persons themselves.

Mongolia lacks a clear picture of how much it spends on LTC. Currently, the Mongolia National Health Accounts fail to produce expenditure estimations with regard to LTC. The classifications of LTC services required to make such estimates are nonexistent or blurred between or within sectors and institutions. In addition, there is no information on private expenditure, i.e., out-of-pocket payments for LTC by individuals and families.

The estimates carried out for this assignment show that **Mongolia needs to allocate 0.35% of its gross domestic product to LTC to provide sufficient social and health-care services for older persons by 2030.** Furthermore, the share of LTC in the government budgets needs to be 1.13% by 2030, assuming that all older persons in need of LTC will have access to services.

I. BACKGROUND AND COUNTRY CONTEXT

1.1 Definition

First, it is important to clarify the meaning of long-term care (LTC) and its significance for this country diagnostic study (CDS), in order to provide a conceptual framework that will enable the study to contribute to the evolving debate around, and understanding of, LTC in Mongolia, and to influence the emerging "vision" of care for older persons there.

The complex nature of LTC and its many overlapping issues essentially defy a precise definition and clear boundaries, so there is a variety of definitions. The Organisation for Economic Co-operation and Development (OECD), for instance, defines LTC as "care for people needing daily living support over a prolonged period of time." InterRAI, a research network that seeks to improve care for people who are disabled or have complicated medical problems, defines LTC as "a set of healthcare, personal care, and social services delivered over a sustained period of time to persons who have lost or reduced functional and psychosocial capacity, due to frailty and chronic diseases."

However, there is a broader conceptualization of LTC, most recently articulated by the World Health Organization (WHO) in its *World Report on Ageing and Health* (2015), which defines LTC as "the activities undertaken by others to ensure that people with or at risk of a significant ongoing loss of intrinsic capacity can maintain a level of functional ability consistent with their basic rights, fundamental freedoms and human dignity."

Therefore, according to WHO, the central goal of LTC systems should be to "maintain a level of functional ability in older persons who have or are at high risk of significant losses of capacity." Key principles of this concept of LTC, as described in the *World Report on Ageing and Health*, are as follows:

- First, even in circumstances in which older persons have a significant loss of functioning, they still "have a life." They have the right to and deserve the freedom to realize their continuing aspirations of well-being, meaning, and respect.
- Second, as in other phases of life, intrinsic capacity during a period of significant loss is not static; instead, a decline in capacity is part of a continuum, and, in some cases, may be preventable or reversible. Fully meeting the needs of someone at this stage of life thus demands that an effort be made to optimize these trajectories of capacity, thus reducing the deficits that will need to be compensated for through other mechanisms of care.

The definition of LTC in WHO's *World Report on Ageing and Health* is a broad one, but it promotes a holistic, person-centered approach to older persons' care, including an emphasis on early intervention for those "at risk" and on the importance of other factors that could affect care. This approach is consistent with the emerging trends in care practices in many countries, including a widespread recognition of the importance

of early intervention, of enabling people with functional limitations to be as independent as possible, of psychosocial well-being, and of environmental factors. Whether these factors are relevant to LTC is less clear, but there is a general consensus about their importance in the development of care systems and services for older persons.

Therefore, for the Mongolian CDS, the authors used the LTC definition and approach proposed by WHO in its *World Report on Ageing and Health*. The CDS also considers the importance of other factors affecting the care ecosystem in which LTC is situated, by reflecting on older persons' care needs and on the good practices or omissions with regard to the other factors that either contribute to an increase in the need for care (e.g., inaccessible housing, lack of availability of assistive devices, and isolation), or to a decrease in the need for care (e.g., living support for social interaction, support with instrumental activities of daily living [IADL], safe and secure housing, rehabilitation services, and occupational therapy).

No definitive, internationally recognized definition of LTC has yet been specified for use in current policy frameworks in Mongolia. However, the Mongolian laws define critical elements of LTC not from the perspective of care, services, or activities, but from a person-centered perspective, in terms of (i) who is the target beneficiary and (ii) what care and services need to be provided. The Mongolian Law on Social Welfare of 2012 contains provisions for the social protection of older persons, including various benefits such as health care, employment support, and pensions. The law defines "a citizen in need of permanent care" as an individual who lacks the capacity to carry out routine tasks in everyday life without another's help, or an individual with a mental development disorder or with serious mental problems. "Specialized care" under the Social Welfare Law means the provision of accommodations, food, clothes, financial support, psychological counseling, nursing, and treatment in order to replicate normal living conditions. The law seeks to protect the legal interests of children in difficult situations, and of older persons and those with disabilities who are unable to live independently, and require permanent care and treatment, but are single or have no relatives to support or look after them. Hence, in Mongolia, older persons who cannot carry out everyday routine activities independently or without help will be provided with psychological, nursing, medical, and other support—services that this CDS attempts to analyze. These services and care systems are further defined and clarified in other legislative and policy frameworks, including the Law on the Elderly, the Health Act, and the Medical Services Act.

1.2 Country Context

Mongolia is the 18th-largest country by land size, but is the most sparsely populated country in the world, at just two people per square kilometer. Mongolia is landlocked and shares borders only with the Russian Federation and the People's Republic of China. Around 45% of the population lives in and around the capital city of Ulaanbaatar, and about 30% of the population is nomadic or seminomadic. Box 1 provides some statistics on Mongolia.

Older persons have lived through times of significant change in Mongolia. The oldest people in the country today were born around the time of independence from the People's Republic of China in 1921 and the Soviet Union's takeover in 1924. This was the beginning of almost 70 years of a Soviet-oriented socialist system. The majority religion is Buddhism, but the practice of religion was subjected to Stalin-influenced repression. The Stalinist purges in 1937 killed more than 30,000 people in the country. World War II reached Mongolia's borders and, after the war, disputes with the People's Republic of China prevented Mongolia from joining the United Nations until 1961. As the Soviet Union was dissolving in 1990, Mongolia underwent a peaceful revolution, establishing a parliamentary democracy and a market economy. Education and health care prior to the socialist era had been organized around Buddhist monks and temples. During the socialist era, primary education was expanded, as was the practice of modern medicine. Almost all older persons have access to a pension. Mongolia has made significant progress on key development indicators since 1990, including increased school enrollment and the decline of maternal and child mortality.

Box 1: Country Context—Mongolia

Population	3,238,487
Population over 60 years of age	215,731
Share of population over 60 years of age	6.7%
Land area	1,565,000 km^2
Density	2.1 inhabitants/km^2
Ethnic groups	
Khalkh	84.5%
Khazakh	3.9%
Durvud	2.4%
Others	9.2%
Religion	
Buddhism	86.2%
Islam	4.9%
Shamanism	4.7%
Christianity	3.5%
Others	0.7%
Geography	Eastern Asia
Climate	Hot in the summer and extremely cold in the winter
Government	Semi-presidential democratic republic
Adult literacy rate	98.5%
Economy	
GDP, million, MNT	32,411.22
GDP per capita, thousand MNT	10,259.80
GDP per capita, by World Bank Atlas method (in US dollars)	4,050.13
Major income sources	Mining (copper, coal, molybdenum, tin, and gold) and agriculture (livestock herding)
Female labor force participation rate	53.4%
Urbanization	68%
Maternal mortality ratio	27.1 per 100,000 births
Infant mortality rate	13.4 per 1,000 live births
Some major historical events	Independence from the People's Republic of China: March 1921 Socialist system: from 1924 to 1990 Democratic system: since 1990

GDP = gross domestic product, km^2 = square kilometer, MNT = togrog, US = United States.

Sources: National Statistics Office. 2019. *Mongolian Statistical Yearbook 2019*. Ulaanbaatar; National Statistics Office. 2016. *Population and Housing By-census Report 2015*. Ulaanbaatar.

II. METHODS

The qualitative and quantitative methods used in this CDS are described below.

2.1 Qualitative Methods

This CDS included a document review with a gap analysis covering major factors such as policies, programs, services, and financing. In addition, key stakeholders were consulted to identify country priorities.

As part of this study, small-scale qualitative research was conducted: (i) with older persons to better understand the need for care in both urban and rural areas; (ii) with key stakeholders to identify levels of knowledge, attitudes, beliefs, and practices regarding aging and LTC; and (iii) with care providers to complement the limited data available on the supply of care, and to better understand current changes in that supply.

The study relied on primary qualitative data in the form of interviews with key informants and focus group discussions; it also obtained quantitative data through an e-mail and phone surveys. Fieldwork involved 24 key stakeholder interviews with high-level officials from relevant ministries and agencies such as the Ministry of Health (MOH), the Ministry of Labor and Social Protection (MLSP), the Ministry of Road and Transport, social welfare agencies, and social insurance agencies. There were also interviews with government officials at the *aimag* (province), *soum* (provincial district), *düüreg* (district of Ulaanbaatar), *khoroo* (subdistrict of Ulaanbaatar), *kheseg* (micro-district of Ulaanbaatar), and *bagh* (hamlet) levels.

In addition, the fieldwork included 24 interviews with service providers and 12 focus group discussions among older persons. All of this fieldwork took place in three areas of Mongolia: two *düüregs* in Ulaanbaatar (Songinokhairkhan and Bayanzurkh), and one rural area (Uvs *aimag*). The two *düüregs* were chosen because of their high population densities, including large numbers of apartments and *gers*,[1] and for their sizable migrant populations. Uvs *aimag* was chosen due to its distance from any urban center (1,300 kilometers from Ulaanbaatar), the presence of active elderly associations, and its status as one of the very few *aimags* with an elderly care center.

[1] A *ger* is a traditional Mongolian house, consisting of tent-like wooden structure covered with woolen felt.

2.2 Quantitative Methods

The secondary data analysis was carried out using the latest statistical data from the Household Socio-Economic Survey. It was conducted separately to provide data for Chapter III, which focuses on understanding the care needs of older persons (section 1), taking into account their poverty levels, disability status, education levels, housing conditions, etc.

A quantitative survey of institutional LTC providers was planned in order to cover both private and public organizations that deliver residential care and home care services. However, the response rate was very low, as most of the residential care centers had already moved to their summer-camp facilities.

III. FINDINGS

3.1 Understanding the Care Needs of Older Persons in Mongolia

3.1.1 Demography

Mongolia has one of the lowest population densities in the world, with an estimated population of 3.2 million in 2018 and a land area of 1,565,000 square kilometers, or two people per square kilometer. Mongolia's population has followed the typical demographic trend of shifting from high to low birth rates, but some special features arising from Mongolia's political economy have resulted in a unique pattern of population change that is not easily comparable to those of other countries.

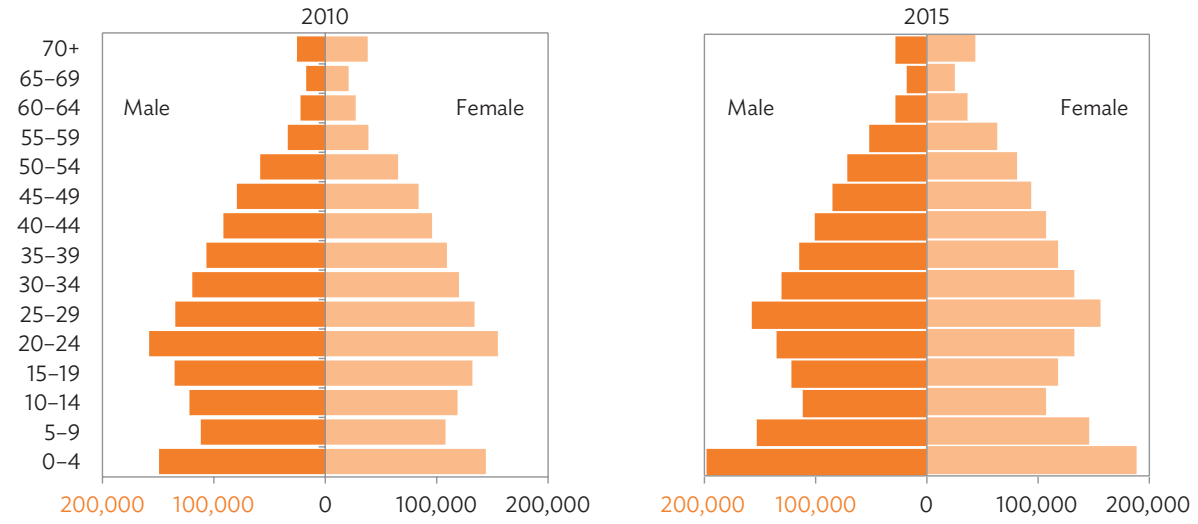
From the first population census, in 1918, until the mid-1950s, Mongolia had a slow rate of population growth (under 1% per year), mainly because the death rate was high and the birth rate was low. The rate of growth accelerated in the late 1950s, reaching a peak between 1969 and 1979. As in other countries, Mongolia's rapid population growth during the 1960s and 1970s was caused by both increasing fertility and decreasing mortality. Government "pronatalist" policies helped to push the birth rate up to a high level, contributing to the high rate of population growth. In the 1980s, these policies were relaxed, and the birth rate began to decline. There have been many important changes in Mongolia since 1990, when the country's political, economic, and social transition began. These have included increasing economic growth and life expectancy, decreasing death and infant-mortality rates, and a high rate of rural-to-urban migration—all in the context of extremely low population density.

Population pyramids showed that the rapid decline in the birth rate during the 1990s and early 2000s resulted in a reduction in the population of Mongolians aged 0–15 by 2005. But there has been an increase in the birth rate since that year, so there is now a larger population of Mongolians aged 0–15 than of those aged 15–30. As a result of these fluctuations, future population growth in Mongolia will be uneven.

Mongolia's population is expected to increase by at least another 1.4 million people by 2040, compared with 2010. The annual rate of growth will probably be within the range of 1.3%–1.4% on average, which is modest by developing country standards. This relatively low rate has already resulted in significant policy challenges, the most important of which is the aging population. From 1990 to 2010, the aging of the population was very slow, with the proportion of the population aged 60 and over remaining below 6% of the total. The rate of population aging has since accelerated, however, and by 2040, 16.7% of the population is predicted to be in that age group.

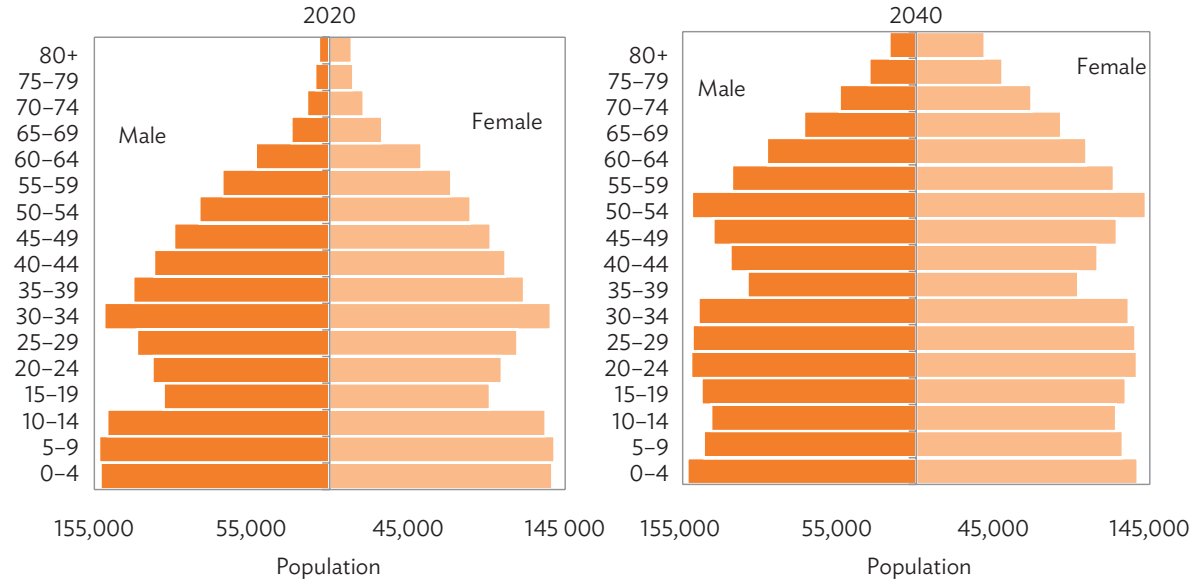
Mongolia's age pyramid has not yet reached the "coffin-shape" that populations in the developed countries have attained, but the process is underway and the direction is clear. The effects of aging are

Figure 1: Population Pyramids, 2010 and 2015 Censuses



Source: National Statistics Office. 2016. *Population and Housing By-census Report*. Ulaanbaatar.

Figure 2: Population Pyramids, 2020 and 2040 Projections



Source: National Statistics Office. 2010. *Population Projection Report*. Ulaanbaatar.

particularly apparent in the 2040 age pyramid, especially in the female population, which is clearly much larger in the 70-and-over age group.

The increase in the absolute numbers and proportion of the older population, particularly the "older old" (over the age of 70) and "oldest old" (over the age of 80), is particularly significant, given that the need for care support increases with age. Table 1 shows the numbers of older citizens and their percentages of the total population for 2000–2040.

Table 1: Numbers and Percentages of the Older Population, by Age Group and Sex, 2000–2040

Year	Sex	Older Persons—Numbers and Percentages of Total Population											
		60–64	%	65–69	%	70–74	%	75–79	%	80+	%	Total	%
2000	Male	20,778	1.8	15,982	1.4	8,766	0.7	5,832	0.5	3,634	0.3	54,992	4.7
	Female	21,514	1.8	19,433	1.6	11,473	1.0	9,011	0.8	7,872	0.7	69,303	5.8
	Total	**42,292**	**1.8**	**35,415**	**1.5**	**20,239**	**0.9**	**14,843**	**0.6**	**11,506**	**0.5**	**124,295**	**5.2**
2010	Male	21,987	1.7	17,169	1.3	13,011	1.0	7,213	0.6	5,084	0.4	64,464	4.9
	Female	27,200	2.1	20,857	1.6	16,164	1.2	11,304	0.9	10,357	0.8	85,882	6.5
	Total	**49,187**	**1.9**	**38,026**	**1.4**	**29,175**	**1.1**	**18,517**	**0.7**	**15,441**	**0.6**	**150,346**	**5.7**
2020	Male	48,516	3.1	25,167	1.6	14,417	0.9	9,352	0.6	6,962	0.4	104,414	6.7
	Female	60,377	3.8	34,460	2.2	22,419	1.4	15,317	1.0	14,424	0.9	146,997	9.2
	Total	**108,893**	**3.5**	**59,627**	**1.9**	**36,836**	**1.2**	**24,669**	**0.8**	**21,386**	**0.7**	**251,411**	**8.0**
2030	Male	73,451	4.2	54,180	3.1	32,642	1.9	14,191	0.8	8,544	0.5	183,008	10.4
	Female	88,591	4.9	72,733	4.0	51,336	2.8	26,557	1.5	21,435	1.2	260,652	14.3
	Total	**162,042**	**4.5**	**126,913**	**3.5**	**83,978**	**2.3**	**40,748**	**1.1**	**29,979**	**0.8**	**443,660**	**12.4**
2040	Male	98,911	5.1	74,644	3.9	50,735	2.6	31,225	1.6	17,636	0.9	273,151	14.2
	Female	112,940	5.6	96,106	4.8	76,212	3.8	56,907	2.8	44,883	2.2	387,048	19.2
	Total	**211,851**	**5.4**	**170,750**	**4.3**	**126,947**	**3.2**	**88,132**	**2.2**	**62,519**	**1.6**	**660,199**	**16.7**

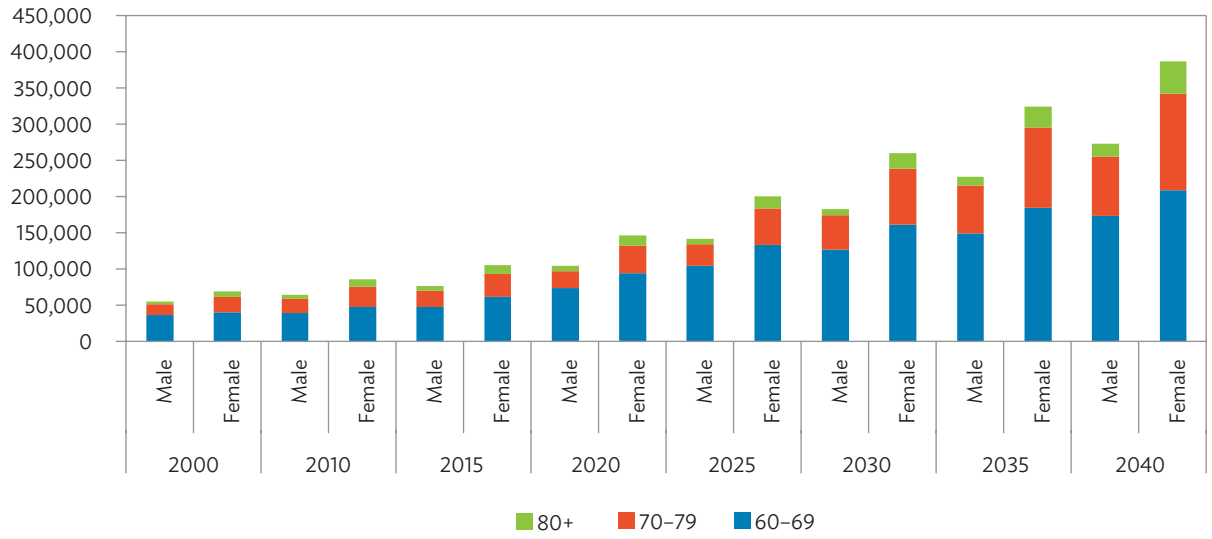
Sources: National Statistics Office. 2010. *Population Projection Report*. Ulaanbaatar; and calculations based on National Statistics Office. 2016. *Population and Housing By-census Report*. Ulaanbaatar.

The changing age and sex structure and spatial distribution of the population have had profound effects in terms of the challenges they present, such as the (i) increasing proportion of "oldest old" persons within the older population, (ii) feminization of the older population, (iii) increasing dependency ratio, and (iv) the pattern of population aging in rural areas.

The proportion of the oldest old (80+) was about 0.6% (15,441 people) of the total population in 2010. That proportion is expected to increase to 1.6% (62,519 people) by 2040.

The population age patterns seen in almost all countries show two trends: population aging and the feminization of the older population. The "feminization of aging" refers to the predominance of females in the older population. This results from the higher life expectancy of females. While the number of male babies born usually exceeds the number of female babies, the longer female life expectancy results in women constituting a majority of the older population. Life expectancy for both sexes has been increasing in Mongolia over time: as of 2019, it was 72.3 years for women and 64.9 years for men. Between 1969 and 2010, life expectancy at birth increased 10 years for women and 4–5 years for men; also, the sex ratio of the population aged 60 and over changed during that period, with the ratio of men per 100 women declining (Table 2).

Figure 3: The Numbers and Proportions of 60-and-Over Age Groups, 2000–2040



Source: National Statistics Office. 2010. *Population Projection Report*. Ulaanbaatar.

3.1.2 Living Conditions for Older Persons

The primary living environment should fulfill the basic need of human beings for a secure, comfortable, and healthy place that protects them from natural and climatic phenomena, external impacts, and other persons.

There is a substantial difference in housing types of the older population between urban and rural areas. Among the total number of households with older persons, 57.9% were living in houses and 42.1% in *gers*.

The traditional *ger* is unique in its structure, arrangement, and features. The size of a *ger* is determined by the number of wooden walls, and this number serves as a measure of the living standards of households. Simple stoves are used to provide the heating for all households.

With respect to the types of housing, Table 3 shows that 52.2% of households with older persons live in single-family houses,[2] 44.5% in apartments,[3] 1.6% in dormitories,[4] 0.9% in convenient single-family houses,[5] and 0.8% in other places.[6] Of households headed by an older person, 65.5% live in urban areas and 34.5% in rural areas.

[2] Mainly built in *ger* districts of urban areas and in rural areas, these houses are made up of one or more rooms and include a kitchen, shower, heating and sanitary facilities, and water supply system.

[3] Entirely or partially used for dwelling during the census date. This type of houses can have substructures with one or more rooms with facilities and equipment for each household occupying the rooms.

[4] A communal dormitory or house designed for students at any level of educational institution, workers or staff of organizations, or for people living in groups including rest homes, sanatoriums, resort centers, hospitals, care centers, prisons, and army barracks.

[5] Designed for one household, connected to the central engineering lines and system or with independent engineering lines or connected to heating, air-conditioning, water supply, sanitation, electricity supply, and information communication lines.

[6] Institutional houses dedicated for people living temporarily in groups such as rest homes, sanatoriums, resort centers, hospitals, care centers, prisons, and army barracks.

Table 2: Life Expectancy at Birth by Sex, 1969–2040

Year	Male	Female	Total	Sex Ratio of Population Aged 60 and Over (males per 100 females)
1969	60.5	61.9	61.2	85.2
1979	60.7	65.1	63.0	78.1
1989	60.3	66.1	63.3	77.8
2000	61.1	66.6	63.7	79.3
2005	62.1	68.6	65.2	79.9
2010	64.6	74.2	69.3	75.1
2015[a]	65.8	76.1	70.9	72.3
2020[a]	67.1	77.5	72.2	71.0
2025[a]	73.2	68.2	78.4	70.7
2030[a]	74.1	69.4	79.0	70.2
2035[a]	74.8	70.4	79.4	70.1
2040[a]	75.4	71.4	79.6	70.6

[a] The values for these years were based on projected population medium variants compared with 2010, provided by Mongolia's National Statistics Office.

Source: National Statistics Office. 2012. *Mongolia in 100 Years*. Ulaanbaatar.

Table 3: Types of Residences of Older Persons, with Numbers and Percentages, 2015 Housing Type

	Urban		Rural		Total	
	Number of Households	%	Number of Households	%	Number of Households	%
Apartment	36,916	51.5	745	5.7	37,661	44.5
Convenient single-family house	717	1.0	34	0.3	751	0.9
Single-family house	32,445	45.3	11,732	90.5	44,177	52.2
Dormitory	1,157	1.6	200	1.5	1,357	1.6
Other places	418	0.6	252	1.9	670	0.8
Total	**71,653**	**100.0**	**12,963**	**100.0**	**84,616**	**100.0**

Note: Percentages may not total 100% because of rounding.

Source: Calculations based on National Statistics Office. 2015. *Population and Housing Inter-Census*. Ulaanbaatar.

The types of households older Mongolians live in are shown in Table 4. In 2015, 66.2% of the households with older persons consisted of nuclear families,[7] and 24.0% consisted of extended families.[8] In rural areas, the proportion of households consisting of nuclear families (68.8%) was higher than in urban areas (63.7%).

[7] A household that consists of a nuclear family includes a married couple with or without children.

[8] A household that consists of an extended family includes (i) a single family nucleus and other persons related to the nucleus, for example, a father with children and other relatives, or a married couple with other relatives only; (ii) two or more family nuclei related to each other without any other persons, for example, two or more married couples with children only; (iii) two or more family nuclei related to each other plus other persons related to at least one of the nuclei, for example, two or more married couples with other relatives only; or (iv) two or more persons related to each other, none of whom constitute a family nucleus.

Households with older persons had an average of 3.4 family members, which is 0.5 persons lower than the national average. This can be explained by the fact that the adult children tended to live separately. Overall, rural households with older persons had an average of 3.5 members, while those in urban areas had an average of 3.0 members. Migration is one explanation for this pattern. In urban households, students and relatives who came from rural areas may have been living with older family members temporarily. In addition, due to the limited housing availability, it is common for several families of friends or relatives to live together in one household in urban areas (NSO 2015).

Opportunities for employment are limited for older persons in Mongolia. According to the 2018 Labor Force Survey, 15% of the older population was employed in some manner. The labor force participation rate of older persons was higher in rural areas, as they had opportunities to engage in agriculture, especially in livestock husbandry.

Table 4: Breakdown of Households with Older Persons by Size, Type, and Urban or Rural Location, 2010 and 2018
(%)

Household Size (Urban, Rural, and Whole Population)	Household Type (2010)				Household Type (2018)			
	Single-Person	Nuclear	Extended	Mixed	Single-Person	Nuclear	Extended	Mixed
Urban								
1	100.0				100.0			
2		77.9	20.3	1.8		87.0	12.8	0.2
3–4		73.0	25.0	2.0		75.2	24.5	0.3
5–6		41.9	54.1	3.9		57.7	41.7	0.7
7+		13.2	80.2	6.5		15.9	82.4	1.7
Total Urban	**9.9**	**57.5**	**30.3**	**2.4**	**8.8**	**63.7**	**27.2**	**0.4**
Rural								
1	100.0				100.0			
2		84.9	13.7	1.3		85.9	13.8	0.2
3–4		86.4	12.3	1.3		80.5	19.2	0.3
5–6		75.7	21.8	2.6		69.2	30.3	0.4
7+		56.3	40.0	3.7		31.6	68.0	0.4
Total Rural	**12.2**	**72.3**	**13.9**	**1.5**	**10.3**	**68.8**	**20.7**	**0.3**
Whole Population								
1	100.0				100.0			
2		80.2	18.1	1.6		86.5	13.3	0.2
3–4		77.3	20.9	1.8		77.8	21.9	0.3
5–6		53.3	43.3	3.5		63.3	36.2	0.6
7+		23.8	70.3	5.8		22.7	76.2	1.1
Total Whole Population	**10.6**	**62.4**	**24.9**	**2.1**	**9.5**	**66.2**	**24.0**	**0.4**

Note: Percentages may not total 100% because of rounding.

Sources: National Statistics Office. 2010a. *Population and Housing By-census Report*. Ulaanbaatar; and calculation based on National Statistics Office. 2018. *Social Indicator Cluster Survey*. Ulaanbaatar.

Table 5: Labor Force Participation Rates for Older Persons, 2018
(%)

Item		Urban			Rural			Total Population		
		Male	Female	Both Sexes	Male	Female	Both Sexes	Male	Female	Both Sexes
Labor force participation rate	2018	9.8	6.3	7.7	37.3	26.1	31.1	19.1	12.1	15.0
Percentage of economically inactive older population	2010	90.2	93.7	92.3	62.7	73.9	68.9	80.9	87.9	85.0

Source: Calculation based on National Statistics Office. 2018. Labor Force Survey. Ulaanbaatar.

Economic activity among older women remains considerably lower than that among older men. This is because they tend to retire earlier, in accordance with Mongolia's Law on Pensions and Benefits as provided by the Social Insurance Fund of 1994. Under this law, women who have paid the pension premium for a period of not less than 20 years and who have reached the age of 55 are entitled to the old-age pension. Women who have given birth to or adopted four or more children (if the children were adopted under the age of 3), and whose youngest child has reached the age of 6, are entitled to the old-age pension at the age of 50. In this situation, they must also have paid a pension premium for not less than 20 years.

Table 6: Employed Older Population, by Age Group and Sex, for Urban and Rural Areas, 2010
(%)

Age Group	Overall Population			Urban			Rural		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
60–64	58.7	56.7	60.9	63.5	60.9	66.2	56.2	54.6	57.9
65–69	22.7	22.1	23.2	21.7	21.8	21.6	23.1	22.3	24.1
70–74	11.1	12.5	9.7	10.1	10.7	9.4	11.7	13.4	9.8
75–79	6.2	6.8	5.5	4.3	5.8	2.8	7.2	7.3	7.1
80+	1.3	1.9	0.7	0.4	0.8	0.0	1.8	2.4	1.1

Source: Calculation based on National Statistics Office. 2018. Labor Force Survey. Ulaanbaatar.

A number of older persons are living in poverty due to inadequate incomes. According to the 2018 Household Socio-Economic Survey, 904,900 people (28.4% of the population) live below the poverty line.[9] Poverty incidence seems to be higher when the household heads are in their 30s, decreases a bit for those in their 40s, and falls for those in their 50s (Table 7).

The main sources of income for older persons are pensions from the Social Insurance Fund and Social Welfare Fund, as well as income earned from jobs, particularly for older persons who care for livestock. The social welfare pension program supports people who are not entitled to receive pensions from the social insurance system. The

[9] The poverty line is estimated by the National Statistics Office every year based on the consumption of a basket of food and nonfood products per person.

following categories of people are eligible for this program: older persons (men aged 60 or more, and women aged 55 or more); persons with dwarfism aged 16 or more; persons with disabilities (PWDs) who have lost 50% or more of their labor capacity; orphaned children under 18; and single parents, such as mothers aged 45+ and fathers aged 50+ with four or more children. There is no automatic adjustment to the value of the social welfare pension, though in recent years the amount has been adjusted quite regularly. Its monthly value was MNT126,500 in 2015, MNT140,000 in 2016, MNT155,000 in 2018, and MNT174,000 in 2019.

Table 7: Poverty Profile by Age of Household Head, 2018

Item	<30	30–39	40–49	50–59	>60	Total
Head count[a]	25.7	33.9	28.5	27.2	20.1	28.4
Poverty gap[b]	5.4	8.5	7.7	7.0	4.8	7.2
Share of the total population (%)	10.0	29.0	27.7	19.7	13.6	100.0
Share of the poor population (%)	9.1	34.6	27.8	18.9	9.6	100.0
Household size (average)	3.2	4.2	4.1	3.3	2.6	3.6
Ages of household heads (average)	26.1	34.5	44.3	54.4	68.8	46.6
Households headed by men (%)	84.9	85.5	80.6	69.6	56.5	75.5

[a] The head count refers to the household head.
[b] The poverty gap is the ratio by which the mean income of the poor in each age group falls below the poverty line, which is defined as half the median household income of the total population.

Source: National Statistics Office. 2018. *Poverty Profile 2018. Household Socio-Economic Survey 2018*. Ulaanbaatar.

According to a study conducted in 2015 by the Mongolian Open Union of Elders, the pro rata pension was MNT195,000, the minimum pension was MNT230,000, and the average pension was MNT283,800. Compared with 2004, the pro rata pension had risen by 9.75%, the minimum pension by 7.18%, and the average pension by 8%. A study by the Mongolian Association for Elderly People concluded that the 14.8% (or MNT20,000) increase in the minimum pension and the 2%–5% increase in pensions in general since 2015 will not be enough to meet ever-rising inflation.

Older persons receiving small pensions contribute to meeting family food expenditures, thus their pensions help reduce the vulnerability of households. When the size of a pension is reasonably high, it becomes a main source of household income and helps prevent poverty. Qualitative studies of older persons identified the following impacts of a contributory pension: (i) it enhances individual satisfaction and self-confidence, (ii) it improves the feeling of being socially protected, (iii) the recipient has money that is her or his own, (iv) it allows the recipient to contribute to the family income, (v) it provides income security, and (vi) it enables increased access to health services and treatment. Another advantage of having a pension is the possibility of obtaining a pension loan from the bank.

3.1.3 Health and Disability

The latest official and nationally approved assessment of the ability of older persons to perform activities of daily living (ADL), conducted in 2016 by the Center for Health Development (Bayart et al. 2017), included questions about feeding, dressing, bathing, transferring, toileting, and continence. Older persons are scored for independence in each of these six functions. A score of 2 indicated full function, 1 indicated moderate impairment, and 0 indicated severe functional impairment. A total score of 10–12 indicated independence, 6–9 indicated moderate dependence, and 0–5 indicated severe dependence.

As reported by the Center for Health Development (Table 8), 25% of persons aged 60 years and above were moderately or severely dependent on others for performing basic daily living activities in 2016, with 18% moderately dependent and 7% severely dependent on others.

The likelihood of needing any help with ADL increased with age. Among the "young old" (60–69), 85% were independent in ADL; among the "middle old" (70–79), 66% were independent; while among the "oldest old" (80+), only 38% were independent (Table 8).

Table 8: Independence in Activities of Daily Living of Older Persons, by Age Group and Sex, 2016

Level of ADL Dependence	Sex	Age Group						Total	
		60–69		70–79		80+			
Independent	Male	16,773	86%	6,407	68%	1,335	42%	24,515	77%
	Female	21,271	85%	7,845	65%	1,746	35%	30,862	73%
	Total	**38,044**	**85%**	**14,252**	**66%**	**3,081**	**38%**	**55,377**	**75%**
Moderately dependent	Male	2,024	10%	2,159	23%	1,212	38%	5,395	17%
	Female	3,014	12%	3,160	26%	1,975	40%	8,149	19%
	Total	**5,038**	**11%**	**5,319**	**25%**	**3,187**	**39%**	**13,544**	**18%**
Severely dependent	Male	622	3%	857	9%	651	20%	2,130	7%
	Female	825	3%	1,048	9%	1,204	24%	3,077	7%
	Total	**1,447**	**3%**	**1,905**	**9%**	**1,855**	**23%**	**5,207**	**7%**
Total	Male	19,419	44%	9,423	44%	3,198	39%	32,040	43%
	Female	25,110	56%	12,053	56%	4,925	61%	42,088	57%
	Total	**44,529**	**60%**	**21,476**	**29%**	**8,123**	**11%**	**74,128**	**100%**

ADL = activities of daily living.

Note: The values in the left-hand column for each age group represent the actual numbers of people interviewed, while the percentages represent the proportion of each sex in each age range (or the total of the age ranges) that falls into a particular level of ADL dependence.

Source: Paper prepared for an international conference, Gerontology and Geriatric Care Today and Tomorrow. Ulaanbaatar. [20–22 August].

Older women were marginally more likely to need help with ADL than older men, with 26.7% of older women moderately or severely dependent on others, compared with 25.3% of older men.

The assessment by the Center for Health Development also measured the ability of older persons to engage in instrumental activities of daily living (IADL), based on the Lawton tool questions about eight types of daily activities: food preparation, housekeeping, laundry, shopping, long distance walking, money handling, using the telephone, and taking medications. In total, there are 24 questions, with the total score categories of 14–16 (independence in IADL), 10–13 (moderate dependence), and 6–9 (severe dependence), as shown in Table 9.

The assessment of the ability to perform IADL showed that 19% of older persons had experienced some loss of independence, and 6% were fully dependent on others for these functions. Not surprisingly, 60% of the "oldest old" people were dependent on others for IADL, while this percentage was 34% for the "middle old" and 14% for the "young old" (Table 9).

Table 9: Independence of Older Persons in Instrumental Activities of Daily Living, by Age Group and Sex, 2016

Level of IADL Dependence	Sex	Age Group						Total	
		60–69		70–79		80+			
Independent	Male	16,895	86%	6,895	69%	1,344	41%	25,134	76%
	Female	20,502	86%	8,145	64%	1,807	38%	30,454	74%
	Total	**37,397**	**86%**	**15,040**	**66%**	**3,151**	**40%**	**55,588**	**75%**
Moderately dependent	Male	2,323	12%	2,442	24%	1,162	36%	5,927	18%
	Female	2,661	11%	3,544	28%	1,936	41%	8,141	20%
	Total	**4,984**	**11%**	**5,986**	**26%**	**3,098**	**39%**	**14,068**	**19%**
Severely dependent	Male	502	3%	722	7%	737	23%	1,961	6%
	Female	625	3%	993	8%	958	20%	2,576	6%
	Total	**1,127**	**3%**	**1,715**	**8%**	**1,695**	**21%**	**4,537**	**6%**
Total	Male	19,720	45%	10,059	44%	3,243	41%	33,022	45%
	Female	23,788	55%	12,682	56%	4,701	59%	41,171	55%
	Total	**43,508**	**59%**	**22,741**	**31%**	**7,944**	**11%**	**74,193**	**100%**

IADL = instrumental activities of daily living.

Notes:

1. The values in the left-hand column for each age group represent the actual numbers of people interviewed, while the percentages represent the proportion of each sex in each age range (or the total of the age ranges) that falls into a particular level of IADL dependence.
2. Percentages may not total 100% because of rounding.

Source: Paper prepared for an international conference, Gerontology and Geriatric Care Today and Tomorrow. Ulaanbaatar. [20–22 August].

The mental state of older persons was also assessed (Table 10), with questions on basic cognitive abilities as standardized in the Mini-Mental State Examination. There were 11 capacities to examine: sense of time; sense of space; attention span; short-term memory; long-term memory; ability to name objects; ability to repeat sentences; and the abilities to understand, write, read, and copy. As shown in Table 10, the scores were categorized as 24–30 (no cognitive impairment), 23–18 (mild cognitive impairment), and below 17 (severe cognitive impairment).

Out of all the older persons examined in 2016, 5% were assessed as having severe cognitive impairment. The prevalence of cognitive deficit increased with age: 11% of those aged 60–69 years, 27% of those aged 70–79 years; and 52% of those aged 80 years and over.

The third important assessment of older persons focused on their nutritional status (Table 11), to identify those who were malnourished or at risk of malnutrition. The Mini Nutritional Assessment test included questions regarding the detection of weight loss and loss of appetite, mobility around the house, incidence of acute illness in the prior 3 months, neuropsychological problems, and the body mass index. The test score categories were 12–14 (normal nutritional status), 8–11 (risk of malnutrition), and 0–7 (malnourished).

Of the people aged 60 years or over, 84% had normal nutritional status and 16% were malnourished or at risk of malnutrition. In a pattern similar to those of the other assessments, the proportion of malnourished older persons increased from the "young old" to the "oldest old" group. This nutritional status tool (Table 12) also showed the level of body mass index of older persons.

Table 10: Mental States of Older Persons, by Age Group and Sex, 2016

MMSE Category	Sex	Age Group						Total	
		60–69		70–79		80+			
No cognitive impairment	Male	17,491	90%	7,369	74%	1,718	52%	26,578	81%
	Female	20,856	89%	8,696	72%	2,294	45%	31,846	78%
	Total	**38,347**	**89%**	**16,065**	**73%**	**4,012**	**48%**	**58,424**	**79%**
Mild cognitive impairment	Male	1,661	9%	2,075	21%	1,076	32%	4,812	15%
	Female	2,160	9%	2,579	21%	1,869	36%	6,608	16%
	Total	**3,821**	**9%**	**4,654**	**21%**	**2,945**	**35%**	**11,420**	**16%**
Severe cognitive impairment	Male	362	2%	497	5%	524	16%	1,383	4%
	Female	516	2%	791	7%	958	19%	2,265	6%
	Total	**878**	**2%**	**1,288**	**6%**	**1,482**	**18%**	**3,648**	**5%**
Total	Male	19,514	45%	9,941	45%	3,318	39%	32,773	45%
	Female	23,532	55%	12,066	55%	5,121	61%	40,719	55%
	Total	**43,046**	**59%**	**22,007**	**30%**	**8,439**	**11%**	**73,492**	**100%**

MMSE = Mini-Mental State Examination.

Note: The values in the left-hand column for each age group represent the actual numbers of people interviewed, while the percentages represent the proportion of each sex in each age range (or the total of the age ranges) that falls into a particular MMSE category.

Source: B. Bayart and T. Dulmaa. 2017. *Current Status of Specialists in Geriatrics and Gerontology in Mongolia*. First draft. Ulaanbaatar: Government of Mongolia, Ministry of Health, Center for Health Development.

Table 11: Nutritional Assessment of Older Persons, by Age Group and Sex, 2016

MNA Category	Sex	Age Group						Total	
		60–69		70–79		80+			
Normal nutritional status	Male	17,810	90%	7,893	80%	2,045	62%	27,748	84%
	Female	21,110	89%	9,911	80%	3,067	61%	34,088	83%
	Total	**38,920**	**90%**	**17,804**	**80%**	**5,112**	**61%**	**61,836**	**84%**
At risk of malnutrition	Male	1,622	8%	1,541	16%	932	28%	4,095	12%
	Female	2,073	9%	1,949	16%	1,407	28%	5,429	13%
	Total	**3,695**	**9%**	**3,490**	**16%**	**2,339**	**28%**	**9,524**	**13%**
Malnourished	Male	316	2%	409	4%	326	10%	1,051	3%
	Female	416	2%	558	4%	545	11%	1,519	4%
	Total	**732**	**2%**	**967**	**4%**	**871**	**10%**	**2,570**	**3%**
Total	Male	19,748	46%	9,843	44%	3,303	40%	32,894	44%
	Female	23,599	54%	12,418	56%	5,019	60%	41,036	56%
	Total	**43,347**	**59%**	**22,261**	**30%**	**8,322**	**11%**	**73,930**	**100%**

MNA = Mini Nutritional Assessment.

Note: The values in the left-hand column for each age group represent the actual numbers of people interviewed, while the percentages represent the proportion of each sex in each age range (or the total of the age ranges) that falls into a particular MNA category.

Source: B. Bayart and T. Dulmaa. 2017. *Current Status of Specialists in Geriatrics and Gerontology in Mongolia*. First draft. Ulaanbaatar: Government of Mongolia, Ministry of Health, Center for Health Development.

Table 12: Body Mass Index of Older Persons, by Age Group and Sex, 2016

Category Based on Body Mass Index	Sex	Age Group						Total	
		60–69		70–79		80+			
Underweight	Male	626	3%	763	8%	451	14%	1,840	6%
	Female	824	3%	907	7%	672	13%	2,403	6%
	Total	**1,450**	**3%**	**1,670**	**7%**	**1,123**	**13%**	**4,243**	**6%**
Healthy weight	Male	14,792	69%	7,130	72%	2,260	68%	24,182	74%
	Female	17,949	73%	9,166	72%	3,455	68%	30,570	72%
	Total	**32,741**	**71%**	**16,296**	**72%**	**5,715**	**68%**	**54,752**	**73%**
Overweight	Male	2,865	13%	1,479	15%	456	14%	4,800	15%
	Female	4,047	16%	2,036	16%	747	15%	6,830	16%
	Total	**6,912**	**15%**	**3,515**	**16%**	**1,203**	**14%**	**11,630**	**15%**
Obese	Male	1,197	6%	485	5%	153	5%	1,835	6%
	Female	1,804	7%	705	6%	243	5%	2,752	6%
	Total	**3,001**	**7%**	**1,190**	**5%**	**396**	**5%**	**4,587**	**6%**
Total	Male	21,284	46%	9,857	43%	3,320	39%	32,657	43%
	Female	24,624	54%	12,814	57%	5,117	61%	42,555	57%
	Total	**45,908**	**61%**	**22,671**	**30%**	**8,437**	**11%**	**75,212**	**100%**

Notes:
1. The values in the left-hand column for each age group represent the actual numbers of people interviewed, while the percentages represent the proportion of each sex in each age range (or the total of the age ranges) that falls into a particular Body Mass Index category.
2. Percentages may not total 100% because of rounding.

Source: B. Bayart and T. Dulmaa. 2017. *Current Status of Specialists in Geriatrics and Gerontology in Mongolia*. First draft. Ulaanbaatar: Government of Mongolia, Ministry of Health, Center for Health Development.

Around one in five older adults in Mongolia assessed for body mass index was either overweight or obese.

Once the participants underwent the above assessments and other medical diagnostics, health facilities classified them into five "health status groups" (Table 13): I—"very healthy," a person whose clinical diagnosis by a health-care provider showed no changes; II—"healthy," a person who did not need medical treatment, who nevertheless had congenital defects or revealed some initial symptoms of disease onset, but had no limitations in the type of work the person could do; III—"acceptable," a person with a compensated chronic condition; IV—"unhealthy," a chronically ill person with a partially compensated condition; and V—"very unhealthy," a decompensated person in the acute phase of a chronic condition.

According to the results, 38% of older persons were very healthy or healthy, and 62% suffered from different stages of some chronic condition as defined for health status groups III, IV, and V. Of the persons classified in health groups III, IV, or V, 35% were women and 27% men (Table 13).

The Ministry of Health (MOH) reported in 2017 that 85.5% of older persons suffered from one or more illnesses as diagnosed and reported by the health authorities. Almost 80% of morbidity among both older men and women registered by health-care providers was for noncommunicable diseases, including cardiovascular diseases and illnesses of the digestive, nervous, urogenital, musculoskeletal, and respiratory systems. According to a Center for

Health Development report (2015), arterial hypertension, ischemic heart diseases, diabetes, liver and gall bladder problems, and pneumonia accounted for the majority of illnesses among older persons.

Table 13: Health Status Groups of Older Persons in Mongolia, 2015

Health Status Group	Sex	Age Group						Total for All Age Groups	
		60–69		70–79		80+			
I	Male	2,608	13%	785	8%	153	4%	3,546	11%
	Female	2,612	11%	732	6%	163	3%	3,507	8%
	Total	**5,220**	**12%**	**1,517**	**7%**	**316**	**3%**	**7,053**	**9%**
II	Male	6,520	34%	2,692	26%	754	19%	9,966	30%
	Female	7,720	32%	3,250	26%	946	17%	11,916	28%
	Total	**14,240**	**33%**	**5,942**	**26%**	**1,700**	**18%**	**21,882**	**29%**
III	Male	8,499	44%	4,649	45%	1,540	38%	14,688	44%
	Female	11,182	47%	5,929	47%	2,065	37%	19,176	46%
	Total	**19,681**	**46%**	**10,578**	**46%**	**3,605**	**37%**	**33,864**	**45%**
IV	Male	1,418	7%	1,620	16%	1,082	27%	4,120	12%
	Female	1,920	8%	2,115	17%	1,679	30%	5,714	14%
	Total	**3,338**	**8%**	**3,735**	**16%**	**2,761**	**29%**	**9,834**	**13%**
V	Male	293	2%	485	5%	492	12%	1,270	4%
	Female	432	2%	566	4%	775	14%	1,773	4%
	Total	**725**	**2%**	**1,051**	**5%**	**1,267**	**13%**	**3,043**	**4%**
Total	Male	19,338	45%	10,231	45%	4,021	42%	33,590	44%
	Female	23,866	55%	12,592	55%	5,628	58%	42,086	56%
	Total	**43,204**	**57%**	**22,823**	**30%**	**9,649**	**13%**	**75,676**	**100%**

Notes:

1. The Health Status Groups were as follows: I—"very healthy," with no change for the worse; II—"healthy," indicating no need for medical treatment, though with congenital defects or some initial symptoms of disease onset, but no limitations in ability to work; III—"acceptable," with a compensated chronic condition; IV—"unhealthy," having a chronic illness with a partially compensated condition; and V—"very unhealthy," a decompensated person in the acute phase of a chronic condition.
2. The values in the left-hand column for each age group represent the actual numbers of people interviewed, while the percentages represent the proportion of each sex in each age range (or the total of the age ranges) that falls into a particular Health Status Group.

Source: B. Bayart and T. Dulmaa. 2017. *Current Status of Specialists in Geriatrics and Gerontology in Mongolia*. First draft. Ulaanbaatar: Government of Mongolia, Ministry of Health, Center for Health Development.

A study conducted in 2008–2009 (Oyunkhand 2011) has confirmed these findings, and has revealed that eight in 10 older adults were suffering from cardiovascular diseases, ischemic heart diseases, atherosclerosis, and/or cardiac arrest. Another study of older adults in health status group V (Table 13) showed that, in 2015, 27.2% of bedridden older persons were affected by stroke, 13.5% by hypertension, 12.0% by injury and accidents, 11.0% by heart disease, and 10.0% by cancer. The study also found that 1,510 older persons had experienced injuries and accidents, which could be an indication of safety issues, both indoors and outdoors.

According to the definition provided in Article 4.1.1 of the Law on Human Rights of Persons with Disabilities of 2016: "Persons with disabilities include those who have long-term physical, mental, intellectual, or sensory impairments, which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others."

Information about disabilities was gathered for this country diagnostic study (CDS) from a number of agencies, including the National Statistics Office (NSO), the MOH, the National Rehabilitation Center (NRC), the National Authority for Children, and the General Office for Social Welfare Services (GOSWS). Overall estimates coming from these and other sources were very similar. The NSO and the MOH estimated 100,000 persons with disabilities (PWDs) in 2014, whereas the NRC, the GOSWS, and others had higher estimates: 113,000 PWDs for the NRC and 117,000 PWDs for the GOSWS, the Household Socio-Economic Survey, and the Living Standard Assessment Database (in 2000, the census provided an overall figure of 108,000).[10]

According to detailed housing and population census data from 2010, there were 108,100 PWDs, which represented 4.1% of the total population. There were about 12,525 older PWDs, accounting for 11.6% of the total population with disabilities and 8.3% of older persons. Out of this number, 47.4% were men and 52.6% were women. As to the cause of these disabilities, 90.3% were acquired and 9.7% were congenital. Among older population with disabilities, 40% had difficulty in moving, 24% had difficulty in seeing, 18% had difficulty in hearing and speaking, and 6.3% had mental disorders.

Table 14: Numbers and Percentages of Older Persons with a Disability, by Sex and Type of Disability, 2010

	Male		Female		Total	
Type of Disability	Number of Persons	% of Total Males	Number of Persons	% of Total Females	Number of Persons	% of Total
Difficulty in seeing	1,072	22.5	820	20.7	1,892	21.7
Difficulty in speaking	152	3.2	200	5.1	353	4.0
Difficulty in hearing	584	12.2	261	6.6	845	9.7
Difficulty in moving	1,379	28.9	1,540	38.9	2,919	33.4
Mental disorder	341	7.1	240	6.1	581	6.7
Others	1,244	26.1	902	22.8	2,146	24.6
Total	**4,772**	**100.0**	**3,963**	**100.0**	**8,735**	**100.0**

Source: National Statistics Office. 2016. *Calculation Based on Population and Housing By-census Report*. Ulaanbaatar.

When comparing the prevalence of disabilities in Mongolia with internationally observed norms, one must consider the high likelihood of bias in Mongolian reporting. The disability prevalence in Mongolia, deemed to be around 4% in 2018, is probably an underestimate of the actual incidence. Moreover, just as the methods used to identify early developmental delays in children are far from cutting edge, disability assessment is similarly impaired, based as it is on an outdated, narrow medical approach to determining work ability loss.

Older persons are not recognized as disabled even if they require long-term care (LTC). Furthermore, although disability rates are expected to increase with age, the reporting in Mongolia shows a sudden decline at pension age (starting from 60 for men and 55 for women) due to a reporting bias that follows administrative classifications: some people report themselves as "disabled" when they are receiving a disability pension, and then as "pensioners" after they reach pension age. Such a result clearly points to a substantial underestimation

[10] Note that such data have been scaled up to take into account incomplete population coverage (nationally, coverage was about 93%).

of disability because the reporting commonly shows the percentage of PWDs continuing to grow with age at an increasing rate.

3.2 Understanding the Supply of Care

As people age, they often experience new needs and challenges. When an older person reaches a point where he or she requires assistance, we need to know what those needs are and how to provide appropriate care. To start with, it should be noted that there are two classifications of care: informal care, which is provided by family and friends, and formal care, which is provided by professionals.

In Mongolia, most care is provided voluntarily by family members. Beyond the family, the availability of formal care at the household and community levels or in institutional facilities is very limited, particularly for the large rural population. This raises concerns about the gaps in care due to the lack of family support for some older persons and to the inadequacy of family care for complex cases.

3.2.1 Types of Care Provision

Informal care. In Mongolia, older persons typically live with their family members, and the adult offspring or other relatives usually care for them. The older persons are mostly cared for either in their own home or in the home of the caregiver. According to the Mongolian patriarchal system, the oldest son is responsible for his parents, although in practice they are usually cared for by his wife and other female family members. Traditionally, parents have tended to rely on their children. Studies conducted in Mongolia confirm that the majority of older persons receive care from a daughter or son. The daughter-in-law and son-in-law are the second most common care providers. Under the Social Welfare Law, caregiver allowances are paid every month to those who care for older persons in need of permanent care (section 4.4). The total fertility rate (TFR) from 1950 to 1989 was quite high, at between 5.6 and 7.5 live births per woman (United Nations Department of Economic and Social Affairs). From 1990 to 2000, the TFR declined rapidly from 4.8 to 2.3, and it has remained between 2.3 and 2.8 ever since. This decline indicates that most of today's older persons are more likely to have a son to live with than future generations will. As mentioned, a significant proportion of older persons already live alone or with only their spouse.

> *As long as we stay together, it does not matter how many years pass caring for him. The allowance money is not important. As he is my blood brother, how could I ask others to take care of him?*[11]

According to the qualitative study conducted for this CDS, the type of care required depends on the care receiver's specific illness and general state of health; but, in most cases, the following two types of care are provided:

- care support for activities of daily living (ADL) and instrumental activities of daily living (IADL), such as cooking, preparing firewood, eating, dressing, changing bedsheets and clothes, laundry, personal hygiene, bathing, shaving, toileting, help with walking, and going outside for fresh air; and
- medical care—giving medicines and nursing, including as physical therapy.

[11] This quote is from an interview with a care provider conducted in 2017, for this CDS, in Uvs *aimag*.

> *My husband is 75 years old. I have to take care of him on a daily basis, as he suffers from heart failure and inflammation of the lungs. He can't even leave home, as he is always out of breath. My children live in the same area, and they bring us items we need. Currently, I cook by myself, while my children help us do the laundry and prepare the firewood. It is difficult for us to stay at home by ourselves. I even keep my cell phone close, as I am afraid that my husband's health condition may get worse at any time. The main point is that patients with such a severe condition as my husband cannot be admitted to resorts or sanatoriums. I have been taking care of my husband for three years, and my legs are starting to hurt. I want to be admitted to a resort or sanatorium to have my legs treated. However, there is no such place where we can be admitted together. If I go to a sanatorium for treatment of my legs, we will need an extra person to take care of my husband. That is why I can't leave him.*[12]

> *My mother is 89 years old. Mentally, she is not well and suffers from dementia. She does not have any other chronic diseases. I help her to go to the toilet, to cook, to wear appropriate clothes, to bathe, and prepare food. She can walk by herself. When my daughter leaves home, I have to lock my mother in her room. I prepare food and drink and leave her, disconnecting all power. When I come back, she switches on all the lights and makes everything messy.*[13]

Most of the care providers get great satisfaction from taking care of their parents, as it gives them a good feeling to look after their parents and to show their gratitude, to earn respect from other members of their family, and to become closer to their parents, as well as to clear up any previous misunderstandings.

Focus group participants (older persons) mentioned that they were "satisfied" with their current level of care; none complained about their caregivers, though this may be more a result of cultural convention than a reflection of the quality of care they are actually receiving. Several mentioned being grateful that anyone was taking care of them at all. On the flip side, several care recipients mentioned feeling lonely, especially because many of them were confined to their beds all day.

> *My grandmother lives alone in her home. She lives next to my ger. Every morning I make a fire and prepare morning tea for her. I also cook her lunch and dinner. I also collect firewood and water and pick up her medicine. I cannot stay with her all the time. I am afraid that I might find her dead in her ger. In the evening I go to her home, and at night I sleep in my ger. She cannot go anywhere else. She stays at home* (footnote 12).

Formal care. The types of care determined by Mongolian law are nursing, residential, and medical care. Among these types of care, nursing and residential have the longest history in Mongolia. The first nursing home in Mongolia was opened in 1924, and since then, seven more regional nursing homes have been opened. The first nonstate nursing home was opened in 2010, and now there are three of them, all located in Ulaanbaatar.

The nursing homes provide shelter, food, clothes, and medicine to the residents, and carry out activities relating to the care, treatment, and rehabilitation of citizens without caregivers, siblings, or relatives, and of those who are unable to live independently. As of 2015, there were eight state-owned and three nonstate-owned nursing homes in Mongolia, providing care to a total of 385 residents and employing 164 staff members.

[12] This quote is from an interview with a care provider conducted in 2017, for this CDS, in Uvs *aimag*.

[13] This quote is from an interview with a care provider conducted in 2017, for this CDS, in Ulaanbaatar.

The majority of the qualitative survey participants had negative attitudes toward current residential care services, and thought of them only as a "last resort."

> *As far as I know, only older persons who do not have children or relatives go to nursing homes. I have seen these places on TV. The older persons there looked so sad and in poor condition. I would never send my parents there* (footnote 13).

> *B has stayed in our residential home for 24 years. She does not have any relatives and does not have any place to go. When someone dies, we arrange all the funerals.*[14]

However, urban and rural residents differed in their attitudes toward residential care services. The attitudes toward residential care institutions were more positive in urban areas than in rural areas, but urban people still preferred more personalized and quality care.

> *Now we need something that complies with developing country standards. For example, there should be a complex residential care center. At present, there are many older single people and couples who have no caregivers. Those people need to be in a residential care center. The accommodation period should be flexible, so that they are not isolated from their children and relatives.*[15]

> *Actually, the traditional Mongolian way of taking care of the parents may continue for a while, and then it will gradually change. The main thing is that they should not be isolated from their brothers, sisters, and children. It's better to have a nearby location. There is no need to locate a residential home in Batsumber, which is 70 kilometers from Ulaanbaatar* (footnote 15).

3.2.2 Trends Influencing the Availability of Care

According to the older persons who participated in the qualitative study, adult children are the expected caregivers, but they have become less available for caring for their older parents because of reduced family size, internal and external migration, and family and work obligations.

According to data from the NSO, Mongolian fertility declined from 7–8 children per woman during the 1960s and early 1970s to 4.6 children per woman in 1990. After the transition to a market economy commenced in 1990, the birth rate dropped further very rapidly. The Mongolian TFR reached its historical nadir in 2005, at 1.95 children per woman. Since then, the TFR has been on the rise, with 2.07 children per woman in 2006 and 3.0 children per woman in 2016. Under the "low" scenario of population projections, the TFR will fall below the replacement level by around 2027, essentially returning fertility to just below the level of 2005 (at 1.9 children per woman). The "medium" scenario assumes an ongoing slow decline in fertility, but with the TFR remaining above the "replacement" level to the end of the projection period. None of the projections assume rising fertility.

Another important population trend in Mongolia is migration. The migration of Mongolians out of the country was restricted during the socialist period, but with the transition to a market economy after 1990, the number of Mongolians who emigrated increased considerably. Internal migration has grown as well, especially from rural to urban areas, mainly to Ulaanbaatar. Mongolia's population was 80% rural in the 1950s, but urbanization occurred

[14] This quote is from an interview with a social worker at a nursing home in Uvs *aimag*; the interview was conducted in 2017 for this CDS.

[15] This quote is from a focus group discussion conducted in 2017, for this CDS, in Ulaanbaatar.

quite rapidly until 1990; as a result, Mongolia's population is now 68% urban and 32% rural. Normally, older persons in rural areas stay on to care for livestock while younger people migrate to cities to study, work, or find market opportunities.

3.2.3 Trends in the Supply of Care

In response to demographic and cultural changes, the supply of formal LTC will increase in the future. Formal LTC could be provided in the patients' homes or at institutions. An assessment report on a social welfare program in Mongolia conducted in 2011 by the Asian Development Bank (ADB), the Ministry of Population Development and Social Protection, the Oxford Policy Management, and the Population Teaching and Research Center (National University of Mongolia) highlighted the point that, even though home-based care was the most culturally appropriate model in Mongolia, such a model must be implemented in conjunction with a suite of other individualized and nonindividualized services. This type of multitiered model could provide additional support to both care providers and care recipients, and offer the option of residential care on a temporary or permanent basis for those who absolutely need it.

From the caregiver's perspective, institutional day and respite care would be hugely beneficial because it would give them extra time to complete their other household chores, and enjoy much-needed emotional and physical relief from having to care for others all day, every day. Nursing homes are needed for those with care needs that may be too complex for the family to provide. According to the qualitative survey participants, the growth of private residential care may increase service choice within residential care and take the pressure away from the state and family. They also suggested that if the care center could provide good services for older persons, that might be the best step for the future. However, most institutional care homes in Mongolia today cannot provide good LTC.

> *Many Mongolians who emigrate ask if a private institution may look after their parents. Unfortunately, the present law states that residential care centers may only accept those people who have no children or siblings to look after them.*[16]

3.2.4 Support Services in the Care Ecosystem

Health services. Different components and stages of LTC are provided by primary health-care providers, palliative nursing care centers, outpatient clinics, general hospitals, sanatoriums, single-specialty centers, specialty hospitals, and nursing homes. In 2016, a revision of the Health Act stipulated that nursing care centers must provide inpatient care to older persons, chronically ill patients, and PWDs in need of permanent nursing care. However, these and other types of long-term medical and nursing care facilities have yet to be developed.

Sanatoriums provide most of the rehabilitative and restorative care available to older persons in Mongolia. They offer mostly medical and rehabilitative services through both traditional and modern medical approaches. Older persons and other clients of these providers typically stay there for about 10 days at a time. Thus, the effectiveness of such institutions for LTC purposes is limited, though family caregivers can perhaps have some respite from their care obligations when their care recipients are at these facilities.

[16] This quote is from an interview with head of the Batsumber state residential care center. The interview was conducted in 2017 as part of the fieldwork for this CDS.

Social services. In Mongolia, the main objective of social welfare is defined in article 3 of the Social Welfare Law. The law aims to protect and assist older persons without social security pensions, PWDs, particular groups of people perceived to be vulnerable (orphans, children at risk, single parents with many children, people who have made special contributions to society, people who have had many children, war veterans, and others), as well as households and individuals that are assessed to be poor (based on a proxy means test) and whose details are recorded in a central database.

Social welfare consists both of cash transfers (pensions and allowances) and services (social welfare services and social development services). The main programs for older persons are social welfare pensions, caregiver allowances, cash allowances for honored mothers, specialized care services, community-based social services, and allowances for special merit.

According to social welfare statistics, 70% of pension-aged individuals are covered by at least one social welfare program (Onishi and Chuluun 2015). Specifically, older persons are entitled to a social welfare pension if they do not have social insurance, but are eligible for specialized social welfare services. Caregivers of older persons can also get a caregiver's allowance, and there is a special allowance for mothers who have had many children.

Enabling environments. The Human Rights of People with Disabilities Law (2016) included specific articles that are relevant to the creation of a barrier-free environment. Access to the physical environment, transport, information, and assistive devices is widely legislated, including under the Law on Urban Development of 2008, which contains a provision on accessible infrastructure; the Law on Construction of 2008, which contains a provision on meeting the needs of PWDs in the design and construction of buildings; several building standards for accessibility[17]; the Law on Auto Transportation of 1999, which includes the requirement that 10% of public transport vehicles be accessible to PWDs; and the Social Welfare Law (2012) and the Law on Social Insurance of 1994, both of which have provisions for the reimbursement of the costs of assistive devices and other equipment. However, the implementation of these laws has not been systematic, and enforcement has been weak. Moreover, no municipalities in Mongolia have yet joined the World Health Organization (WHO) Global Network for Age-friendly Cities and Communities.

3.3 Regulatory and Policy Framework

Mongolia has developed a strong foundation of policies, strategies, and regulatory frameworks dedicated to its older population. The principles and policies for providing care and favorable living conditions for its older population are embedded in the country's Constitution and in its social and health sector strategies.

3.3.1 Policy Landscape

The Constitution of Mongolia ensures that no person shall be discriminated against on the basis of age. Also, all citizens are guaranteed the right to life, health care, medicines, and education, as well as the right to material and financial assistance in old age, cases of disability, or other circumstances, as provided by law. Mongolia has always had provisions intended for the well-being of older persons, but the Parliament of Mongolia has passed and enforced a specific package of laws on social insurance, social welfare, health, and old age.

[17] These included regulations on pavements (MNS 5682: 2006 and MNS 6056: 2009), and on the estimated space required for PWD needs to be considered in civil construction planning (MNS 6055: 2009).

The government approved the National Program on Health and Social Welfare of Older Persons in 1998, and Parliament revised the State Population and Development Policy of Mongolia in 2004. These developments contributed significantly to the creation of a favorable policy environment for the development of services for older persons and for directing the attention of the public, donors, and international community to these issues, as well as for creating a supportive foundation for cooperation among them. The National Program on Health and Social Welfare of Older Persons aims to improve the quality of lives of older persons and create sound and favorable conditions for their participation in social life by enhancing their health and social welfare. The State Population and Development Policy addresses population aging issues. Meanwhile, other relevant laws and regulations tackle the issues of social welfare, protection, social and health insurance, and care services provided by the state for older persons, as well as the creation of favorable living and working conditions for them.

Law on Social Insurance. According to the Social Insurance Law (1994, 1997, 1999, 2004, 2007, 2008, 2015, and 2017), men aged 60 and women aged 55 are entitled to an old-age pension. As provided by the law, older persons are entitled to a pension from the government's social insurance fund that is based on their wages during their working lives, and they can also benefit from the government's social welfare fund in the form of assistance and concession services, which enable older persons to live above the poverty line.

Mongolia inherited a pay-as-you-go public pension system from the socialist period that provided universal coverage and benefits (based on preretirement income), consistent with the state provision of all forms of social insurance. The system was reformed in 1995 to introduce contributions for pensions and other forms of social insurance, but it remained dependent on government budgetary transfers and subsidies. In 1999, a Notional Defined Contribution scheme was established for workers born after 1960, with the intention of gradually moving from notional accounts to partial funding.

Law on Social Welfare. According to the Social Welfare Law, women aged 55 and over and men aged 60 and over are regarded as members of the aged population. First approved in 1995, the law created a social welfare system that aimed to ensure state support for life for vulnerable people who could not afford to live independently. The law was amended and revised in 1998, 2000, 2005, 2008, and 2012. It defines social welfare as "acts providing pension, allowances and special care services by the government to citizens with special needs who are in a poor state of health, lacking family care and incapable of conducting normal life independently or without help, and to individual members of households requiring social welfare assistance or care in order to meet his/her minimum needs" (Article 3.1.1).

The main objective of social welfare is defined in this law as including protection and assistance for the older persons without social security, PWDs, particular groups of people perceived to be vulnerable (orphans, children at risk, single parents with many children, people who have made special contributions, war veterans, those who have had many children, etc.), as well as households or individuals that are assessed to be poor.

Social welfare services for older persons include social pensions, benefits, allowances, specialized care centers, community-based centers, a welfare service supporting employment, a health-care service, and a social development service. An evaluation conducted in 2015 showed that social welfare services needed to be increased and made more available to older persons in need of social care and protection (Narangerel, Purevsuren, and Nemekhbaatar 2015). It also highlighted the importance of intensifying activities at specialized care centers, community-based care centers, the employment support service, and social development services, all of which are stipulated in the 2012 revision of the Social Welfare Law.

The Health Act. The Health Act (1998, 2006, 2011, and 2016) established the right to primary health care, maternal care, and childcare, and other key public health services, regardless of socioeconomic status or health

insurance eligibility. With respect to LTC, the law specifies that primary care, ambulance care, mental health treatment, and the costs of drugs for conditions requiring long-term restorative care or palliative care shall be funded from the government budget.

The Health Act is the fundamental law of Mongolia's health system, regulating the delivery of health care across the country through 14 types of health-care providers. In 2016, new types of care provision were legislated, including rehabilitation centers, nursing care centers, and palliative nursing care centers. Once they are developed, these centers will offer new types of LTC services, and will play an important role in the well-being of older persons. The Health Act stipulates that nursing care centers must provide inpatient care to older persons, chronically ill patients, and to PWDs in need of permanent nursing care.

The Law on Health Insurance. The Health Insurance Law (1994, 1998, 2002, 2006, and 2015) governs the relationship among insured persons, health-care providers, health insurance institutions, and others (including the government), with respect to the collection of member contributions and the spending on health-insurance-covered services, as well as the governance of the health insurance system in Mongolia. As reported by the General Authority of Health and Social Insurances, health insurance covered 96% of the Mongolian population in 2016, reaching near-universal coverage. According to this law, there are 11 types of health services that an insured person can access. These are outpatient and inpatient care, diagnoses and tests, medicines prescribed by primary- and secondary-level care providers, palliative care for cancer, high-cost medical devices required for surgery, some orthopedic and prosthetic devices, rehabilitation, home care and day care, nursing care and diagnostics, and chemotherapy and radiation therapy for cancer patients. Health insurance plays an important role in preventive, medical, rehabilitative, and palliative care for older persons in need of LTC.

According to the Health Insurance Law, the premium contributions of older persons are fully subsidized by the government for no more than 1% of their monthly minimum wages; four other population groups are also subsidized by the government, including children under 18 years old.

Law on the Elderly. The Parliament of Mongolia adopted the Law on the Elderly in February 2017. This law is an updated version of the Mongolian Law on Social Security for Senior Citizens of 2005. The purpose of this law is to regulate the factors that help determine the type and extent of social security services each senior citizen would receive, and to define the rights and duties of state and business entities and of organizations regarding these services.

The new law supports the livelihood, development, and participation of older persons, protects the rights of older persons, enhances the possibility of their receiving social services, and identifies the duties of state and business entities and other organizations. The Law on the Elderly is consistent with the Constitution of Mongolia, the Social Welfare Law, the Social Insurance Law, the Labor Act, the Health Act, the Law Against Violence, and any other legislation enacted in accordance with the Law on the Elderly.

According to the Law on the Elderly, older persons shall receive the following types of services:

- information and communication services,
- counseling services,
- mobile services,
- medical services provided during office hours,
- voluntary services,
- day care and nursing services,
- residential care services,

- food and nutritional support, and
- protection from domestic violence and other risks.

Of these nine types of services offered to older persons, day care and nursing services, as well as residential care services, are the most important in terms of LTC.

In principle, the provisions of this law, if implemented, would provide a good basis for the biopsychosocial elements of LTC service provision. For example, some of the services related to the basic rights of older persons specified in the law are as follows:

- The state shall support organizations providing social, psychological, economic, and legal counseling, and legal services to older persons.
- The state shall organize outreach services such as cleaning, and provide fuel, cooking, and laundry services for those who need permanent care.
- The state shall organize day care services, such as temporary shelters for feeding, training, and development.
- The state shall support citizens and organizations that have a desire to volunteer to support older persons.
- The state shall organize treatment and nursing homes based on local needs, and cover those who need permanent care.
- Older persons who are incapable of living independently shall receive specialized services at nursing homes, based on their own wishes.
- Older persons shall receive protection against domestic violence or the risk of violence, based on their own wishes.

National strategies and programs. The government adopted the National Strategy for Population Ageing (2009–2030) on 26 May 2009, subsequent to the Madrid International Plan of Action on Aging of 2002. The National Population Committee was established by the government on 16 March 2013, chaired by the Minister of Population Development and Social Welfare.

The national strategy includes the following:

- a strategy for preparing for population aging:
  - social security for the working-age population
  - measures to encourage fertility growth
- a strategy to improve the livelihoods of older persons:
  - employment
  - income
  - good quality of, and access to, health services
  - improved infrastructure
  - age-friendly environments and communities

The strategy clearly sets out the responsibilities of the various ministries involved in implementation, with funding from annual government budgets. It also outlines the activities to be carried out by government agencies, civil society organizations (CSOs), nongovernment organizations (NGOs), the private sector, the media, and research institutions.

To support the implementation of this long-term plan, the government approved the National Program on Healthy Aging and Health of Older Persons (2014–2020) by Resolution No. 416 in 2013. The goal of the program

is to enhance the quality of life of older persons by promoting active, healthy aging and by working to improve older persons' health, wellness, social protection, and social participation. This program was approved by the government as proposed by the Ministry of Health (MOH), even though it covered a wide range of policy areas, including employment and the environment.

A 2016 evaluation of the implementation of the program noted that, in terms of moving toward a friendlier legal, social, and economic environment conducive to healthy aging, little was being done to develop and implement subprograms in local provinces. Regarding the objective of promoting the health of older persons and preventing disease, most activities undertaken by that time were in the form of training for caregivers. With respect to improving the participation of older persons in social life, their development, and protection, there had been only limited implementation in both rural and urban areas. The actions taken to expand health-care services that would be adjusted to the needs of older persons had mediocre results. Problems in implementation included a lack of understanding and information about the program; difficulty in establishing the subprograms in localities; insufficient funds; and the lack of monitoring, coordination, and cooperation among government sectors.

On the whole, the policy and legal framework for protecting and caring for older persons has been developed, and is comprehensive in its coverage of areas affecting their quality of life, including social protection, welfare, health care, and employment services. Mongolia's commitment to the well-being of its older citizens is evident in the country's Constitution, and in its sector-level policies, strategies, and programs. It is a good indication of an equitable society when older persons and other vulnerable groups are protected by the government's redistribution system and when the necessary care is ensured.

Nevertheless, the stakeholders point out that the lack of effective policymaking and implementation remains a major challenge. One of the underlying reasons is weak governance on issues concerning older persons, as this prevents solutions that are coherent and multifaceted. For example, laws and programs are developed in a fragmented manner, and thus often fail to ensure that the complementary roles and contributions of different sectors meet the needs of older persons as a whole. Furthermore, the government has no dedicated policy or strategy for LTC. The concept and elements of LTC appear in various policies and strategies in a fragmented manner, often straddling the line between the social and health sectors. At the same time, they tend to exclude other sectors, such as infrastructure and housing, that are key to the general well-being of older persons in Mongolia.

3.3.2 Stakeholder Landscape: Leadership, Governance, and Coordination

The Ministry of Labor and Social Protection (MLSP) and the MOH are the main government agencies responsible for the care of older persons in Mongolia, while other stakeholders include associations and groups that protect the rights and interests of older persons. Unfortunately, the understanding of LTC among policymakers is inadequate at all levels, except for sector ministries such as the MLSP and the MOH, and implementation units such as the National Gerontology Center, according to interviews with key informants in the government. Among other relevant ministries, including the Ministry of Construction and Urban Development and the Ministry of Road and Transport, there is apparently no effective mechanism for collaboration and coordination in the interest of creating a healthier and safer ecosystem for older persons.

Policymaking and planning. The MLSP is the leading agency within the government for making and implementing policies concerning older persons. It has specialized departments, such as the Population and Development Department, which has the main responsibility for issues relating to population groups, particularly the older population.

Specialized agencies within the MLSP are responsible for the implementation and/or regulation of social insurance, social assistance, and employment and labor markets. These include (i) the General Office for Labor and Social Welfare Services, which is tasked with delivering social welfare services and social assistance benefits, and is responsible for providing employment services to the unemployed at its offices throughout the country; and (ii) the Social Insurance General Office, which is the leading agency responsible for social insurance. Both agencies run a decentralized network of branch offices at the *aimag* and *soum* and *düüreg* levels.

In addition, the Social Welfare Law (2012) specifies the following obligations regarding the social welfare of older citizens, most of them for governors at various levels of administration, within the domain of their authority:

- The governors of *baghs* and *khoroos* shall question and register older citizens; provide professional assistance with the preparation of documents; and issue accurate information regarding pensions, allowances, and the availability of help and support.
- The governors of *soums* and *düüregs* shall organize activities to enforce social welfare laws and secure the insurance due to older citizens, propose ways to involve them in social welfare and care services or refer them to authorized organizations, help them participate actively in social life, address their health issues, create a database of older citizens who have migrated or whose previous places of employment have been dismantled, and provide social welfare services.
- The governors of Ulaanbaatar and the provinces shall propose and implement measures to provide social welfare to older citizens, and make the necessary budgetary allocations; take into consideration the meetings of people's representatives; monitor and ensure the implementation of legislation; and make proposals to the social welfare agency regarding the coverage of older citizens by specialized care services.
- Businesses shall support the efforts of their retired employees to obtain additional pensions, allowances, and fuel; find employment elsewhere; receive goods and services; and find accommodations.

The MOH is the central government institution in charge of health policies, including those related to the health of older persons. The ministry implements its national-level policies and strategies through the 22 health departments in the *aimags* and in Ulaanbaatar, as well as through health-service-delivery institutions in localities. It is also responsible for monitoring the institutions under its jurisdiction, such as the National Gerontology Center.

The Ministry of Construction and Urban Development oversees policymaking and implementation regarding care-related issues within its domain, and monitors infrastructure such as buildings and public spaces, as well as hospitals and other care-delivery institutions. The Ministry of Road and Transport is in charge of setting road and public transport safety standards and ensuring the implementation of these standards.

Monitoring and evaluation mechanisms. Both the MLSP and the MOH have a monitoring and evaluation unit with a mandate to provide professional guidance to grassroots and mid-level social and health service organizations, and to monitor expenditure and the quality and accessibility of services. In addition, the General Agency for Specialized Inspection is the government regulating agency in charge of monitoring the implementation of state regulations and standards, including those related to the social and health systems. It has the power to impose sanctions and plays an important role in ensuring that social and health facilities adhere to established standards and policies regarding the quality of care.

Coordination mechanisms and effectiveness. The minister of labor and social protection and the minister of health are jointly responsible for the national plans of action for various strategies on aging and the care of older persons, and they undertake the implementation of these strategies by incorporating the strategy objectives into medium- and long-term sector-specific and national-development policies, laws, and regulations.

Nongovernment organizations, civil society organizations, and partnerships. Intervention by NGOs and CSOs is essential for the development of state policies and the creation and promotion of a favorable legal environment for older persons. There are several NGOs and CSOs in Mongolia, with different levels of activity.

Older persons join NGOs and CSOs that address their interests and needs. In Mongolia, the largest and longest-standing NGO for older persons is the Mongolian Association of Elderly People (MAEP). The branches of the MAEP are the main organizations working for elders in the *aimags* and *soums* and in Ulaanbaatar. The association functions on a voluntary basis, with some support from local governments. It was set up in 1988 to protect the interests of Mongolians aged 60 years and over who are on an old-age pension. The association attempts to involve older persons in the country's social, political, economic, and cultural life. As an NGO, the MAEP collaborates with the government and other relevant bodies engaged in policymaking or providing services for the elderly, such as improving the living conditions of older persons and taking care of their health. In addition, it monitors the implementation of laws and regulations concerning old people passed by the government. The MAEP has branches in all 21 *aimags* and 9 *düüregs*.

The Mongolian Liberal Association for the Elderly is another active NGO established in 2005. Its mission is to give support and help to Mongolian older persons, resolve their pressing issues, and increase their contributions to civil society.

Both NGOs collaborate with the MLSP under performance-based annual contracts. However, the activities of both NGOs show that older persons' associations in Mongolia have limited budgets and that the majority of older persons do not participate very much in their activities.

One other form of support for older persons is through the organizations or companies where they worked before they had retired. Their associations for former employees carry out activities to honor their older workers and retirees during Seniors' Day, traditional holidays, and other celebrations by giving presents, food, and/or financial assistance. In reality, the nature of this support and assistance is more psychological than economic. However, older persons whose former places of employment have gone bankrupt or no longer exist (e.g., agricultural cooperatives and factories), and older persons who have changed their place of residence, do not have any such associations to turn to for care and support. For older persons who had been herders or worked for agricultural cooperatives before the 1990s, the issue of affiliation remains a particular problem.

Some international organizations (e.g., the Red Cross) and churches provide direct support to older persons. They deliver services that enable people to run private businesses by offering microcredit, supplying food items such as flour and rice, and providing housing assistance in the form of *gers* and temporary shelters. In terms of services, NGOs and other private organizations provide humanitarian, community-development, religious, recreational, and counseling services. However, these services are incremental and temporary, rather than continuous.

NGOs are only just emerging in the health sector, and professional associations and groups are still in their nascent stages. Associations differ from each other in the degree to which they are proactive. Consequently, their contributions to strengthening the capacity of health-care professionals and the health system are still limited. On the other hand, there are numerous public health NGOs that are very active in the areas of health promotion and public awareness of HIV/AIDS, domestic violence, drug and alcohol problems, and other health issues.

Since the early 1990s, international partners have been engaged in major health sector reforms, and have not only provided direct financial assistance for the social sector, but have also influenced certain policies and programs that have shaped the health policy agenda. The major international donors include ADB;

the World Health Organization (WHO); the Global Fund to Fight AIDS, Tuberculosis and Malaria; the World Bank; and the United Nations Population Fund (UNFPA), as well as other United Nations organizations.

In summary, Mongolia is in a relatively strong starting position with regard to governance and stakeholder engagement, given the government's commitment to its social policies and legal and policy frameworks. However, key issues regarding coordination, the stimulation of service provision, regulation of private providers, development of an adequate LTC workforce, and LTC financing will have to become policymaking priorities.

The government remains the main body responsible for the development and implementation of policies related to aging. However, if the government is to provide effective leadership, its knowledge and awareness of LTC for older persons must be strengthened. As with other sectors, the role of CSOs is limited to participation in policymaking and perhaps some limited implementation activities. Nevertheless, they are needed to ensure accountability, and thus effective public policymaking and implementation. As for NGOs, those related to the care of older persons need to be more active as stakeholders and extend their areas of service delivery. They could be contracted for peer education and caregiving, for instance; but they will need to learn from the examples of successful cases in Mongolia and elsewhere. Private sector support has been meager, except for some very limited residential care for older persons and health services such as palliative care and sanatoriums. These services have been proven to have potential, but they need to be supported by policies and funding. Finally, at the initial stages of some of the major policy reforms, implementation gaps need to be filled by international partners such as ADB, especially by providing a clear concept and structure for the LTC system, and by introducing new LTC services or investing in new and existing efforts for which the government lacks resources.

3.3.3 Developments and Future Planning

In February 2017, the Law on the Elderly was approved by Parliament, and a national council was established under the Prime Minister to ensure broad inter-sector coordination on the rights of older persons. In cooperation with other stakeholders, the MLSP developed the National Program on the Development and Protection of Elderly People, which was approved in 2019. The program will offer a comprehensive framework for the coordination of all partner inputs in the area of older persons' care and development in Mongolia. However, thorough consultations and a consensus will be needed to integrate this program with the government's National Strategy on Aging (2009–2030) and National Program on Healthy Aging and Health of Older Persons (2014–2020).

With respect to addressing the needs of older persons, stakeholders agree that there is a concrete agenda for establishing additional residential care institutions and nursing care centers in the near future for people (especially older persons) in need of LTC. For example, the 2016 revision of the Health Act stipulates that a nursing home will "provide inpatient care to older persons, chronically ill patients, and disabled people in need of permanent nursing care." In addition, community-based services, especially rehabilitative care, are gaining in popularity through the encouragement of international organizations such as the United Nations, and through the exposure of policymakers to new service delivery approaches elsewhere.

The other important issue for future planning is the need to improve the coordination and implementation of inter-sector or multisector policy design. The MLSP and CSOs in Mongolia are calling for effective action and good practices through better governance and management.

There are plans to increase and strengthen human resources for the care of older persons, including geriatricians; nurses specializing in geriatric care; social workers (in *khoroos* and *baghs*); and, more importantly, trained frontline primary health-care providers.

Finally, NGOs (PWDs' organizations and other active groups) have called attention to the need to make indoor and outdoor environments safer and friendlier for their clients. As a result, the government and international partners, including ADB, have been introducing measures to improve housing and transport standards, especially for PWDs. Such efforts, however, need to be supplemented with specific measures that address the needs of older persons and the challenges of aging.

3.4 Long-Term Care: Service Provision

3.4.1 Types of Care

In Mongolia, LTC services are provided in the form of family care, residential care, day care, medical and geriatric care, nursing care, rehabilitative care, mental care, palliative care, and care using assistive devices.

3.4.2 Family Care and Community-Based Care

There are two ways of providing family care in Mongolia: caregivers either take care of people in their homes or bring them to their own homes. The home-based care approach is relevant to Mongolia's circumstances for both practical and cultural reasons. Traditionally, if a person needs care in Mongolia, a relative would take care of him or her—usually a spouse, parent, child, or grandchild. The majority of caregivers are women who have other nonremunerated obligations relating to running the household and taking care of children or other family members. A quantitative study conducted in 2012 reported that caregivers took up their entire day cooking and cleaning for care recipients, as well as feeding and bathing them (MacAuslan et al. 2012).

Also provided under the Social Welfare Law are the community-based social welfare services.

According to the Law on the Elderly (2017), day care is one of the nine types of care provided to older persons. The law allows *soums, baghs,* and village administrations to establish a "center for older persons" to provide information, counseling services, training, and development activities, as well as mobile services and other day care services to older persons. Several *aimags* and *soums* have already established such centers. Primary health-care providers can offer the necessary medical day care, home care, and rehabilitative care services. These services have been recently added to health insurance benefit packages, but the additions have yet to be implemented. However, the concept of a day care model suitable for Mongolia raises issues that policymakers must consider. For example, providing older persons with day care services in urban settings versus rural settings will involve different challenges. With regard to rural areas, the design of day care centers for the provision of information, communication services, and volunteer services for older persons in sparsely populated environments will be problematic. It will be economically unfeasible to build a day care center and provide other community-based services in every rural *soum* and *bagh*, and it will be impractical to transport all older persons to one location or to expect the family to take them there on a daily basis, considering the vast geographic area of Mongolia.

3.4.3 Residential Care Services

The Social Welfare Law defines "residential care" as specialized assistance that provides permanent and full-care services, including accommodations, meals, clothes, medical care, and cultural services for older persons, PWDs, and children in difficult circumstances. Box 2 describes the selection of and support provided for caregivers under this Law. There are eight state-owned residential care centers and three private residential care centers (one NGO, two religious) operating in Mongolia. All three private care centers are in Ulaanbaatar.

Box 2: The Selection and Support of Caregivers

According to the Law on Social Welfare, allowances are paid every month to those who look after older persons in need of permanent care. The law defines a person in need of permanent care as "an individual with no capacity to carry out routine life independently or without others' help, or an individual with a mental disorder or with a serious mental impairment." The recipient's status is certified by the Medical and Labor Examination Commission (also known as the "medical doctors' committee") at the *aimag* (province) or *düüreg* (Ulaanbaatar municipal district) level.

Care recipients have to nominate a care provider to receive an allowance, typically a close relative. The caregiver and care recipient then write an application or a request letter. The application is submitted to a social worker based in the local *khoroo* (Ulaanbaatar subdistrict) and *soum* (provincial district). The social worker submits the application to the Livelihood Support Council (LSC). Every application is reviewed by the LSC.[a] Then a social welfare officer from the LSC visits the care recipient's household to determine the suitability of the proposed caregiver and to validate the care recipient's status. The LSC makes the final decision on eligibility for the program. Under the previous Social Welfare Law, any individual of working age who is unemployed could be nominated as a caregiver. The July 2012 revision of the law allows anyone over the age of 16 to be a caregiver, irrespective of work status. Where there is no caregiver, the social welfare officer can find a service provider and make a service agreement. Service providers are usually from nongovernment organizations that offer trained caregivers. Following the recipient's verification by the LSC, the *soum* or *khoroo* social worker is notified, and a contract is drawn up involving the social worker, the caregiver, and care receiver.

Following the July 2012 revision of the Social Welfare Law, caregivers are supposed to receive 20 hours of training provided by *soum* teachers or doctors; and in Ulaanbaatar, this training is given by contracted agencies. This training program has only just been developed, however, and it has not yet been rolled out. Details on the content of the curriculum can be found in section 3.6 (on human resources) of this report.

The allowance tries to improve care for those in need of permanent care by paying caregivers to look after them. Caregiver allowances are paid every month and cover cases such as caregivers of older persons and persons with disabilities, as well as carers of persons in need of permanent care.

Monthly payments are relatively small—MNT70,000 in 2018, after having increased by about MNT4,000–MNT6,000 per year from 2012 to 2014, when it was MNT48,000. There is also an allowance for the person in need of permanent care. For adults, this is paid every quarter, and is known as the "medicine allowance"; the amount was MNT30,000 in 2012, but has since risen to MNT60,000 in 2018. As of 2018, 59,087 people were covered by these conditional cash transfer programs.

[a] After the application is submitted, the maximum waiting time for a decision is 2 weeks.

Sources: MacAuslan, I., L. Tincani, B. Enkhtsetseg, and R. Attah. 2012. *Social Welfare Program Assessment Report: A Conditional Cash Transfer Program for People Caring for Those in Need of Permanent Care and a Voucher for Discounted or Free Prosthetic and Orthopedic Equipment*. Ulaanbaatar; and National Statistics Office. 2019. *Mongolian Statistical Yearbook 2019*. Ulaanbaatar.

The facility in Tuv *aimag*, in the city of Batsumber, is the biggest national residential care center under the MLSP. It has been functioning as the only LTC facility for older, disabled, and mentally ill patients, with a capacity of 130 beds. Currently, there are 116 adults (66 men and 50 women), more than half of whom are disabled (64). The other *aimag* centers are relatively small, with a capacity of about 30 (maximum 50, minimum 20). The NGO Bat-Gerelt Ireedui serves PWDs in Ulaanbaatar who are above the age of 18; adults with mental, intellectual, and other types of impairments; and people who have no caregivers, the homeless, and unattached older persons. In 2015, 44 older persons (34 men and 10 women) lived at the center. The Vatican Care Center has two branches in Ulaanbaatar, each with a capacity of 10 beds. Box 3 describes Mongolia's Community-Based Welfare Services program.

3.4.4 Health Care

The health sector is expected to meet the health needs, especially in terms of medical treatment, of all Mongolian citizens. This includes older persons, as 85.5% of Mongolian older persons are reported to suffer from one or more illnesses (MOH 2016).

Box 3: The Community-Based Welfare Services Program

Mongolia's Community-Based Welfare Services (CBWS) program envisages welfare services being driven by citizens' demand and provided by individuals, private entities, and nongovernment organizations. The CBWS program represents a new form of social welfare in Mongolia that is based on the demand for social welfare services in communities and mobilizes nonstate actors (private entities, nongovernment organizations, and citizens) to deliver social welfare. This is in contrast to "traditional" models of social welfare delivery in Mongolia, in which the government played a more central role in decision-making and service provision.

The CBWS program provides five types of service: counseling and life training, funding of community groups, rehabilitation services, temporary shelters, and home-based care. It targets five types of beneficiaries: older persons, fully incapacitated individuals, children in difficult circumstances, abused individuals, and individuals from socially vulnerable groups whose social welfare pension or welfare benefits were terminated. In 2018, the program reached 19,258 people. Among the five types of service, rehabilitation was "the most demanded and highly engaged service."[a]

Overall, the CBSW program appears to be a promising model for the delivery of welfare services in Mongolia, so it seems reasonable to expand it. However, the program will not be successful, and will not be worth expanding, unless two key constraints are dealt with. The main problem of the CBSW program is staff capacity. This reflects what was found in assessments of other social welfare services in Mongolia: first is the lack of time or capacity of the social welfare staff to provide sufficient information to citizens and effectively match citizens with the services they needed, which are both time-intensive activities. Second, the standard of service provision varies substantially, and some services could not be provided at all because of limited or poor quality.[b]

[a] Interview with Songino Khairkhan, a social worker, in 2011.
[b] For more details, see the 2012 consultants' report on *Social Welfare Programs Assessment Report: Food and Nutrition Social Welfare Program and Project Monitoring and Evaluation Report* prepared by Oxford Policy Management for the Asian Development Bank.

Source: National Statistics Office. 2019. *Mongolian Statistical Yearbook 2019*. Ulaanbaatar.

Figure 4: Locations of the Residential Care Centers in Mongolia

Source: Illustration by authors.

Table 15: Information on the Residential Care Centers in Mongolia, 2015

Location	Type of Service	Capacity	Number of Residents	Number of Employees
State-Owned				
Tuv *aimag*	National-level state residential care center	130	116	48
Khovd *aimag*	Disability and elderly rehabilitation center	30	30	15
Baynkhongor *aimag*	Elderly care center for the Central region	20	12	7
Dornod *aimag*	Elderly care center for the Eastern region	20	20	7
Bayn-Ulgii *aimag*	Disability and elderly rehabilitation center	20	11	7
Dornogobi *aimag*	Elderly care center for the Gobi region	30	21	15
Khuvsgul *aimag*	Elderly care center for the Khangai region	50	52	28
Uvs *aimag*	Elderly care center for the Western region	25	20	11
Nonstate-Owned				
Bat-Gerelt Ireedui NGO, Ulaanbaatar	Private care center for disabled and elderly	40	40	8
Vatican Care Center, Yarmag, Ulaanbaatar	Elderly care center	10	9	10
Vatican Care Center, Dari-Ekh, Ulaanbaatar	Elderly care center	10	4	8
Total		385	335	164

NGO = nongovernment organization.

Note: *Aimags* are provinces.

Source: J. Amarsanaa. 2015. *The Current Situation and the Future Direction of Institutional Care Services for the Elderly in Mongolia.* Consultant's report. Ulaanbaatar.

Table 16 shows that the Mongolian health system is structured and equipped to ensure access to various types and levels of health services needed by older persons, as they are among the main users. For example, the basic health services for older persons are provided by the family and by *soum* health centers. Furthermore, 7 *düüreg* and 16 *aimag* general hospitals have established outpatient geriatric medical offices or departments in other *aimag* and *düüreg* hospitals that provide secondary-level health care. These medical offices and departments aim to provide accessible, elderly-friendly geriatric services and to promote healthy aging, health education, and physical exercise for older persons in Mongolia. The main function is to first undertake detailed assessments of the health and physical fitness of older persons, and then prescribe medical and/or rehabilitative care, which would then be delivered by other specialty departments, such as medicine and rehabilitation, in the form of either outpatient day care or inpatient care.

In 2005, the MOH established the National Gerontology Center as Mongolia's first institution specializing in gerontology and geriatric care. Today, the center is responsible for studying the causes and risk factors of illnesses affecting Mongolia's aging population, providing geriatric and rehabilitative community-based care to older persons, and for implementing and monitoring technical oversight of lower-level health-care institutions. Since its establishment, the center has been retraining medical professionals in gerontology and geriatrics,

Table 16: Providers of Long-Term Health Care to Older Persons, 2005–2015

Type of Facility	2005	2010	2015
Family health centers	228	218	218
Soum and village health centers	311	291	291
Inter-*soum* hospitals	31	37	39
District general hospitals and health centers	12	12	12
Rural general hospitals	4	6	6
Aimag general hospitals	18	17	16
Regional diagnostic and treatment center	3	4	5
Private hospitals[a]	160	166	224
Private outpatient clinics	523	947	1,006
Sanatoriums, including natural-resource/mineral-based sanatoriums	12	16	166
Central hospital and specialty centers[a]	17	16	13
Palliative care centers	...	...	12

... = data not available.

Note: *Aimags* are provinces and *soums* are provincial districts.

[a] The categories of "private hospitals" and "central hospital and specialty centers" both include the National Gerontology Center.

Source: Government of Mongolia, Ministry of Health, Center for Health Development. 2016. *Statistics*. Ulaanbaatar.

pursuing scientific research, expanding cooperation to promote healthy aging, and inspiring community-based rehabilitation activities to ensure a good quality of life for older persons. Also in 2005, the Mongolian National University of Medical Sciences introduced a new training program for geriatricians and geriatric nurses.

Sanatoriums provide most of the rehabilitative or restorative care for older persons in Mongolia. The number of sanatoriums has increased due to higher government budgetary allocations after an increase in social health insurance funding in 2011. The sanatoriums provide mostly medical and rehabilitative services, using traditional, alternative, and modern approaches. Older patients generally stay there for only about 10 days at a time. Thus, the effectiveness of such institutions for LTC purposes is questionable.

On the other hand, the government recognizes the need for LTC for older persons and chronically ill patients, so it has been engaging in some ad hoc efforts to support the private provision of palliative, nursing, and residential care for older persons. Almost none of these efforts have succeeded, however, due to the lack of concrete financial and regulatory support. For example, in 2014, the MOH supported the private sector's effort to establish residential care homes for older persons by offering concessional loan projects. But they failed to get much support from government decision-makers. Furthermore, the Japan International Cooperation Agency funded a small and medium-sized enterprise project that promoted the founding of private residential care facilities and nursing homes for older persons, but it received few business plans for such projects due to the lack of expertise and experience in Mongolia.

Since around 2015, however, more attention is being given to the improvement of palliative care. Relevant policies, legislation, and implementation standards and guidelines have been developed. For example, the Health Act of 2016 recognized palliative care as a category of health services, and its strategy for

noncommunicable diseases also promotes palliative care development. Palliative care is typically given at the homes of patients by primary care providers, or at district and *aimag* general hospitals (that have inpatient facilities with at least five beds), or at the National Cancer Center. However, not all *aimag* hospitals have a palliative care department and/or beds designated for palliative care.

In addition, some palliative home care outreach services have been established at centers and hospices in Ulaanbaatar, and at three *aimag* centers, mostly with the support of religious or charity organizations. The palliative-care service standards in Mongolia prescribe the types of care to be provided, including curative treatment, pain relief management, nursing, social welfare assistance, psychological counseling, and emotional support for those in mourning. Of these, pain relief management is the main function of these organizations. Accordingly, two dedicated pain management clinics have been established—at the National Cancer Center and the First Clinical Central Hospital. Patients now have access to pain relief medicines fully subsidized by the government. However, health-care providers claim that there is a shortage of such medicines.

Also, for cancer patients needing end-stage palliative care, the National Health Program against Cancer (2015–2019) was approved by a government resolution in 1997, which was updated in 2014. The objective of this program was to improve cancer prevention, early screening, and diagnosis and treatment, as well as palliative care, hospital registration, and research.

Despite such developments, the provision of palliative care services is still insufficient, as patients in need of long-term palliative care are still looked after in hospitals for only a short period of time, and then discharged as "incurable" cases to be cared for at home.

There is only one specialized psychiatric hospital in Ulaanbaatar: the National Mental Health Center, which has 450 beds. This hospital treats 17.7 patients per 100,000 population, and has an occupancy rate of above 80%. Most psychiatric inpatient services in the country are provided by mental health units attached to general hospitals.

The National Mental Health Center is responsible for specialized mental health services, including the coordination and management of preventive and curative services, continuous and postgraduate training, and professional and policy guidance. Following the approval of the Law on Mental Health of 2000 (revised in 2010), the government ratified the National Program on Mental Health, which was implemented between 2002 and 2007, and a second program in 2009. Specifically, the programs aimed to protect the human rights of mental health patients; introduce new drugs for mental health services, and increase the supply of these drugs; improve access to and quality of community-based mental health services; and enhance human resources at every level. There are psychiatric units with 5–15 beds in *aimag* general hospitals.

In summary, a couple of important priorities can be identified for future policy changes and reforms of LTC service provision in Mongolia. There are challenges in the existing services in terms of coverage, quality, and comprehensiveness. For example, the residential nursing home capacity covers only 1.6% of older persons in need of such care (Bazarragchaa 2016). The existing rehabilitation services are limited to sanatoriums and hospital physical therapy departments, which have outdated service models, technologies, and personnel training. Moreover, LTC in Mongolia has been largely medically driven, with a strong emphasis on medical and rehabilitative care. As such, other LTC services, including social and psychosocial care, have been ineffective or virtually nonexistent. Many of these services are largely reliant on informal caregivers or family members. Without a doubt, more acute challenges will arise as the number of older persons increases with population aging.

More measures therefore need to be taken, given the limitations on what is available and the need to strengthen and modernize LTC services for older persons, in addition to medical and residential nursing care. For example,

access to service providers should be enhanced by the revamping of old institutions, the building of new infrastructure, and the increased provision of community-based LTC services.

3.4.5 Assistive Devices

The vouchers for prosthetic and orthopedic equipment program, under the Social Welfare Law, provides free or discounted assistive equipment to older persons and to those living with a disability, with the objective of allowing them to participate more fully in society and in the economy. Eligible recipients include children and older persons with disabilities, as well as anyone with a disability who does not receive payments from the Industrial Accident or Occupational Disease Insurance Fund. There is a price list for available equipment indicating the maximum expenditure that will be paid for by the government. The voucher program provides equipment for basic health conditions such as replacement joints, dental prosthetics, and disability aids (such as crutches). False teeth, walking sticks, and wheelchairs are the commonly provided items, along with hearing devices, assistive equipment for blind people, eyeglasses, glass eyes, knee joints, hip joints, prosthetic legs, orthopedic shoes, spinal back braces, and bedpans.

Most Mongolians do not ordinarily have access to assistive equipment, and could never afford it without government subsidies, particularly the equipment that is more complex. The smaller and simpler types of equipment (such as false teeth and walking sticks) are probably affordable to most, and most people would spend their money on these items because they are so useful. But the poorest Mongolians would not be able to afford even these items. Patients have also requested items that are not provided, including artificial elbow joints, spinal belts for correcting back injuries, and motorized wheelchairs. The impact of the program has been very positive in cases where people received helpful equipment. In fact, the program has frequently been life transforming, as many people would have otherwise been unable to obtain the equipment due to the high costs (MacAuslan et al. 2012).

To be covered by this program, an individual would need to start the application process after a doctor at a public or private health center assesses the individual's equipment needs. The individual sends the application and documentation to the Livelihood Support Council after receiving approval from the *soum* social worker. The application is then forwarded to the *düüreg* or *aimag* social welfare agency for verification. The agency may raise concerns if the equipment requested is deemed too expensive. When this happens, the social worker is supposed to follow up by advising the individual to go elsewhere to get quality equipment. But such cases are rare.

Patients can pay in advance and receive the equipment immediately, and be reimbursed after the acceptance of their applications; or they can wait for the successful outcome of the applications to obtain the desired equipment, after which the social welfare agency pays the hospital directly. If the recipient pays in advance, the receipt must be presented during the application process, and the recipient will be reimbursed accordingly when the application is approved. Payments are usually made on the 7th and the 20th of every month. If the recipient does not pay in advance, he or she must submit a notarized invoice from the hospital along with the application.

3.5 Long-Term Care: Quality Management and Innovation

This section aims to provide an overview of the quality-management tools used in Mongolia and the monitoring of these tools. The ultimate goal of quality management of LTC is to improve older persons' quality of life by optimizing their capacities and compensating for any loss in capacity. This is done through a system that provides care, additional services, and transforming environments to maintain functional ability at a level that ensures

the older persons' well-being (Nies et al. 2010; National Center for Assisted Living and American Health Care Association, n.d.). The responsibility for quality management rests with the government, which oversees both public and private care provision.

3.5.1 Existing Quality-Management Tools and Structures

The quality of health and social services is ensured through professional licensing; accreditation; and annual management agreements on performance, planned monitoring, and evaluation by government institutions. In addition, there are institutional service delivery standards, as well as guidelines and quality teams, in place in all institutions that provide health care. However, this does not mean that all these methods are developed and designed to meet the needs of people, especially older persons, nor does it mean that they are in line with any internationally recognized approach or that they are even feasible for local implementation.

The General Agency for Specialized Inspection and the State General Audit Bureau undertake external monitoring and evaluation of care providers on the basis of planned inspections and other monitoring activities. Such inspections involve the detailed checking of financial data, service data, and documents, leading to recommendations, or to a notice indicating required improvements, or to punitive measures, if necessary.

According to the Health Act, the MOH and local governors must certify every health facility before it can provide health services to the population. To optimize and ensure access to relevant health services, the MOH approves a list of priority service areas to be licensed every 3 years. Palliative care has remained on the list for several years in recognition of the need for long-term nursing care for oncological and other chronically ill patients. On the other hand, periodic rehabilitative care obtained by older persons at sanatoriums on an ad hoc basis has been on the nonpriority list.

The MOH is also responsible for giving accreditation to health-care providers for monitoring the implementation of policy decisions concerning health service quality (Health Act 2016). Despite being voluntary, health facility accreditation is one of the methods used to control the quality of health-care providers' services. The MOH developed a guidebook on how to prepare all types of health facilities for accreditation. Following MOH guidelines, in 2014, *soum* health centers reported 205 indicators under various categories. The categories are listed in Table 17, along with a sample of indicators.

The accreditation indicators refer more to the processes and forms of output, rather than to outcomes. The accreditation process involves desk reviews of health-facility accreditation applications and on-site reviews by evaluators of the facilities' self-assessment reports. For example, a family health-care center might report on two indicators related to the medical and preventive care it must provide to older persons. Each indicator is given a score, and the total constitutes the accreditation score for that applicant health-care center. For a private hospital, the accreditation score determines the rates of payment to that hospital as a percentage of what is paid to public facilities.

The Center for Health Development of the MOH is the statutory body that registers qualified medical practitioners. The license is revalidated every 5 years, and health-care practitioners are required to earn a certain number of professional education credits in order to be relicensed.

As in many other countries, the government implements service-delivery agreements and corresponding monitoring activities and assessments to ensure the performance of health-care providers. First, agreements with providers are implemented by the MOH, by *aimag* and *soum* governors, and by the local branches of the social insurance agency. All public health-care providers conclude annual agreements with local governors or

Table 17: Selected Indicator Categories Related to the Care of Older Persons at *Soum* Health-Care Centers, 2014

Indicator Categories	Accreditation Field	Number of Indicators	Indicators Related to Aging and Older Persons
1. Management and organizational structure	Management and leadership	9	All health worker positions filled Professional standards and guidelines, and staff training ensured
	Human resources management	4	Continuous training for medical personnel organized
	Health services quality management	7	Quality unit or team established and functional Quality indicators developed and implemented, and progress made Regular staff satisfaction survey conducted and feedback reported Regular patient satisfaction survey conducted and feedback given Patient complaints received and resolved
	Safety and risk	4	Medical errors and staff mistakes registered and resolved
2. Adherence to health service technology	Public health	22	Population monitored for risk factors of noncommunicable diseases Activities conducted among the population to promote a healthy lifestyle Training conducted for PWDs and their caregivers Increased percentage of the population involved in regular physical exercise Space established for physical training by population, and equipped with necessary gear
	Outpatient care	40	Medical services provided to older persons and PWDs, and results assessed Disease prevention checkups conducted among older and vulnerable persons, and such persons registered for regular monitoring and treatment Home care provided to older persons, PWDs, and other patients Community-based services provided to mental health patients Rehabilitative care provided to chronically ill patients and PWDs.
	Inpatient care	51	Nursing care provided in accordance with guidelines Palliative care provided at residential care and nursing homes

PWD = person with disabilities.

Notes:
1. *Aimags* are provinces and *soums* are provincial districts.
2. This table is meant for illustrative purposes only.
3. Indicators are assessed as follows: 100 = complete, 50 = partial, and 0 = none.

Sources: Government of Mongolia. Ministerial Order #07, 2014; accreditation indicators self-reported for this country diagnostic study by rural district and village health-care centers.

with the minister of health. These agreements specify the types of outputs and the relevant cost and quality of indicators. The health-service-quality aspects of the agreements focus largely on output- and outcome-oriented indicators. The agreements are evaluated annually, and serve as the basis for extending labor agreements with the directors of the relevant health-care institutions. Agreements with both public and private health-care providers are implemented by local public health insurance offices because a substantial share of their funding comes from the government's health insurance fund. Next, periodic on-site monitoring and evaluation missions are organized by the MOH for tertiary referral care institutions; such missions are organized by the *aimag* and *soum* health departments for local health-care providers, and by the government's social health insurance scheme for contracted health-care providers.

The MOH is the central government body responsible for overseeing the management of health-care service quality, and for providing technical guidelines to hospital units that monitor the quality of internal health services. Such units were established in 2010 by a joint order of the MOH and the General Agency for Specialized Inspection. However, these activities still need to focus more on patient-centered services and continuous quality improvement, rather than on traditional inspection-based quality assurance and control approaches. In addition, there is a lack of financial support for the quality units and quality-improvement activities in hospitals.

Since around 2005, most health-facility and clinical standards have been updated, and manuals and guidelines on specific diseases and conditions have been published. For example, to improve the quality of palliative care, the National Standard and Measurement Office approved the National Standard of Palliative Care Services and the National Standard of Palliative Care Facilities in 2005. Tertiary-level care providers such as central hospitals and specialized centers are in charge of developing clinical guidelines for the care of specific diseases in outpatient, inpatient, and day care settings. The National Gerontology Center developed a series of guidelines for geriatric care providers that were approved by the MOH and published in 2014. Among these were

- a guideline for assessing the physical and health conditions of older persons (Ministerial Order #182, 2010), and
- a geriatric nursing care guideline (Ministerial Order #1, 2012).

Health-care facilities will need substantial support to implement both of these guidelines.

However, surveys and reviews have revealed that the poor quality of services remains a major constraint in the Mongolian health sector (Munkhzaya 2013, MOH 2013, ADB 2011). Patient safety measures have not been enforced at hospitals, and hospitals usually fail to report incidents involving patient safety. The disparities between urban and rural health-service quality may be explained by the significant decline in health-care quality in rural areas due to inadequate staffing and poor personnel training, and to the lack or inadequate supplies of essential medical equipment and medicines. The government's health insurance scheme is responsible for reviewing and monitoring the quality of medical services, but this approach has been ineffective, as only a few cases have resulted in penalties for poor quality.

In 2008, the Mongolian Agency for Standardization and Metrology introduced the National Standards for Residential Care Setting for the Aged. All residential care centers for older persons are required to maintain these standards in order to be accredited. Since the standards were developed, residential care centers for older persons have been accredited three times: in 2012, 2013, and 2014. According to the accreditation process, out of 11 state or private residential care centers, three have met the standards (the national center in Batsumber, Tuv *aimag*; and Dornogobi and Khuvsgul *aimag* centers), six were in the process of meeting the standards (Uvs, Khovd, Dornod, and Baynkhongor *aimag* centers; and the two branches of Vatican Care Center in Ulaanbaatar), and two were at the stage of implementing the standards (Bayn-Ulgii *aimag* and Bat-Gerelt Ireedui).

The accreditation process has revealed that most of the residential care centers are operating according to state laws and regulations, and that the quality of services has improved. The main difficulties those care centers had faced were poor living conditions due to the low quality of construction (most of the structures are very old), and a lack of comfort due to the need to renovate the home care centers. In terms of the private residential care facilities, the Bat-Gerelt Ireedui center receives funding from the government to cover food, clothes, and medicine for the residents. Compared with other residential care centers, the Vatican Care Center in Yarmag, Ulaanbaatar, has better living conditions, but its service-development programs have been inadequate (Labor and Social Welfare Agency 2014). According to the new regulations of 2014, those facilities that meet the standards will be reaccredited every 3 years, while those still in the process of meeting the standards will have to seek reaccreditation every 2 years.

However, in 2014, the National Human Rights Commission of Mongolia conducted an inquiry into nine accredited home care centers for older persons to monitor the implementation of the relevant legislation. It was found that older persons in those centers could not exercise their legal rights fully due to a lack of oversight. For this reason, the Commission proposed a review of the Accreditation and License Awarding Procedure for Institutional Care in order to revise the qualification requirements, increase the budget of government-run care centers, provide better support to private care centers, and improve oversight mechanisms to prevent human rights violations at these centers (National Human Rights Commission 2015).

With regard to the care of older persons, there has also been legislation regarding the physical environment, transport, information, and assistive devices, including the Urban Development Law (2008), which contains a provision on accessible infrastructure; the Construction Law (2008), which contains a provision on integrating the needs of persons with disabilities (PWDs) into the design and construction of buildings; several building standards on accessibility; the Auto Transportation Law (1999), which includes a requirement that 10% of public transport vehicles be accessible to PWDs; and the Social Welfare Law (2012) and Social Insurance Law (1994), which have provisions for reimbursement for assistive devices and equipment. However, the implementation of these laws has not been systematic, and enforcement has been weak.

Evaluations of service accessibility for PWDs conducted in 2014 and 2015 in Ulaanbaatar by the Mongolian National Wheelchair Users' Association and the National Human Rights Council, along with the World Health Organization (WHO), which evaluated public service organizations, found that less than one-third of facilities could be considered satisfactorily accessible, and 2% were completely inaccessible (Mongolian National Wheelchair Users' Association, National Human Rights Council, and WHO 2015).

The Ministry of Road and Transportation reported that only 3% of public transport operating in Ulaanbaatar is accessible to PWDs. In the experience of the Mongolian National Wheelchair Users' Association, accessibility is actually half that rate. Both of these estimates are far below the 10% prescribed in the Auto Transportation Law.

3.5.2 Areas for Future Development

In general, there is a need to reconsider whether the indicators used in accreditation assessments are useful and adequate for measuring the performance of LTC, given that the clinical issues, care delivery process, and outcomes for LTC are different from those for other health-related areas. Nevertheless, the more important issues and challenges, as reported by stakeholders, involve (i) the poor enforcement of various tools and instruments, and a weak system of accountability; (ii) the lack of an effective service contracting and purchasing capacity on the part of public agencies; and (ii) LTC human resources capacity constraints in Mongolia.

3.6 Long-Term Care: Human Resources

3.6.1 Who Provides Care?

As mentioned on several occasions in this report, LTC is not legally recognized as a separate type of service system in Mongolia, so the various elements and components of LTC services are divided between the health and social welfare sectors. Although informal care providers, including family members, are the large majority of caregivers for older persons in Mongolia, most of them have no training. The 2012 revision to the Social Welfare Law indicates that informal caregivers should receive a minimum of 20 hours of training; however, this has not yet been implemented. According to the Social Welfare Law, the curriculum would include the following:

Compulsory Training (20 hours: 10 hours of lectures and 10 hours of practical instruction)

- The concept and principles of care
- The concept of human rights
- The role of the family
- The ethics of communicating with and greeting the clients and their families
- The concept of necessities

Elective Training (20 hours: 10 hours of lectures and 10 hours of practical instruction)

- Methods of caring for older persons and PWDs
- Physical and physiological characteristics of older persons, and cognitive changes
- Physical and physiological characteristics of PWDs
- Assessment of activities of daily living (ADL) and insomnia
- Social welfare laws and regulations concerning older persons and PWDs

Most of the formal care providers are professionals with various certifications, and they belong to the health-care or social work sectors. The information in this section deals mainly with the personnel in health care and social work, as there is essentially no formal caregiver workforce providing home- and community-based care for ADL, instrumental activities of daily living (IADL), or psychosocial issues. This is a major gap in human resources in Mongolia. The residential care centers are mainly based on the medical model, with doctors, nurses, caretakers, therapists, hygiene specialists, and social workers on staff—but no trained caregivers.

3.6.2 The Care Workforce

The medical conditions of patients requiring LTC are predominantly managed by medical doctors and nurses at primary health-care facilities, sanatoriums, rehabilitation centers, hospitals, and specialty centers. As of 2015, there were 11,357 nurses and 9,563 physicians in Mongolia. There were 4,230 nurses with bachelor's degrees (requiring 4 years of training) and 6,880 nurses with diplomas (2 years of training). Geriatricians and geriatric nurses are the first points of contact for older persons in the hospital care system, so they play a key role in effectively managing the health concerns of older persons.

Table 18 shows the current levels and capacities of the Mongolian health-care system with regard to key specializations relevant to older persons.

As reported by the MOH Center for Health Development (2015), there were 37.4 nurses and 29.4 medical doctors per 10,000 people in Mongolia, implying a nurse-to-doctor ratio of 1.2:1, significantly lower than the

Table 18: A Distribution of Some Key Medical Professionals Involved in Long-Term Care, 2015

Levels of Health-Care Providers	Health-Care Providers	Medical Doctors					Nurses				
		Rehabilitation	Palliative	Geriatrics	Traditional Medicine	Internal Medicine	Rehabilitation	Palliative	Geriatrics	Traditional Medicine	Internal Medicine
Primary health-care providers	*Bagh* paramedic posts (inpatient)	0	0	0	0	0	0	0	0	1	0
	Physician health posts (inpatient)	0	0	0	1	2	0	0	0	0	0
	Family health centers	0	0	0	54	10	3	3	0	3	1
	Village health centers	0	0	0	2	6	0	0	0	2	0
	Soum health centers	1	1	0	50	39	21	0	1	17	2
	Inter-*soum* health centers	0	0	0	12	13	4	0	3	6	0
	Primary Health Care Total	**1**	**1**	**0**	**119**	**70**	**28**	**3**	**4**	**29**	**3**
Level II health-care providers	District general hospitals	18	1	7	29	124	50	0	1	32	123
	Rural general hospitals	0	0	1	8	10	4	0	1	1	6
	Aimag general hospitals	11	6	14	26	90	55	13	12	43	92
	Level II Total	**29**	**7**	**22**	**63**	**224**	**109**	**13**	**14**	**76**	**221**
Level III health-care providers	Regional diagnostic and treatment centers	7	3	4	11	46	16	8	4	23	23
	Central hospitals and specialty centers	25	5	4	33	133	87	10	2	24	133
	Level III Total	**32**	**8**	**8**	**44**	**179**	**103**	**18**	**6**	**47**	**156**
Private hospitals		14	4	0	169	212	20	1	1	98	235
Private outpatient clinics		15	3	0	127	91	13	0	0	43	25
Department of Health		0	0	1	1	1	1	0	2	0	1
Sanatoriums		30	1	0	117	61	53	3	3	78	50
Others		6	0	1	56	93	41	0	1	51	138
Total		**127**	**24**	**32**	**696**	**931**	**368**	**38**	**31**	**422**	**829**

Note: *Aimags* are provinces, *soums* are provincial districts, and *baghs* are hamlets.
Source: B. Bayart and T. Dulmaa. 2017. *Current Status of Specialists in Geriatrics and Gerontology in Mongolia*. First draft. Ulaanbaatar: Government of Mongolia, Ministry of Health, Center for Health Development.

Table 19: Geographic Distribution of Geriatrician and Geriatric Nurses and Projected Needs, 2015

Geographic Regions	Number of Older Persons	Geriatricians Needed	Geriatricians Available	Gap in Geriatricians (%)	Geriatric Nurses Needed	Geriatric Nurses Available	Gap in Geriatric Nurses (%)
Central region	40,786	8.10	3	63	16.2	5	69
Western region	28,931	5.87	3	49	11.7	8	32
Khangai region	47,459	9.50	4	58	19.0	4	79
Eastern region	16,296	3.20	2	38	6.4	3	53
Ulaanbaatar	110,690	22.00	12	45	44.0	8	82
Total	**244,162**	**48.67**	**24**	**51**	**97.3**	**28**	**71**

Source: B. Bayart and T. Dulmaa. 2017. *Current Status of Specialists in Geriatrics and Gerontology in Mongolia*. First draft. Ulaanbaatar: Government of Mongolia, Ministry of Health, Center for Health Development.

average of 3:1 for the countries of the Organisation for Economic Co-operation and Development (OECD) and of 2.5:1 for the former Soviet bloc countries. Hence, the nurse-to-doctor ratio has become one of the pressing issues in the effort to provide an effective LTC system for older persons. MOH (2011) estimates show that Mongolia needs at least 14,000 nurses to provide good-quality inpatient services, given the nurse-to-doctor ratio of 3:1 or 2:1 for other health services. However, no changes have occurred in this regard, which is not surprising given the fact that nurses in Mongolia are among the country's lowest-paid professionals. Other reforms to increase the number of nursing graduates include, for example, greater allocations from the government budget to support the training and hiring of additional nursing staff, a change in national staffing standards, and a revision of the job description for nurses.

With regard to geriatric specialists, a study in 2016 investigated the current situation and projected the future needs for geriatric professionals in Mongolia based on an internationally acknowledged methodology provided by the National Institute of Aging in the United States (Bayart and Dulmaa 2017). The study estimated that the availability of trained geriatricians is 49%, and of trained geriatric nurses 28.7%, of the total number needed by older persons requiring care in 2015. The study thus argued that there is a growing need to employ more trained geriatric specialists. For example, to accommodate 535,761 older persons by 2030, Mongolia will need to train 6–10 geriatricians and 13–18 geriatric nurses every year. In addition, not all geriatric doctors have been trained as geriatricians (Table 21).

In terms of the core tasks of health personnel, the health facility standards and policy directions of the MOH state that primary health-care facilities are tasked with providing basic medical care, prevention, and outreach consultations to the general public. Hence, these providers do not employ specialized doctors for rehabilitation, palliative, and geriatric care. However, recent changes in the Law on the Elderly suggested employing geriatricians or retraining doctors in geriatric care, which would require the preparation and/or hiring of doctors at 218 family health centers and in 298 *soum* and village health centers from 2020 onward. The current family health center standards prescribe the following services for older persons:

- Organize prevention checkups for older persons once a year, and not fewer than two times a year for veterans; and refer patients to treatment and sanatorium services, if necessary.

- Conduct detailed assessments of bedridden and disabled older persons, and provide them with regular care.
- Encourage older persons to take up age-specific physical exercise and fitness activities.

As of 2015, there were around 1,500 specialists working in the social welfare sector. This number included not only social workers and social welfare specialists, but also other types of specialists such as monitoring and evaluation officers. In 2016, the Federation of Mongolian Human Resource Management conducted an assessment at the request of the Ministry of Labor and Social Protection (MLSP). The results of the assessment are shown in Table 20.

Table 20: Human Resources Assessment of the Social Welfare Sector, 2016

Item	Percentage (%)	Item	Percentage (%)
Gender		Age	
Male	32	Up to 35	55
Female	68	36–50	34
		51 and over	11
Number of Years Worked		Level of Education	
0–5 years	40	Secondary	1
6–10 years	23	Diploma course	4
11–15 years	12	Bachelor's degree	80
16–20 years	8	Master's degree	14
21–25 years	7		
26 and over	10		

Source: Federation of Mongolian Human Resource Management and the Ministry of Labor and Social Protection. 2016. *Human Resources Assessment of the Social Welfare Sector 2016*. Ulaanbaatar.

Social workers in Mongolia are expected to manage the administrative side of health care for all the beneficiaries in their areas, as well as carry out monitoring and evaluation via visits to the beneficiaries' homes. The responsibilities of the social worker, as stated in Article 28.8 of the Social Welfare Law (2012), are outlined below:

- conduct needs assessments of households and citizens of the *soums* and *khoroos* that are in need of social welfare, and create a database;
- assess the conditions of households and individuals to be covered that are in the social welfare target groups, formulate a development program jointly with each household and individual, and ensure its implementation;
- identify households and individuals to be covered by the social welfare pension, allowances, and social welfare and social development services; and make the relevant decisions;
- provide professional and methodological assistance to households and individuals seeking to organize groups based on their will, aims, and demands;
- provide advice and training to households and individuals seeking to improve their lives;
- inform local residents, business entities, and government and nongovernment organizations (NGOs); provide professional and methodological assistance; and cooperate with these groups;

- strictly adhere to the social workers' professional code of ethics;
- maintain the confidentiality of clients (except in incidents of violation of laws);
- facilitate the implementation of social welfare legislation, rules, and guidelines; and
- assist in the implementation of national programs on population and families at the local level, in collaboration with workers from the social, health, and education sectors.

Social workers interviewed for the qualitative study complained that they did not have enough time to visit households regularly (see quotes below), and many older persons stated that they were rarely visited by the social worker. Social welfare specialists carried out monthly monitoring and evaluation, but also noted the lack of time (and transport) to visit remote beneficiaries.

> *Much of my working time is taken up by home visits. If I start visits at 3 p.m., then around 8 p.m. I go home. The farthest distance is 3 kilometers. If I start making the visits earlier, then I do not finish my paper work at the khoroo. Citizens hardly ever appear at the khoroo office in the summer; they come mainly in the autumn. Despite my many administrative work responsibilities, I still manage to visit households.*[18]

> *Almost no visits can be made to older persons in rural areas as no fuel funding is available. I assume that as caregivers know their patients well, they care for them well. I keep the minutes of the livelihood council meetings and do the monthly reporting for the province's Labor and Welfare office. I do most of my monitoring by visiting patients' homes in urban areas.*[19]

In addition to social workers at the national and local levels, the personnel at residential care homes play important roles. According to the National Standards for Residential Care Settings for the Aged, residential care homes with a capacity of no more than 30 beds require a staff of 16 members, those with a capacity of 31–60 beds require 19 staff members, and those with a capacity of 61 beds and more require 24 staff members. If the nurses and caregivers, social workers, therapists, and assistant workers can be collectively referred to as "care staff," they make up less than 40% of the workforce in the health sector. In practice, however, this staffing requirement is not followed at many institutional care centers for older persons (Amarsanaa 2015).

There is a lack of professionally qualified psychologists, nurses, and social workers at residential care centers. This is one of several factors that can lead to inadequate and inconsistent social work and health care at these facilities. Although the residential care centers in Mongolia are required to employ a social worker, nurse, and psychologist, many of the care centers, such as the Bat-Gerelt Ireedui facility and the *aimag* centers, cannot hire the required specialists (Amarsanaa 2015).

In a residential care center, the staff are responsible for the following activities and services:

- Quality assurance and monitoring
- Food services
- Nursing
- Social services
- Activities
- Finance

[18] This quote is from an interview with a social worker conducted in 2017 for this CDS, in Bayanzürkh, a *düüreg* in Ulaanbaatar.

[19] This quote is from an interview with a *soum* social welfare specialist conducted in 2017 for this CDS.

- Human resources
- Environmental services

A consultant's report has further revealed that a lack of professionally qualified administrators and managers at residential care centers may be linked to poor working and living conditions (Amarsanaa 2015). In particular, the managers of private care centers cannot supervise and coach their care teams so as to ensure the delivery of services. And these managers do not know about effective methods for monitoring their performance.

3.6.3 Workforce Management

As with all civil servants in Mongolia, the performance of medical and social sector personnel, such as geriatricians, nurses, and social workers, is monitored and assessed according to the prescribed guidelines—based on civil servant performance agreements at publicly owned health facilities and labor agreements in the private sector. Such agreements are assessed by the managers' superiors such as the chief of medicine for geriatricians or the chief of nursing.

3.6.4 Responsibilities of Developing Workforce

The Ministry of Education, Culture and Science (MECS) and the MOH are the main government ministries in charge of developing health-sector workforce policies in Mongolia. The MOH produced a human resources policy paper that was recently integrated into the State Policy on Health (2017), and it provided estimated projections of the numbers of health-care personnel during 2011–2020. The MECS, on the other hand, approves the medical training curricula and monitors the training institutions. There has been a problem with coordination between the two ministries for years, which led to the establishment of the Inter-Sectoral Coordinating Committee on Health Sector Human Resources, chaired by the Prime Minister of Mongolia. There is still no sector-specific workforce development plan for the provision of LTC services, particularly for the social and personal care components. A plan will be needed if Mongolia is to develop an LTC system that can support family caregiving.

There are eight licensed higher education institutions in the health and medical field, offering a total of nearly 20 courses of study. The Health Sciences University of Mongolia is the only state institution specializing in this area, and it has seven schools: the School of Medicine, the School of Biomedicine, the School of Traditional Medicine, the School of Dentistry, the School of Pharmacy, the School of Public Health, and the School of Nursing. The university also has a branch in three *aimags*. All of the training institutions operate under the management of the MECS, which registers and issues official licenses and curricula for the carrying out of preservice training for health professionals. All the institutions were established based on the Soviet model; hence, the educational institutes are still in the nascent stage of training health professionals that are common in Western countries, such as occupational therapists, physiotherapists, optometrists, speech therapists, and geriatric care workers. Medical training and mid-level preservice training have started to gradually move away from a specialized to a more generalist focus. Until 2016, medical school graduates who passed the licensing exam were granted a 2-year provisional license that permitted them to practice in a primary health-care setting (Tsolmongerel et al. 2013). Such arrangements clearly did not respond to the specific needs of older persons and PWDs, and thus led to a poor quality of service.

A recent study assessed the gerontology component of the social work curriculum at the Mongolian National University of Medical Sciences (MNUMS). Since 2003, the MNUMS has been offering a bachelor's degree in social work leading to employment in hospitals. In 2015, the MNUMS faculty did a comprehensive curriculum assessment in which they carefully evaluated their gerontology program. The study looked at the general course

Table 21: University Programs in Health Care, Degrees Granted, Years of Study, and the Main Focus of Each Field, 2015

University Programs in Health Care	Degree	Years of Study	Main Focus	Number of Students in 2015
Medical doctors (including geriatricians)	Bachelor's degree	6	Medical services Surgical procedures Public health Emergency services Training and research Others	7,390
Traditional medicine doctors	Bachelor's degree	6	Medical services Dispensing of traditional medicines Public health Emergency services Training and research Others	676
Physiotherapists, speech therapists, occupational therapists	Bachelor's degree	4	Rehabilitation Public health Emergency services Training and research Others	127
Pharmacists	Bachelor's degree	5	Assurance of the readiness of necessary medicines and supplies Assurance of the quality and safety of medicines and supplies Promotion of rational drugs use Training and research Others	1,504
Social workers (public health or health care)	Bachelor's degree	5	Health promotion Health education Prevention	751
Traditional medicine nurses	Bachelor's degree	4	Nursing care (including medical checkups, rehabilitation, palliative care, etc.) Public health services Emergency care Training research and studies Others	425
	Diploma	2		
Nurses	Bachelor's degree	4	Nursing care (including medical checkups, rehabilitation, palliative care, etc.) Public health services Emergency care Training research and studies Others	4,230[a]
	Diploma	2		6,880
Physician's assistants (including *bagh* [hamlet] paramedics)	Diploma	4	Health promotion Basic emergency care Medical checkups Referrals Dispensing of essential medicines	1,023
Health manager	Bachelor's degree	5–6	Leadership Planning and strategy Management of personnel, including supervision, monitoring, and reporting	769

[a] Of the 4,230 nursing students, 31 were specializing in geriatrics.

Source: B. Bayart and T. Dulmaa. 2017. *Current Status of Specialists in Geriatrics and Gerontology in Mongolia*. First draft. Ulaanbaatar: Government of Mongolia, Ministry of Health, Center for Health Development.

components, learning outcomes, content, and assignment design to see if they were appropriately aligned (Box 4). The study also focused on specific competencies that were grouped into four categories and evaluated according to the Geriatric Social Work Competency Scale. These were (i) values, ethics, and theoretical perspectives; (ii) assessments; (iii) interventions; and (iv) aging services, programs, and policies.[20]

The MNUMS offers professional social work training, including courses on physiotherapy and occupational therapy. It has also been developing a core curriculum in community-based rehabilitation. The university estimates that its graduates constitute 70% of all medical professionals working in the state sector in Mongolia, including its physiotherapy graduates. The physiotherapy program was established in 2007 with support from the Government of Japan. The 2016 graduating class is expected to increase the total number of physiotherapists working in government-owned hospitals to 100.

The Mongolian Palliative Care Society was established in 2001, and has been involved in the development of palliative care curriculum, ensuring that the curriculum is included in undergraduate and some postgraduate training, establishing a training center, and developing textbooks and training materials on palliative care.

In terms of mental health care for older persons and other population groups, since the early 2000s, the government has been establishing in-service mental health training for family doctors and revising undergraduate curricula to include community-based approaches to mental health.

Box 4: Assessment of the Gerontology Curriculum at the Mongolian National University of Medical Sciences

"Introduction to Gerontology and Geriatrics" is a three-credit course that is taught during the last semester of the university's 4-year bachelor's degree program in gerontological social work. It was first introduced in 2008 and then renewed twice, in 2010 and 2013. The course has changed from a knowledge-based orientation to one that is more skill- or competency-based. It includes seven learning outcomes that align well with the content and with the assignments. The guidelines for the course paper are well developed, and they align well with the other course components and with the overall course requirements.

The course applies the four categories of competencies according to the Geriatric Social Work Competency Scale: the first category includes values, ethics, and theoretical perspective; the second category is assessment; the third is intervention; and the fourth includes aging services, programs, and policies. The categories were mostly well integrated into the course design, with the exception of values and ethics under the first category, and the fourth category as a whole, which were somewhat less well integrated.

The components of the course were all appropriately aligned. The course covered a range of topics, but the learning outcomes focused more on competencies than on fundamental knowledge. The assignment guidelines emphasized the assessment and intervention-planning stages of gerontology social work, rather than delivery and evaluation.

A study by Bagaajav and Myagmarjav (2015) recommends that closer attention be paid to the teaching of the competencies of values and ethical issues as they apply to professionals dealing with older persons.

Source: A. Bagaajav and S. Myagmarjav. 2015. *Gerontology Component in the Curriculum of Health Social Work, Department of Behavioral Sciences and Community Health*. Ulaanbaatar: Mongolian National University of Medical Sciences.

[20] The New York Academy of Medicine's Hartford Partnership Program in Aging Education developed the Geriatric Social Work Competency Scale in order to measure outcomes of aging-enhanced social work field education.

The Social Welfare Law specifies the educational and professional qualifications of social workers, as follows:

- Social workers must hold a bachelor's degree or higher in social work, have specialized professional training, and hold a required license or permit to engage in social work.
- An adjunct council at the central state agency in charge of social welfare matters is responsible for issuing licenses to those offering social work services and for the approval of the social workers' professional code of conduct.
- The adjunct council consists of representatives of social workers' professional associations, social worker training institutes and universities, and of the relevant state administrative agencies.

Professional social work programs are currently offered at 14 tertiary-level educational institutions in Mongolia, including private universities. One of these, the Mongolian University of Science and Technology, has been offering a 4-year bachelor's degree and a 5.5-year combined bachelor's and master's degree in social work since 1997, at its School of Business Management and Humanities. The social work program is accredited by the MECS. According to current MECS estimates, only 17% of operational social workers are graduates of social work programs. Since 2016, the university has partnered with the MLSP to upgrade the professional skills of the employed but unqualified social workers.

The salaries of health-care workers are generally low in both the public and private sectors. A wage structure survey conducted by the Ministry of Labor (2013) showed that the MNT563,500 average monthly salary of medical personnel in 2013 was low compared with the average salaries in other sectors: for instance, 34% lower than in finance and transport, 81% lower than in mining, and 20% lower than in other areas of civil service. A medical doctor's salary was low compared with salaries in other sectors such as education. An MOH estimate suggests that nurses earn at least 30% less than medical doctors in Mongolia. In addition, the baseline study of incomes and wages of health sector workers (2013) estimated that 70% of the total staff had asked for advances on their monthly salaries or wages.

Unsurprisingly, not all trained geriatricians and geriatric nurses remain in their disciplines—a likely indication of poor incentives. According to National Gerontology Center data, only 11 out of 24 geriatricians and 16 out of 28 geriatric nurses actually work in geriatric departments or units. This is a clear indication of substantial shortages of geriatric health-care personnel in Mongolia. In addition, poor working conditions have boosted staff turnover—for example, at the National Gerontology Center itself—especially among younger employees. Health-care workers reported that the main factor contributing to their excessive workload is the need to cover for others due to staff shortages caused by high turnover. The staff turnover rates are particularly high at 15%–30% of public hospitals in Mongolia. This survey revealed that 54% of quality managers were tasked with doing two jobs (MOH 2014).

In accordance with its health and human resources policy, the MOH implemented a subprogram to improve the livelihood of health sector workers; introduced various incentive packages for health sector workers in remote areas; approved the Housing Program for Health Workers; and tried to increase the salaries for all health sector workers, specifically for those job categories where there were staff shortages. For example, MOH Order #123 attempted to address shortages of medical professionals—including doctors and nurses specializing in tuberculosis, pathology, pediatrics, intensive care units, emergency room medicine, and obstetrics, as well as midwives—by offering 50% increases in their base salaries. Such measures have resulted in a greater retention of health-care employees and increases in staff.

In summary, qualified human resources are key to ensuring good-quality and accessible LTC services for older persons. However, human resources for LTC in Mongolia are over-medicalized, and there is a lack of staff needed to meet the other care needs of older persons. For example, day caregivers, respite caregivers, and trained community-

based service providers appear to be very limited in number or almost nonexistent in Mongolia. Informal caregivers form the bulk of the LTC workforce. Thus, the training, recruitment, and retention of formal (frontline) and informal caregivers should be among the key human resources development issues in LTC. Even in the health sector, there is a severe shortage of caregivers and medical professionals who can provide rehabilitative care in the form of physical and mental therapy, nursing, and geriatric care. On the other hand, it is important to note that over-medicalization, overspecialization, and over-professionalization may lead to higher LTC costs. As preventive medicine gathers momentum globally as a cost-effective approach to health care, Mongolia needs to make the shift from medical care to more disease prevention, which will require a workforce with a different mindset and skill sets.

In the short to medium term, and for the sake of ensuring efficiency, gaps in LTC skills could be filled by modifying the curricula and/or retraining primary health-care workers, social workers, community-based volunteers, and NGO staff. Furthermore, older persons themselves can be taught how to care for other older persons. For example, Mongolia needs to adjust its job descriptions for primary health-care providers, and retrain these providers in essential LTC for older persons, as they are the first entry point for health services.

Moreover, the incentive system and wage levels for LTC workers are generally weak, especially for nurses, as their roles in the LTC system are changing. Any government policy dealing with the shortage of LTC personnel should thus offer more incentives and higher wages to nurses and other LTC workers.

3.7 Financing

3.7.1 Economic Background

The decline of Mongolia's gross domestic product (GDP), which is largely dependent on mining revenues, has had a negative effect on the country's public spending and per capita income, and thus also on the average wage levels. However, government spending on social protection increased from 7.5% in 2012 to 8.8% in 2015, while expenditure on health services remained stable. This is an indication of Mongolia's political commitment to addressing pressing issues in these sectors.

3.7.2 Sources of Funding for Long-Term Care

Internationally, LTC expenditure is classified under a country's national health accounts.[21] Mongolia's first national health accounts were produced in 2005, and the second round of estimates came out in 2017. Both estimates have failed to show any pattern for total LTC expenditures, largely due to the lack of a data system for recording private spending on these services. This lack of expenditure data is also explained by poor conceptualization and the lack of a clear LTC policy in Mongolia. Thus, the available LTC expenditure data is (i) largely based on public sources of funding for social protection and health care, (ii) includes only data on services provided by government facilities, and (iii) shows expenditures for only a limited range of LTC services in broad categories.

Public funding sources for LTC are reflected in the portfolios of the MLSP and the MOH, as approved by Parliament in the fall of every year. Available data on expenditures for LTC are not disaggregated by sources of funding, so Figure 5 shows public social protection and health expenditures according to the sources of revenue.

[21] National health accounts are calculated by using the System of Health Accounts (SHA) as defined by the OECD. The SHA framework is an internationally recognized methodology for tracking all health expenditures in a given country over a defined period, regardless of the entities or institutions that financed or managed the expenditures. It ensures comparability of health-related expenditures across countries and over time.

Table 22: Key Economic Indicators, and Spending on Social Protection and Health Care, 2012–2015

Item	2012	2013	2014	2015
GDP ($)	14,858,981,765	12,582,101,934	12,226,505,990	11,741,334,054
GDP per capita ($)	4,377	4,401	4,202	3,968
Average monthly wage ($)	496	534	438	410
General government expenditure ($)	5,336,740,954	4,045,254,900	3,930,035,095	3,622,766,925
Central government expenditure ($)	3,840,266,615	3,104,609,660	2,847,378,351	2,322,450,376
Local government expenditure ($)	453,109,753	1,142,318,880	1,114,863,884	1,044,191,070
General government expenditure (% of GDP)	35.9	32.2	32.1	30.9
Central government expenditure (% of GDP)	25.8	24.7	23.3	19.8
Local government expenditure (% of GDP)	3.0	9.1	9.1	8.9
General government expenditure on social security and social protection ($)	1,116,101,245	910,674,712	979,521,804	1,035,966,247
General government expenditure on social protection (% of GDP)	7.5	7.2	8.0	8.8
Government expenditure on health ($)	362,947,618	272,859,581	326,345,677	295,398,875
Government expenditure on health (% of GDP)	2.5	2.2	2.6	2.5

GDP = gross domestic product.

Notes:
1. Each monetary value is given in United States dollars of the year represented by the column in which the value is listed.
2. "General government expenditure" refers to funding from the general national government budget, rather than from dedicated sources such as the social insurance fund.

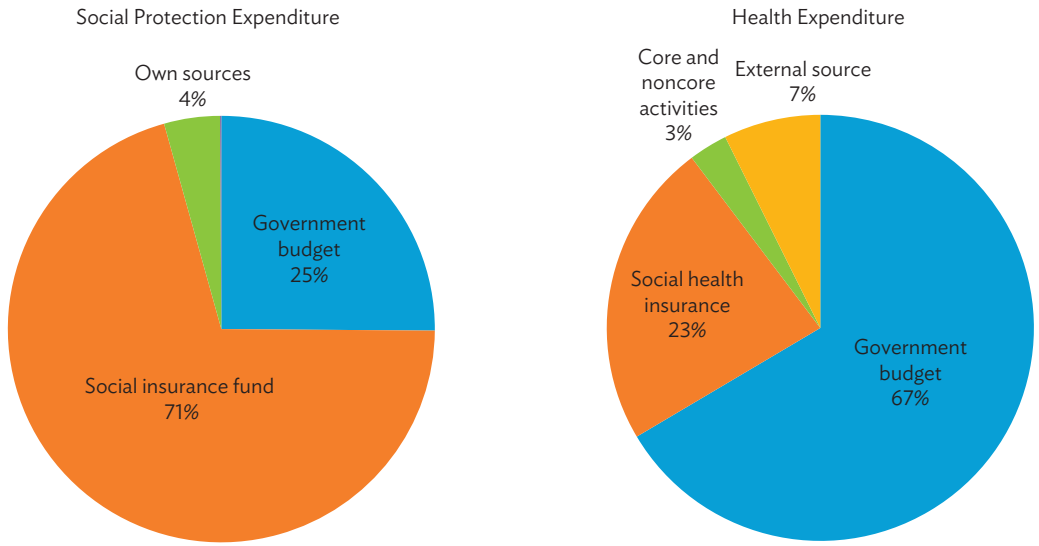
Source: Government of Mongolia, Ministry of Finance and National Statistics Office, Central Bank of Mongolia. 2017. *Statistics*. Ulaanbaatar.

The social insurance fund pays the largest share of social protection expenditures,[22] while the health sector is predominantly reliant on the general government budget.

The proportions of expenditures of institutions and individual providers of LTC to older persons are shown in Figure 5 according to certain classifications of service providers. As noted in the section of this report on the supply of care, there are a number of public facilities and some private ones in Mongolia that provide different elements of LTC. This means that LTC is only one of the services offered by these institutions.

[22] Mongolia's social insurance fund encompasses five schemes: health insurance, pension insurance, pensions and benefits, unemployment insurance, and insurance for those with occupational diseases and injuries.

Figure 5: Public Social Protection and Health Expenditures, by Source of Funding, 2015
(%)



Note: "Core activities" include user fee collections, while noncore activities cover nonmedical services (e.g., space rental).

Sources: Government of Mongolia, Ministry of Labor and Social Protection. 2017. Routinely collected administrative data reported by the Government. Ulaanbaatar; and Government of Mongolia, Ministry of Health, Center for Health Development. 2016. *Statistics*. Ulaanbaatar.

Figure 6 and Tables 22–24 show that hospital and primary health-care expenditure has been high, as they provide medical services not only to older persons, but also to other groups within the population. Among the four main types of LTC institutions, sanatoriums that provide rehabilitative care for older persons account for the greatest share of expenditures.

The MLSP funds social welfare services and provides assistance in the form of cash transfers, allowances to older persons and their caregivers, and direct payments to a limited range of institutions that provide care (Table 23). Almost one-third of the total social protection expenditure for the LTC of older persons was spent on conditional cash transfers and vouchers, to help compensate for missing LTC that would have otherwise been provided by informal or family caregivers. The funding allocated to community-based social welfare services is the lowest, perhaps due to a poor understanding of such services and a limited capacity to provide them. On the other hand, the MOH directly funds preventive, curative, nursing, rehabilitative, and palliative care for older persons in health facilities at three levels of care provision. It is impossible to separate overall health-care expenditure from the services specific to LTC, as all services and types of care have elements of LTC, depending on the physical and medical condition of the patient.

On the other hand, the social protection sector tends to be clearer with respect to spending on LTC, including for older persons and PWDs. Thus, we can see that only 2.3% of the public social protection budget in 2015 went to LTC, but the data do not allow us to estimate the share of LTC in the total public expenditure.

Table 23: Public Expenditures on Key Long-Term Care Providers, 2015

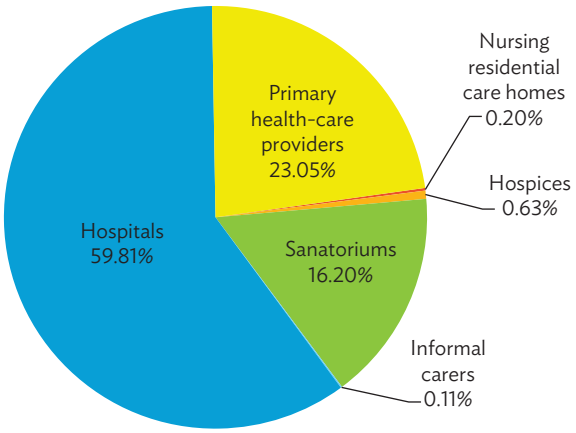
Long-Term Care Providers	Expenditure ($)
Nursing homes	510,825
Hospices	1,605,558
Sanatoriums	41,564,049
Informal caregivers	288,203
Hospitals	153,445,143
Primary health-care providers	59,147,959

Notes:
1. This table includes institutions and individual providers of full or partial long-term care.
2. The values in this table are in 2015 United States dollars.

Sources: Government of Mongolia, Ministry of Labor and Social Protection. 2017. Routinely collected administrative data reported by the Government. Ulaanbaatar; and Government of Mongolia, Ministry of Health, Center for Health Development. 2016. *Statistics*. Ulaanbaatar.

Figure 6: Public Expenditures on Key Long-Term Care Providers, 2015

(%)



Sources: Government of Mongolia, Ministry of Labor and Social Protection. 2017. Routinely collected administrative data reported by the Government. Ulaanbaatar; and Government of Mongolia, Ministry of Health, Center for Health Development. 2016. *Statistics*. Ulaanbaatar.

Table 24: Public Expenditure on Social Protection, Long-Term Care, and Health Care, by Type of Service or Program, 2015

Social Protection Service or Long-Term Care Program	Expenditure ($)	Health-Care Service or Program[a]	Expenditure ($)
Conditional cash transfers and vouchers[b]	7,535,189	Primary care	59,147,959
Community-based social welfare services	795,735	Secondary-level hospital care	81,663,663
Rehabilitative care	10,091,947	Specialized tertiary care	81,929,766
Residential and temporary nursing care	1,581,689	Public health programs	9,971,501
Total	**20,004,560**	**Total**	**232,712,889**

Note: The values in this table are in 2015 United States dollars.

[a] The health services and programs listed here are not limited to long-term care.

[b] Mongolia's conditional cash transfer for carers program helps those in need of permanent care by paying caregivers to look after them full time. The vouchers for prosthetic and orthopedic equipment program provides free or discounted equipment to those living with a disability and to older persons, to enable them to participate more fully in society and in the economy (MacAuslan et al. 2012).

Sources: MacAuslan et al. 2012. *Social Welfare Program Assessment Report: A Conditional Cash Transfer Program for People Caring for Those in Need of Permanent Care and a Voucher for Discounted or Free Prosthetic and Orthopedic Equipment.* Ulaanbaatar; Government of Mongolia, Ministry of Labor and Social Protection. 2017. Routinely collected administrative data reported by the Government. Ulaanbaatar; and B. Bayart and T. Dulmaa. 2017. *Current Status of Specialists in Geriatrics and Gerontology in Mongolia*. First draft. Ulaanbaatar: Government of Mongolia, Ministry of Health, Center for Health Development.

The allocations of the health insurance fund provides a clearer picture. This fund is used mostly for hospital inpatient care, but outpatient and preventive care also accounts for a substantial share of the fund. A new trend has become apparent, as the 2015 revision of the Health Insurance Law broadened the scope of the supported services to include prevention and early diagnosis of diseases. The allocations of funding to palliative care since 2009 has been very little, however, at just 0.06% of the fund, despite a fourfold increase in the payment rates to palliative care providers. Rehabilitative care, which is one of the more important components of LTC, accounts for less than 10% of the fund's total budget.

It is important to note that the essential medicines prescribed by the family and *soum* health centers are a vital support for older persons with conditions that require LTC. The health insurance pays 40%–80% of the prices of 183 essential medicines. However, older persons in Mongolia claim that the effectiveness of this program is poor,

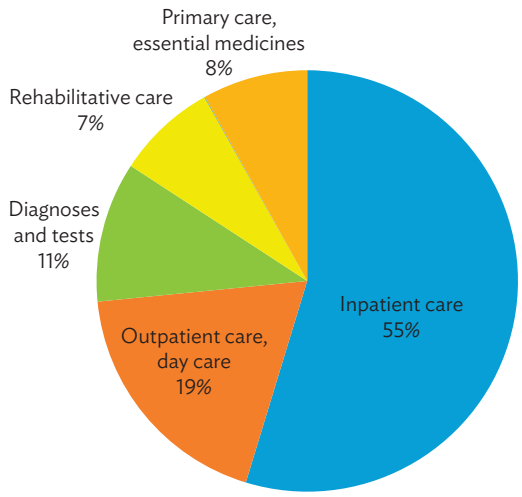
Table 25: Services Covered by the Health Insurance Fund, 2015

Services	Expenditure ($)
Inpatient care	56,709,987
Outpatient care, day care	19,404,478
Diagnoses and tests	11,166,265
Rehabilitative care	7,965,505
Palliative care	62,876
Primary care, essential medicine	8,349,359
Total	**103,658,470**

Note: The values in this table are in 2015 United States dollars.

Source: Government of Mongolia, Ministry of Health, Center for Health Development. 2016. *Statistics*. Ulaanbaatar.

Figure 7: Breakdown of the Services Covered by the Health Insurance Fund, 2015
(%)



Note: Palliative care excluded in the figure because of minimal amount. Percentages do not add up exactly to 100%.

Source: Government of Mongolia, Ministry of Health, Center for Health Development. 2016. *Statistics*. Ulaanbaatar.

as the allocated funds for each contracted pharmacy are depleted within the first 10 days of every month, leading to long queues and unnecessary stress.

The government budget allocation for health covers public health initiatives, the treatment of communicable diseases, primary health care, maternal care and childcare, and other key health services. LTC, primary care, ambulance transport, mental health, drugs for conditions requiring long-term restorative care, and palliative care are also included in the government budget. Health expenditure data do not specify how much of the budget is allocated to restorative-care medicines.

3.7.3 Financial Management

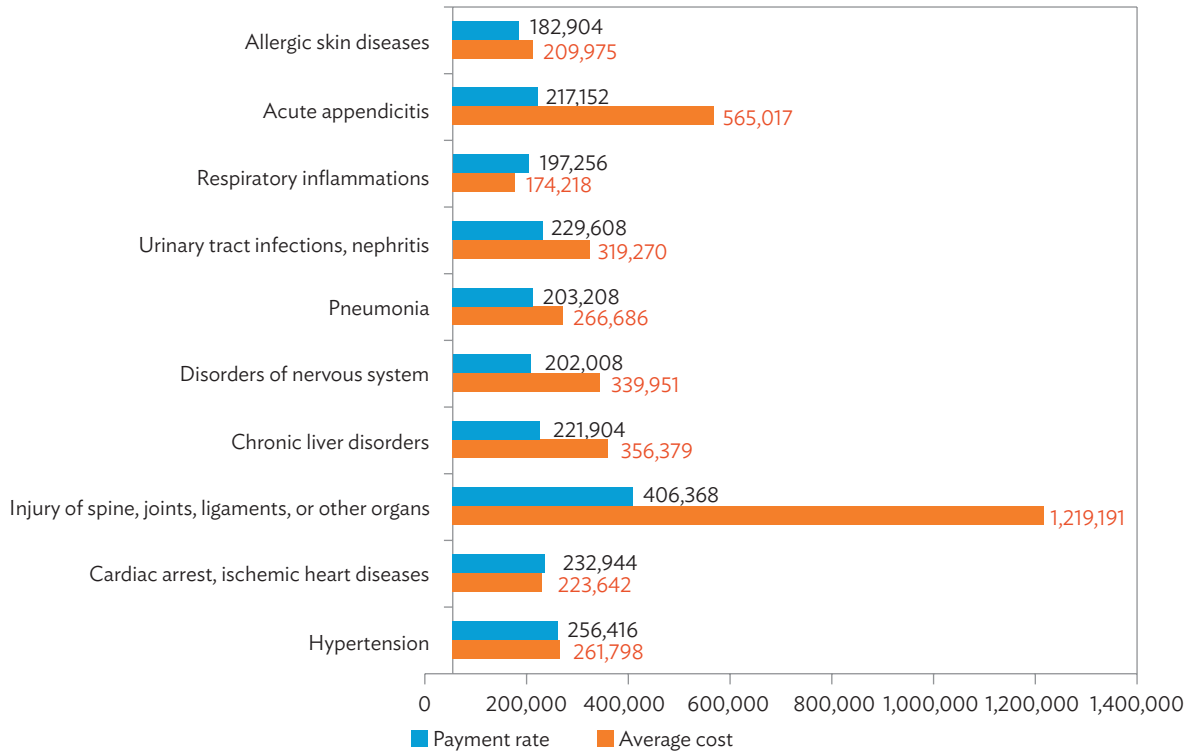
Financial management institutions include the Ministry of Finance, the MOH, and the MLSP, which control the state budget for their own sectors. Of these, the Ministry of Finance is the central government body in charge of revenue and expenditure management of the public budget in Mongolia. This ministry operates the central treasury and local treasury offices, managing the financial flows of state-funded entities, including health-care providers. The MOH oversees the entire public health budget, including fund disbursements, and takes care of treasury functions for its tertiary health-care centers. The local treasury offices are responsible for state-funded institutions located in their areas.

3.7.4 Costs and Affordability of Health Care

Although there are difficulties in calculating the cost of providing LTC as a whole, the costs of some elements of LTC can be found in MOH and MLSP policy documents, as well as in studies undertaken to inform those policies. However, there is a lack of data on the impact of LTC on household income.

The MOH conducts various service studies to set and revise health insurance payment rates to providers. Figure 8 compares the costs and payment rates claimed in Mongolia for key medical conditions that are prevalent among older adults. The government funding allocated to these medical conditions is lower than the actual costs by 8%–62%, though in some cases higher payments are made, compared with the actual costs incurred during the delivery of the services.

Figure 8: Costs of Health Services vs. Payments to Providers, by Medical Condition, 2012
(MNT)



MNT = togrog (Mongolian currency).

Source: Government of Mongolia, Ministry of Health. 2014. *Hospital Services Costing Study 2014*. Ulaanbaatar.

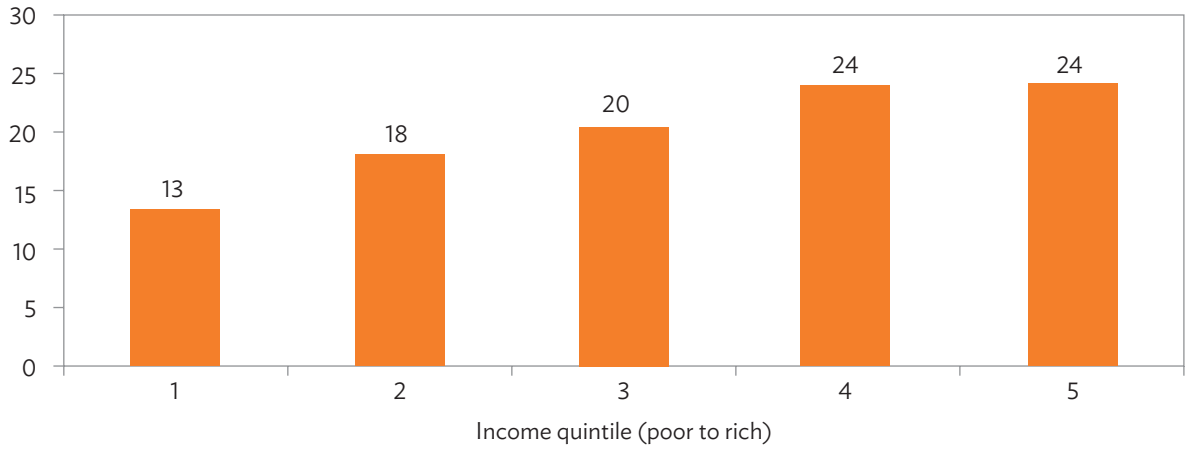
Social and health service costs are generally high relative to the incomes of older persons. Despite receiving a basic income, 80% of older persons in Mongolia consider themselves poor due to the fast-rising prices of consumer goods (Mujahid, Namdaldagva, and Banaragch 2010). In 2014, a group of researchers surveyed 2,000 older persons in Ulaanbaatar city and in the Central, Southern, Western, and Eastern regions, using a multistage random cluster sampling method (Oyunkhand, Enkhzul, and Ayush 2014). The survey revealed that 81.7% of

older Mongolian citizens were living on an income of $300 or less per month, and 45.5% of them regarded their financial capability as poor. In terms of monthly income, 51.7% had an income of below $200, 30.4% had an income of $200–$300, 10.6% had an income of $300–$400, 4.6% had an income of $400–$500, 2.5% had an income of $500–$1,000, and only 0.2% had an income of more than $1,000. While 57% of those interviewed were capable of buying medical supplies, only one in three of them said that they had enough money for an emergency such as a catastrophic accident or illness. The great majority of the interviewees, 89.2%, felt that they needed a higher income and more support to improve their financial security (Mujahid, Banzragch, and Oyun-Erdene 2010).

In 2016, the Mongolian Association of Elderly People reported that pensions were the *key* source of income for older persons. For 95% of older persons, their pensions were their *only* source of income, and most of them have a pension loan, which is used to support their families. The pensions of some 64,500 retirees need to be reviewed because the income basis that was used to determine their pensions was minimal.

By contrast, several household socioeconomic surveys found that the distribution of government expenditures on health has been regressive, benefiting the rich more than the poor. The poorest 20% of Mongolian people received only 13% of the government resources spent on health, while the richest 20% received 24% of government spending in this sector. Hence, there is clear evidence that poor people in Mongolia lack accessibility to health-care funding, compared with the rich. Outpatient health service utilization is also lower for the poor than for the rich. For various reasons, the poor are less likely to report their illnesses than the richest quintile, although they have greater health needs.

Figure 9: Shares of Government Health Subsidies, by Income Quintile, 2012
(%)



Note: Percentages may not total 100% because of rounding.

Source: T. Tsolmongerel. 2015. *Distribution of Catastrophic Health Payments and Benefit Incidence of Government Health Expenditure*. Ulaanbaatar.

Table 26: Outpatient Health Service Use and Health-Seeking Behavior, by Income Quintile, 2010–2012
(%)

Income Quintile	2010		2011		2012	
	Reported Illness	Health Service Use	Reported Illness	Health Service Use	Reported Illness	Health Service Use
1	5	73	4	75	4	77
2	6	74	5	78	6	79
3	7	79	6	79	7	78
4	8	81	7	79	8	82
5	10	82	10	80	9	84
Total	7	78	6	79	7	80

Source: T. Tsolmongerel. 2015. *Distribution of Catastrophic Health Payments and Benefit Incidence of Government Health Expenditure.* Ulaanbaatar.

3.7.5 Estimation of Future Needs and Funding for Long-Term Care

From July 2013 to December 2014, the Ministry of Population Development and Social Protection and the United Nations Country Team for Mongolia facilitated an assessment-based national dialogue on social protection and employment promotion. The United Nations Social Protection Working Group (UNSPWG) estimated the costs of relevant programs and services under different scenarios based on possible social protection floors in Mongolia. The exercise only considered the cost of cash benefits and certain social services such as social insurance subsidies, tax-funded social protection programs (for instance, social welfare benefits and services, and the Child Money Program), and the index of existing benefits. These services and benefits constituted the government's total social protection budget (United Nations, International Labour Organization, and Government of Mongolia 2015).

The definition of a social protection floor for older persons in Mongolia is as follows:

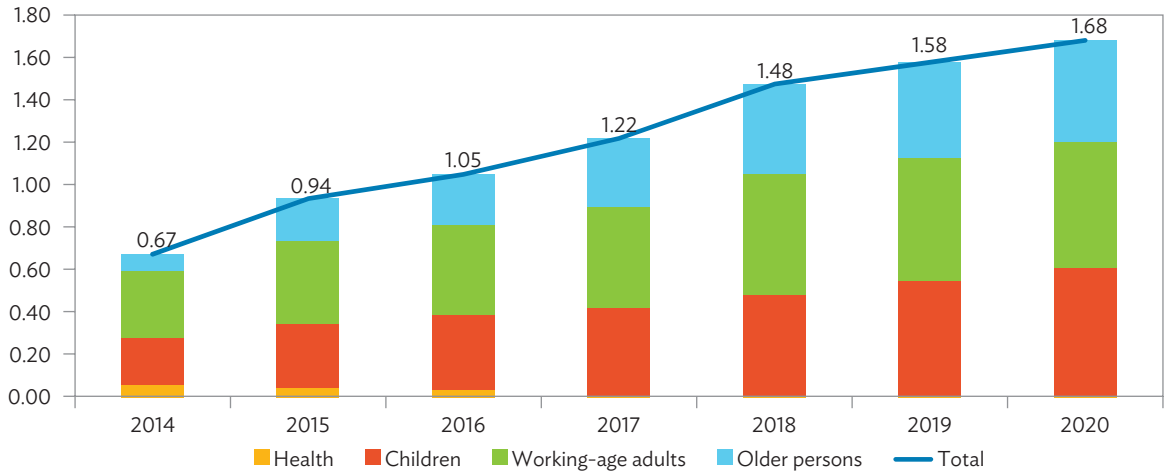
(i) A three-pillar pension system composed of
- a universal basic pension indexed to the cost of living;
- mandatory social insurance old-age pension coverage, with subsidized contributions for herders, the self-employed, and informal economy workers (50% subsidized by the state budget); and
- supplementary pension plans.

(ii) An integrated benefits and services package, including an LTC system for older persons, based on existing social welfare programs, to provide cash or in-kind assistance to poor older persons.

The UNSPWG estimates showed that it would have cost an additional 0.94% of GDP to achieve the agreed-upon social protection floor in Mongolia in 2015, and that would have risen to 1.68% by 2020, on top of the already-allocated social protection expenditures (Figure 10). Because universal social and health insurance has almost been achieved, additional investment would mainly reinforce the social protection, health, and nutrition of children; enhance the income security and employability of working-age persons; and ensure old-age protection. By 2020, the additional cost of completing a social protection floor would be spread as follows: 0.60%

for achieving the children's guarantee, 0.60% for the working-age persons' guarantee, and 0.48% for the older persons' guarantee.

Figure 10: Estimates of Additional Costs for Completing a Social Protection Floor, per Guarantee Type, as a Share of Gross Domestic Product, 2014–2020
(% of GDP)



GDP = gross domestic product.

Source: International Labour Organization. 2015. *Rapid Assessment Protocol Calculations*. Ulaanbaatar.

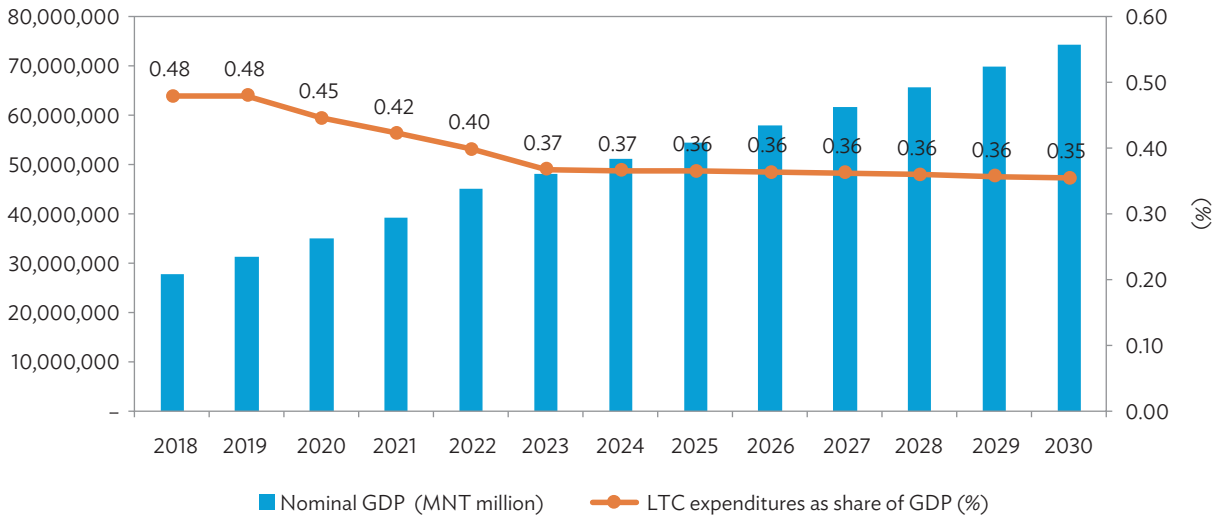
The UNSPWG further estimated that the total cost of a social protection floor in Mongolia would be around 4.7% of GDP in 2020, which would still fall below the global average public social protection expenditure rate of 6.0%.

For this country diagnostic study (CDS), the authors did a similar projection, specifically to gauge the LTC-related needs of older persons during 2018–2030, using the same model (Rapid Assessment Protocol) applied by the International Labour Organization (ILO). This projection was based on macroeconomics, population data, labor indicators, government social protection expenditures, service utilization targets, and service cost assumptions. Unlike the ILO projection for the social protection floor in 2015, the authors of this study used LTC service utilization by older persons based on the MOH data reported for the older persons with an independent, moderate, and severely dependent status in terms of activities of daily living (ADL). The projection also assumed a scenario in which older persons needing LTC would have full coverage. It should be noted, however, that demand for formal LTC services is not simply based on functional disability, but also on the LTC take-up rate, the availability of informal care, and the supply of LTC services, among other factors. Nevertheless, the authors' estimates are based on an ideal scenario that could be achieved if full-service coverage targets are reached for dependent older persons. Such targets would hopefully be clearer and more feasible once the government stakeholders agree on the conceptualization and development of LTC in Mongolia.

According to the projection done for this CDS, Mongolia would need to allocate 0.35% of its GDP to LTC by 2030, including social and health-care services for older persons. As under the previous Rapid Assessment Protocol model, this projection assumed that the ideal target of coverage for all older persons needing LTC would be achieved with the help of caregiver allowances, community-based services, relevant medical services at all

levels, and care providers. In particular, under the new Law on the Elderly (2017), primary health-care providers have become pivotal players in the LTC of older persons; hence, their costs should be properly factored in. In addition, it was estimated that about 5% of older persons who are dependent on others would be covered by nursing homes but, as of early 2020, this coverage was less than 1%.

Figure 11: Long-Term Care Expenditure as a Share of Gross Domestic Product, 2018–2030



GDP = gross domestic product, LTC = long-term care, MNT = togrog (Mongolian currency).
Source: Projection by the authors.

As can be seen in Figure 11, LTC expenditure as a share of GDP has been declining. This trend is at least partly explained by the fact that GDP growth is projected to rise to 6.4% per year, according to the available official estimates by the International Monetary Fund and Mongolia's Ministry of Finance.

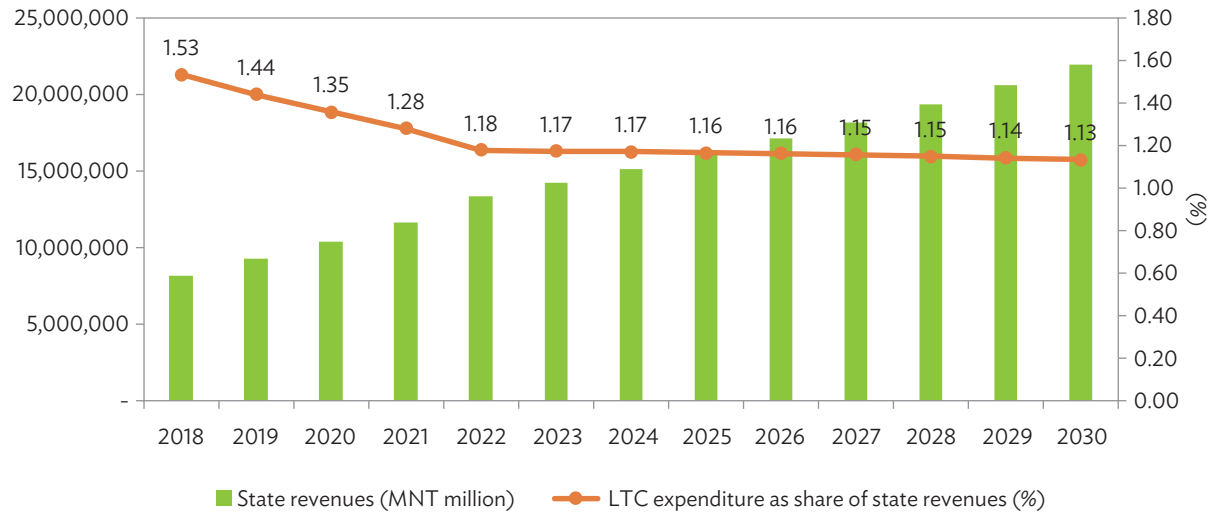
Further, the share of LTC in government revenues would have had to be 1.53% in 2018, based on the assumption that all older persons in need of LTC would be using those services. The level of coverage is expected to start stabilizing by 2022, with the share of government revenues at 1.13% by 2030 (Figure 12).

3.7.6 Current Debates on Long-Term Care Financing

A number of policies have been proposed regarding the financing of LTC for older persons in Mongolia. They include (i) addressing the income and poverty status of older persons through pension system reform and social welfare assistance; (ii) ensuring access to necessary medical and social services, including residential care centers, nursing homes, and rehabilitative care centers; and (iii) expanding the coverage by existing services such as primary health-care outreach and home services.

There is currently no comprehensive approach to LTC as a system. As a result, no dedicated financing system (including LTC insurance) has ever been discussed by stakeholders nor has any been proposed by the government.

Figure 12: Long-Term Care Expenditure as a Share of State Revenues, 2018–2030



LTC = long-term care, MNT = togrog (Mongolian currency).
Source: Projection by the authors.

The most important recent policy reform occurred in the form of the new Law on the Elderly, introduced in January 2017. Chapter 3 of this law focuses on the financing of services for older persons. This reform shows that both the government budget and the health insurance fund will continue to be the most important sources of funding for the LTC of older persons in Mongolia. Table 27 lists the funding sources as described in the Law on the Elderly.

As discussed, the government lacks a complete picture of how much the country spends on LTC in general. This is because the provider and functional classifications of LTC that are required for such estimates are nonexistent or blurred between or within sectors and institutions. In addition, there is a major data gap on private expenditure, i.e., out-of-pocket payments for LTC by individuals and families. A major reason for this gap is the absence of any conceptualization of LTC in government policies and strategies and, therefore, in institutional arrangements and the allocation of resources.

Despite these setbacks, Mongolia must start implementing the National Health Accounts in general and, more importantly, providing LTC expenditure estimates. This would help the government embark on evidence-based policymaking with regard to LTC, and would ensure the allocation of adequate resources.

In addition, the financing of future LTC should be discussed and clarified in government policies, as related expenditure is likely to grow due to various factors, including service expansion and increases in take-up, and the government budget alone might not be enough to carry the financial burden of LTC.

Table 27: Services under the Law on the Elderly of 2017, and Funding Sources

Services Specified in the Law on the Elderly		Funding Sources
7.1	The following types of services shall be provided to older persons:	Social welfare fund[a]
7.1.1.	Information and communication services	
7.1.2	Counseling services	
7.1.3	Mobile services	
7.1.4	Services provided during office hours	
7.1.5	Voluntary services	
7.1.6	Day care and nursing services	
7.1.7	Residential care services	
7.1.8	Food and nutritional support	
7.1.9	Protection from domestic violence and other risks	
8.1.2.	Subsidized vouchers for admitting older persons to a spa and sanatorium once a year	
8.1.3.	Annual pecuniary assistance in paying apartment rental if a senior citizen does not have a child to take care of him or her, or if it is determined that his or her legal caregiver is not able to provide the necessary support and assistance, or if a senior citizen is an honored donor senior citizen; and assistance in buying fuel if the senior citizen lives in an apartment without centralized heating or in a *ger*	
8.1.4.	Funeral cost support for deceased older persons not eligible under the Law on Social Insurance	
10.1.2.	One-way transportation fee and 50% of voucher fee once a year for rest and treatment of an honored donor senior citizen or senior citizen in unavoidable need of medical treatment and care in a domestic sanatorium or nursing center, according to the decision of a medical institution	
10.1.3.	Annual reimbursement for a one-way transportation fee if a senior citizen who resides 1,000 kilometers or more from the capital city is hospitalized or has a medical examination in the capital city, according to a decision by the physicians' commission of the local medical center	
10.1.5.	Allowance for emergency and livelihood support paid one time to disabled older persons in need of permanent care at home	
7.2.6.	Day care, nursing, rehabilitation care, and, when necessary, home care provided by *soum* (provincial district), villages, and family health centers	Health insurance fund
10.1.1.	Informative and educational activities organized by *soum*, village, and family health centers once a quarter for older persons on the prevention of diseases due to aging	
10.1.4.	Regular checkups of bedridden, chronically ill, and disabled older persons conducted by *soum*, village, and family health centers, which would also provide mobile nursing services with a team including a senior physician, nurse, and trained volunteer worker	

[a] The social welfare fund covers social welfare pensions and benefits and social welfare services specified under the Law on Social Welfare of 2012 (revised version).

Source: Government of Mongolia. Law on the Elderly of 2017.

IV. DISCUSSION AND COMMENTARY

4.1 Limitations of Findings and Major Knowledge Gaps

Most of the findings of this CDS relied on official government statistics, including information on population, aging, and the care of older persons from the National Statistics Office (NSO), including census information and data from a household statistical booklet and regular household surveys; the MOH; the National Gerontology Center; and the General Office for Social Welfare Services (GOSWS). However, as with any such statistics, the authors faced issues of delayed data reporting, poor coverage, and the questionable quality and reliability of available data. Such situations have been noted where encountered, but it is worth reiterating some of these below.

There were particular difficulties with the data from the Center for Health Development on the assessment of the health and physical condition of older persons. In 2010, the center introduced formal approaches and methodologies for assessing the physical well-being and health condition of older persons. The official health statistics compiled from these assessments are available from 2015. Although there are guidelines for covering all older persons, this CDS could utilize the assessment data for only 38.7% of the total number of people aged 60 and above in Mongolia in 2016. It is expected that, over time, the Center for Health Development data will show a full picture of the entire older population. However, as of early 2020, the data on the remaining population of older persons have not been estimated or studied.

On the whole, Mongolia lacks data on LTC due to the fragmentation and segmentation that exist across and within the social and health sectors. Thus, the authors of this CDS relied on the few available studies related to population aging and the health situation of older persons. For example, only a few small-scale studies were available on the psychological needs, loneliness, social networks, depression, and other factors affecting the quality of life of older persons, including the environment. Unfortunately, there are no data available that could elucidate the situation, especially with regard to the existing and projected care needs that involve important socioeconomic dimensions, including the disparity between urban and rural areas and in the income levels of older persons. Such disparities, especially the urban versus rural, are very important in the Mongolian context.

In terms of care providers, information about the number of people working at formal care centers, hospitals, and other institutions could be gathered through administrative data. However, there are no data on the number of informal care providers in the country, even from government ministries.

Older persons have expressed their views regarding the knowledge of, and attitudes toward, their concerns on the part of others. But older persons' views have not been investigated from the perspective of other stakeholders, including, for example, policymakers, care providers, and the younger generation.

Efforts to forecast expenditure on LTC for older persons have also revealed a number of key limitations. The first is the fact that the types and categories of LTC services are not well defined in Mongolia, so the projection offered in this CDS is based only on current services, which largely consist of medical, social, community-based services; residential care services; and allowances to informal caregivers; as well as other services specified under the Law on the Elderly. This means that some LTC services, such as those involving home care and respite care, are not reflected in the analysis. Second, data on the target for LTC service coverage are based on the assumption of full coverage for those older persons assessed to be in need of LTC. However, a projection would need to be done for at least three different scenarios if it is to reflect the practical realities of availability and accessibility for older persons. The third limitation relates to the number of older persons assessed by others as being in need of LTC or as severely dependent in terms of the activities of daily living (ADL) and/or the instrumental activities of daily living (IADL). Although Mongolia has initiated a new approach to assess and address the LTC needs of its older population, the implementation of this new system will require some time to deliver reliable statistics. Thus, the baseline data of the LTC needs of older persons, as well as any forecasting based on population growth patterns, might not produce an entirely true picture.

With respect to knowledge gaps, stakeholder interviews conducted during the qualitative survey for this CDS showed that the concept of LTC is not widely integrated into government policies and strategies, and so is not clearly understood by stakeholders, including policymakers and older persons' groups.

4.2 SWOT Analysis of Long-Term Care

Below is an analysis of the key strengths, weaknesses, opportunities, and threats (i.e., SWOT) with regard to LTC in Mongolia.

Key Strengths

- There has been a general recognition of the issues affecting older persons, as well as a commitment to addressing these issues, by the government and major political parties.
- The Law on the Elderly has been approved, and other policies and strategies have been laid out regarding healthy and active aging and care for older persons.
- A progressive policy on cash allowances for caregivers has been implemented to encourage the further development of an informal family-based caregiver system.
- The health service delivery system is accessible at all administrative levels, and attempts have been made to train professionals in geriatric care.
- Internationally used assessment tools have been introduced in Mongolia to identify older persons in need of care, including LTC.

Key Weaknesses

- There is no national policy or legislation specifically on LTC.
- Mongolia's strategies and programs on aging have been poorly implemented, especially the National Strategy on Aging (2009–2030) and the National Program on Healthy Aging and Health of Older Persons (2014–2020).
- There is a lack of understanding and information about LTC among key medical and social sector professionals and policymakers.
- The government does not provide effective oversight, coordination, or cooperation among its agencies.

- The participation of government agencies in other sectors is poor, except for the MOH and the Ministry of Labor and Social Protection (MLSP).
- Mongolia's civil society groups have poor capacity for addressing issues related to LTC for older persons.
- The health system is burdened with a poor institutional capacity for delivering LTC, as well as an inadequate nurse-to-doctor ratio.
- Service delivery guidelines are poorly enforced, and there is a lack of quality monitoring.
- Care for older persons in Mongolia is over-medicalized.
- The medical schools and other university programs lack LTC courses.
- The funding to implement the laws and strategies on care for older persons is inadequate.
- There has been a poor use of potential opportunities for LTC, including those involving community-based services.

Key Opportunities

- The government's action plan for the older population should be used to enable more funding opportunities, including external projects.
- An international or external focus on aging would increase knowledge and awareness of aging and LTC issues among policymakers.
- Frontline health-care personnel and social workers should receive training in LTC.

Key Threats

- There is the problem of fragmentation and overlapping of efforts among government line ministries.
- Participation and commitment on the part of the infrastructure and housing sectors have been poor.
- There is no dedicated financing system or fund for the implementation of LTC policies.
- The service delivery workforce is burdened with low salaries and a poor incentive system.
- There is always the potential for the over-medicalization of the LTC workforce.
- The dominance of institutional care as the key service delivery model for LTC could hinder reform.
- The staff turnover rate at the relevant government agencies is high.

4.3 The Current Debate on Long-Term Care Reform

The development of a clear understanding of the need for LTC is only at a nascent stage in Mongolia. Therefore, LTC policy debates and options appear only on an ad hoc basis. But discussions are taking place on how to improve the well-being of older persons and on relevant policies and laws, and these discussions are well supported by decision-makers when engaged in by line ministries and interest groups. The quality of such debates and policies has thus been strongly affected by the capacity of the professional community and interest groups, although the latter play only a limited role.

The recent approval of the Law on the Elderly (2017) is one example of a reform that was successfully promoted by professionals and interest groups. The law recognizes the nine types of services offered to older persons, and, in doing so, addresses the important aspects of LTC. More specifically, the law defines the following LTC services:

- outreach services such as cleaning, fuel preparation, cooking, laundry, and essential nursing services;
- for older persons who need permanent care: day care, nursing care, rehabilitative care, and, when necessary, home care, to be organized by primary health-care providers; and
- nursing home services for older persons.

Furthermore, the institutions that will be responsible for providing these LTC services have also been defined, at least to some extent. For example, the Law on the Elderly and the revised Health Act (2016) proposed that

- the state provide financial support to privately owned nursing homes, and that the Ministry of Finance and the MLSP endorse related regulations;
- an "older persons' center" be established by local government and nongovernment organizations (NGOs) at the *soum*, *khoroo*, and *bagh* levels, and that they provide counseling, mobile, and day services;
- citizens and organizations that want to volunteer to help older persons should be supported; and
- nursing homes provide inpatient care for older persons, chronically ill patients, and persons with disabilities (PWDs) in need of permanent nursing care.

Moreover, there is growing pressure to train more geriatric specialists and to retrain primary health-care providers in the care of older persons. The National Gerontology Center piloted a multidisciplinary team of care providers in 2007 to address the varying needs of older persons who required care. The team, which is still in operation, includes geriatricians, geriatric nurses, physiotherapists, social workers, and nutritionists. As this approach has proven to be effective, it is in popular demand, so the government intends to support it and expand it to a broader level.

V. POLICY IMPLICATIONS

5.1 Policy Conceptualization of Long-Term Care

There is no explicit policy or strategy regarding LTC in Mongolia. The concept and elements of LTC appear to be fragmented, straddling the social and health sectors, and to exclude other important systems such as infrastructure and housing. Therefore, Mongolia needs to develop a national LTC framework and holistically define the vision and the values underpinning its LTC system.

In this regard, the government must clearly delegate the responsibility for coordinating inputs and for integrating consultations into LTC policymaking. The resulting strategy and action plan would establish national priorities for LTC, its objectives, and measurable targets.

Mongolia's weak system of governance on aging and the care of older persons appears to be one of the main obstacles, and this weakness needs to be addressed at the political level through wider consultations between government and nongovernment stakeholders. Moreover, different government ministries could be responsible for different aspects of the strategy and action plan, but an interministerial coordinating body should also be established, or some other mechanism for tracking the progress of implementation.

There should also be a strong emphasis on the implementation of the Law on the Elderly (2017). Overall, there is a need to promote a wider dissemination of information, as well as education and debate, about LTC, so that informed opinion can lead to effective policymaking.

5.2 Long-Term Care Services and Care Provision

The increasing proportion of older persons in the population will certainly require correspondingly increased care services compared with what is currently offered. Thus, the current services need to be reviewed and assessed thoroughly. And the comprehensiveness, extent of coverage, and quality of the services now available should be improved in line with the increasing care needs of older persons, and with developments and innovations in Mongolia and globally.

To effectively address the diverse care needs of older persons, the instruments and tools currently being used to assess the physical and mental abilities of older persons need to be further studied and evaluated. Doing so will also ensure cross-sectoral acceptance of their implementation and usage. In addition, care strategies and plans for older persons need to take into account such factors as the feminization of the older population and the higher percentages of older women with ADL and IADL difficulties and mental health issues.

There is a need to raise awareness among both the public and policymakers of the practical and psychological impacts on older persons of being left alone when their adult children and grandchildren move to the city, and of the need to provide support for them and plan for the future.

Furthermore, during interviews conducted for this CDS, older persons often mentioned the problem of age discrimination. Policymakers should be made aware of the existence of age discrimination and the stereotyping of older persons. They should work to foster attitudes of respect and concern, and introduce legislation to prevent age discrimination and to protect the rights of older persons in general. Actually, age discrimination intersects with gender discrimination, so all policies and plans should be analyzed from the perspectives of both gender and age.

Different models of service delivery should be developed for older persons in urban settings, on the one hand, and in rural and remote areas, on the other. It is clear from the findings of this CDS that a policy of creating accessible day care centers in urban communities would be strongly welcomed and could serve several functions such as providing basic health and social services. Younger and fitter older persons could play a vital role in running these centers. However, delivering day care services to older persons in rural areas or sparsely populated environments will present challenges, as it is impractical to transport all the older persons in an area to one location, or to expect their families to take them there on a daily basis, considering the vast distances in Mongolia. Therefore, a different approach and service modality would have to be employed to address the care needs of older persons in rural Mongolia. Globally, there may be good practices and better ways to respond to this issue that Mongolia can learn from—for example, the availability and use of appropriate technologies.[23] Another key approach might be to improve the accessibility and quality of existing services such as rehabilitative sanatorium services, and to support the temporary summer *ger* camps in rural areas, where older persons can stay over a period of time and communicate and engage with one another. Therefore, it would be beneficial to provide resources for the design, piloting, and evaluation of different innovative LTC models based on experiences in Mongolia and around the world.

Nevertheless, the tradition of family members caring for older persons needs to be encouraged and supported. Family caregivers require financial and practical support, as well as information that will help them deliver an adequate level of care to older persons. The availability of planned and emergency respite care, adult day care centers, and at-home care support could make it possible for family members to continue providing care for older persons.

There is some evidence that loneliness can negatively affect health outcomes and functional ability. This is a greater problem among older women due to widowhood and the feminization of aging, although older men living alone often have more difficulty coping with loneliness. Efforts to reduce loneliness are likely to coincide with efforts to increase the availability of community-based care services such as day care centers, or approaches such as strengthening summer *ger* camping activities in rural areas, as mentioned above. Another feasible approach, specifically for urban or semi-urban areas, might be to establish community groups or expand the functions of existing ones, such as those of the Mongolian Association of Elderly People, which currently has 255,000 members in 2,400 units at the council level and 4,000 units at the company level. These units exist in all 330 *soums,* in all 21 *aimags*, and in all 9 *düüregs* in Ulaanbaatar. Such groups may already help reduce the loneliness of their active members, but they could expand to provide health or care support, by inviting health-care workers to give checkups or by organizing volunteer-based care, as is done in some Southeast Asian countries (e.g., intergenerational self-help clubs in Viet Nam).

[23] For more information on the use of technology in LTC, see UNESCAP Nanjing expert consultation conference report. Available at http://www.unescap.org/events/regional-expert-forum-integrated-care-older-persons. An unpublished paper was presented on the topic of use of technology for LTC.

The lack of accessibility to disease prevention and treatment services needs to be addressed. Policies and strategies should be developed to bring prevention, screening, and treatment services closer to where older persons live, and to move away from over-medicalization and hospitalization. For instance, research for this study showed that almost one in four older adults is either overweight or obese, which means that they have a high risk of noncommunicable diseases such as hypertension, diabetes, and stroke. The prevention of such illnesses through activities that promote changes in lifestyle, and that address other risk factors, is highly recommended, as they are cost-effective and can bring other benefits to individuals and to society. One such lifestyle change might be an emphasis on healthy nutrition, which is important throughout life. Older persons could be trained as peer educators in good nutrition and healthy eating, and could be influential in their families and communities. In addition, the existing health clubs for older persons need to be supported, as they can promote physical exercise and other preventive activities.

The various components and stages of LTC are provided by different types of social and health-care options, including residential care facilities, primary health-care providers, outpatient clinics, general hospitals, sanatoriums, single-specialty centers, specialty hospitals, and nursing care centers. Thus, the capacity of all kinds of care providers must be studied, taking into account the LTC needs of the population.

Sometimes, a residential care facility is needed, and it is likely to remain one of the major LTC service models in Mongolia. There should be discussions among policymakers about the different models of residential care, with an emphasis on smaller facilities that are situated close to people's own communities. In both wealthy and lower-income countries, the older persons in residential care are at risk of neglect and poor-quality services, so it is essential to develop clear standards and to have regular inspections to enforce those standards. Moreover, experiences elsewhere show that locating residential care facilities for older persons close to children's day care centers can benefit both groups.

With the aging of the population, it is important to address related challenges such as dementia, and to develop the capacity to diagnose and treat the mental and cognitive impairment of older patients. The care of persons with dementia in mental health institutions needs to be reevaluated, as it may not be the best solution. Dementia-related issues should be a part of the public health framework (which is structured around awareness, risk reduction, diagnosis, and support for caregivers).

Efforts to reform and strengthen rehabilitative and nursing care for older persons deserve the full support of decision-makers in the form of greater allocations of resources, such as increased funding or training for more workers. For example, guidelines for nurses on caring for older patients would be a good start toward streamlining and standardizing LTC. But broad-based policy support would be needed for the effective implementation and enforcement of such guidelines.

The findings of this study show that older persons with chronic conditions have difficulty obtaining an uninterrupted supply of medicines. This problem should be addressed as a weak link in the management of chronic conditions. When medications for common chronic conditions such as diabetes or hypertension are not taken regularly, these conditions could worsen. Ensuring a regular, affordable, and accessible supply of properly labeled medicines will save money in the long run by reducing the disabling complications of chronic conditions.

Although Mongolia has a history of promoting good-quality health care, the health sector is beset with problems for both clients and care providers. The quality of health care and social services must therefore be improved through interventions such as the enforcement of guidelines and best practices through (i) efficient and systematic monitoring, (ii) financial and nonfinancial incentives, and (iii) support for frontline health-care professionals and social workers.

Road traffic injuries are common among older persons in Mongolia, and this is true for other countries as well. Transport authorities need to address the issue of the safety of older pedestrians, who are usually disproportionately represented in the incidence of road traffic injuries; and these figures should be monitored.

5.3 Human Resources and Long-Term Care

Trained human resources personnel are key to ensuring good-quality and accessible LTC services for older persons, but human resources departments concerned with LTC are too medically oriented in Mongolia, so there is a lack of staff trained to meet other LTC needs. For example, day service caregivers, respite caregivers, and trained community-based service providers appear to be nonexistent in Mongolia. Informal caregivers (e.g., family members) constitute the bulk of the LTC workforce. Thus, the training, recruitment, and retention of formal frontline and informal caregivers should be the key to human resources management for LTC.

In the short to medium term, for the sake of ensuring efficiency, training programs need to be modified and medical workers retrained to fill skill-set gaps in LTC. Training programs should address the needs of primary health-care workers, social workers, community-based volunteers, NGO staff, and of the older persons themselves. Mongolia must also revise the job descriptions of primary health-care providers and retrain them in essential LTC skills geared to the care of older persons, as they are currently the first point of contact for people with LTC needs.

It is important for policymakers to discuss and decide which types of personnel will be appropriate for taking on caring roles, including those involving home visits and day care, and to develop job descriptions, a career structure, and a management and coordination plan. The policy of relying heavily on geriatric care specialists needs to be reviewed, and a plan to retrain existing frontline workers such as primary health-care workers needs to be implemented. The numbers that will have to be recruited, trained, and deployed should be estimated using evidence-based projections, and closely monitored as care needs increase. Both men and women should be recruited and trained, so that older persons can receive personal care from a worker of the same gender.

5.4 Financing

The government should do estimates of LTC expenditure using the country's National Health Accounts statistics. Such estimates will show the overall picture of LTC, and they could inform future policies for meeting the care needs of older persons. In addition, there should be policy debates on LTC financing, as the growing older population and the corresponding increase in care needs are unlikely to be adequately addressed within the existing fragmented financing model of the government's budget and social health insurance program.

5.5 Poverty and Gender Analysis

According to the latest Household Socio-Economic Survey data (2018), 28.4% of the population (904,900 people) lives below the poverty line, and many poor families have older members; in fact, 20.7% of households headed by an older person are poor.

The survey also found that one out of six people in Mongolia lives in a household headed by a woman, a proportion that increases to one out of five in urban areas, and decreases to one out of eight in rural areas.

Almost equal proportions of households led by men and women are observed among the poor. These results must be treated with caution, however, as they involve comparisons of families with very dissimilar structures. Three demographic features of the households may illustrate this point. First, almost seven of every 10 female heads are widowed, divorced, or separated, while more than nine out of 10 male heads are married. Second, the average size of households headed by women (three members) is smaller than that of households headed by men (four members). And, third, a substantial age difference is observed by gender, as the female heads are, on average, 8 years older than the male heads.

Table 28: Population and Household Profiles, by Area of Residence and Sex, 2016

Item	National		Urban		Rural	
	Female	Male	Female	Male	Female	Male
Proportion of households with single heads, of either gender (%)	30.3	29.5	30.0	26.3	31.6	35.4
Poverty gap[a]	8.3	7.6	8.4	6.9	7.8	9.0
Proportion of the population (%)	19.3	80.7	22.2	77.8	13.3	86.7
Proportion among the poor (%)	19.8	80.2	24.5	75.5	12.0	88.0
Average household size (members)	2.7	3.7	2.9	3.8	2.3	3.7
Household dependency ratio (%)[b]	49.1	39.2	46.6	39.7	56.2	38.2
Children (% of household size)	20.4	27.2	21.6	27.5	17.2	26.5
Average ages of household heads	51.5	43.8	50.3	43.9	55.0	43.5
Married, living together (%)	16.4	92.8	10.0	91.8	15.0	92.4
Widowed, separated, divorced (%)	72.3	4.5	76.4	4.4	73.2	4.5

[a] The poverty gap is a ratio showing the average shortfall of the population relative to the poverty line, which is the minimum income needed to obtain the basic necessities of life (the nonpoor are counted as having a zero shortfall).

[b] The household dependency ratio is the ratio of the number of nonworking-age household members (aged 0–14 and over 65) to the number of working-age household members (aged 15–64). In this table, the values shown are the average percentages of nonworking-age members (presumed to be dependents) in the types of households shown here.

Source: National Statistics Office. *Poverty Profile 2016, Household Socio-Economic Survey 2016*. Ulaanbaatar.

In general, women constitute the majority of the older population (58% female vs. 42% male), and even more of the population of oldest olds (61% vs. 31%). A higher proportion of older women than older men are "single," that is, unmarried (3.2% vs. 2.8%) or widowed (62.7% vs. 24.4%). Moreover, older women face a higher incidence of disability (53% vs. 47%), fewer opportunities for productive employment (4.8% vs. 13.1%), and a higher prevalence of difficulties with ADL (57% vs. 43%) and IADL (55% vs. 45%) (Tables 8 and 9). As older women tend to be less secure in terms of finances, care, and support, they are more vulnerable than older men.

The greater levels of poverty and poorer socioeconomic situations for older women than for older men should be addressed. And there should be policies to increase the availability of flexible work for women. Also, social welfare projects—including community-based programs in which active older persons provide services such as shopping, cooking, and cleaning for dependent older persons for a small fee—should be encouraged and facilitated.

5.6 Conclusion

This report highlights the current LTC situation in Mongolia. The recommendations included in this section should be followed by a more detailed planning process to support the development of an LTC system that provides needed care, ensures equity, and functions efficiently. This report recommends that home and community-based care should be the primary approach for formal services, not only for older persons with mild or moderate ADL or IADL limitations, but for everybody except the minority who truly need residential care or hospitalization. This will require an expansion of formal care support, as well as support for individuals and informal caregivers. Solutions are also needed for supporting the care of older persons living in rural areas, particularly those with nomadic and seminomadic lifestyles. The delivery of integrated care would benefit from a single point of entry, as would case management, and particularly the coordination of the health and social systems. Improved accessibility to needed medicines, assistive devices, and equipment would also improve the lives of many older persons.

The development of such a system would require government leadership on strategy, oversight, planning, and the quality of overall management; it would also require inter-sectoral and multi-stakeholder engagement. As Mongolia's population ages and need for care grows, prioritizing LTC system development will be necessary to ensure that the care needs of the population are met. An efficient system will reduce the fiscal burden, and the resulting expansion of the health sector could have positive impacts in terms of job creation and macroeconomic growth.

GLOSSARY

The terms below have been adapted from a number of sources. Those which are directly taken from the *World Report on Ageing and Health*, published by the World Health Organization (WHO) in 2015, are referenced as "WHO 2015."

accessibility	Describes the degree to which an environment, service, or product allows access by as many people as possible (WHO 2015).
activities of daily living (ADL)	The basic activities necessary for daily life, such as bathing or showering, dressing, eating, getting in or out of bed or chairs, using the toilet, and getting around inside the home (WHO 2015).
adult day care	Medical or nonmedical care on a less than 24-hour basis, for persons in need of personal services, supervision, protection, or assistance in sustaining daily needs, including eating, bathing, dressing, ambulating, transferring, toileting, and taking medications (California Code Insurance Code, 2018, Section 10232.9).
aging in place	Supporting older persons to live in their homes and communities safely, comfortably, and independently.
Alzheimer's disease	The most common cause of dementia. It destroys brain cells and nerves disrupting the transmitters that carry messages in the brain, particularly those responsible for storing memories (Alzheimer's Disease International. Alzheimer's disease). See: dementia
assessment	A systematic process to collect information on care needs of older persons, based on a set of predefined concepts and data categorization to guide care planning. Clinicians or trained professionals typically use assessment to evaluate the physical, cognitive, and functional care needs of older persons and rank their levels of impairment (OECD/European Union. 2013. *A Good Life in Old Age? Monitoring and Improving Quality in Long-term Care*). See: comprehensive assessment

assisted living	Accommodation for adults who can live independently but require regular help with some daily activities: hospitality services, personal care, home care. Usually available through subsidized or private-pay operators. Alternatives: extra-care housing
assistive technology (or assistive devices)	Any device designed, made, or adapted to help a person perform a particular task; products may be generally available or specially designed for people with specific losses of capacity; assistive health technology is a subset of assistive technologies, the primary purpose of which is to maintain or improve an individual's functioning and well-being (WHO 2015).
care coordination	The provision of care that coordinates various services around an individual. Typically, it involves a "care coordinator" who ensures goals agreed with the individual are achieved through effective delivery of care by appropriate agencies. Care coordination is most appropriate for older persons who are supported by a high number of different agencies, or who have complex needs. See: integrated care
care services	Services provided by others to meet care needs.
care setting	The place where users of care services live, such as in the home and the community, nursing home, assisted living facilities/sheltered housing or private homes, care at home and in the community.
caregiver	A person who provides care and support to someone else; such support may include • helping with self-care, household tasks, mobility, social participation, and meaningful activities; • offering information, advice, and emotional support, as well as engaging in advocacy, providing support for decision-making and peer support, and helping with advance care planning; • offering respite services; and • engaging in activities to improve the patient's intrinsic capacity. Caregivers may include family members, friends, neighbors, volunteers, care workers, and health professionals (WHO 2015).
case management	Collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs (Case Management Society of America. *What Is A Case Manager?*). See: integrated care

catastrophic expenditure	A term used to describe high levels of out-of-pocket expenditure on essential services (e.g., health and social care).
community care	Services and support to help people with care needs to live as independently as possible in their communities (Better Health Channel. Carer Services and Support).
complex care	Complex care requires a higher level of personal assistance often requiring 24-hour supervision, personal nursing care, and/or treatment by skilled nursing staff (Government of British Columbia. Long-Term Care Services).
comprehensive assessment (CA)	A multidimensional process that incorporates an in-depth assessment of a person's physical, medical, psychological, cultural, and social needs, capabilities and resources, and is inclusive of carers (Victoria State Government. Assessment Process).
compression of morbidity theory	Conceptualized by James Fries. The theory that increasing longevity can be accompanied by shorter periods of chronic disease and disability. Under this theory, people live longer and healthier lives (J. Fries. 2003. Measuring and Monitoring Success in Compressing Morbidity. *Annals of Internal Medicine*. pp. 139, 455–459).
dementia	A loss of brain function that affects mental function related to memory impairment, low level of consciousness and executive function. The most common form of dementia is Alzheimer's disease (National Institute on Aging. What Is Dementia? Symptoms, Types, and Diagnosis).
demographic dividend	Refers to a period—usually 20–30 years—when fertility rates fall due to significant reductions in child and infant mortality rates. The proportion of nonproductive dependents reduces and is often accompanied by an extension in average life expectancy that increases the portion of the population that is in the working-age group (A. A. M. Shohag. 2015. Demographic Dividend: Reality and Possibility for Bangladesh. *The Independent*. 22 August).
dependency	The need for frequent human help or care beyond that habitually required by a healthy adult. Alternatively, the inability to perform one or more activities of daily living and instrumental activities of daily living without help (Alzheimer's Disease International. 2013. *World Alzheimer Report 2013. Journey of Caring: An Analysis of Long-Term Care for Dementia*). Disability may be a cause of dependency, but many disabilities can be managed without frequent human help. Dependency can be categorized on a scale or in categories with a very small amount of people being considered totally dependent.

dependency ratio	The ratio of dependent people (older persons and children) to working-age people (aged 15–64). May be split into old-age dependency ratios and child dependency ratios (B. Mirkin and M. B. Weinberger. 2001. *The Demography of Population Ageing*).
disability	Disability is an umbrella term, covering impairments, activity limitations, and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations (WHO definition).
eligibility	Entitlement of an individual to access the programs or services funded directly or indirectly by the government. Often determined on the basis of income or severity of dependency.
environment	All the factors in the extrinsic world that form the context of an individual's life; these include home, communities, and the broader society; within these environments are a range of factors, including the built environment, people and their relationships, attitudes and values, health and social policies, and systems and services (WHO 2015).
environmental hazards	Hazards associated with one's living environment, in and outside the home. Hazards may be objective (real, observable), e.g., lack of electricity; or subjective (simply based on perception), e.g., anticipation of risk such as high crime rate in the neighborhood.
evidence based	Professional practice that is based on a theoretical body of knowledge, empirically evaluated, and is known to be beneficial and effective for the client.
filial piety	The virtue of respect for one's father, elders, and ancestors. In the care context, it relates to the obligation of children to care for their parents, directly and indirectly (through material means).
formal care	The divide between formal and informal care differs between countries. Generally it is determined based on whether the individuals providing care are paid or unpaid, trained or untrained, and/or organized or unorganized. Formal care can take place in the home (home help, home care, home nursing), the community (adult day care, respite care), or in residential care (nursing home, residential care home, hospice care). See: informal care
functional ability	The health-related attributes that enable people to be and to do what they have reason to value; it is made up of the intrinsic capacity of the individual, relevant environmental characteristics, and the interactions between the individual and these characteristics (WHO 2015).

functioning	An umbrella term for body functions, body structures, activities, and participation; it denotes the positive aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environmental and personal factors) (WHO 2015).
health literacy	The skills and information to allow people to better manage and improve their health.
healthy aging	The development and maintenance of optimal mental, social, and physical well-being and function in older adults. This is most likely to be achieved when communities are safe, promote health and well-being, and use health services and community programs to prevent or minimize disease (New Mexico Department of Health. *Healthy Aging*). Alternatives: active aging
healthy life expectancy	The average number of years that a person can expect to live in "full health," excluding the years lived in less than full health due to disease and/or injury (WHO definition).
home- and community-based care	Services that support older persons continue to live in their own homes and communities (National Institute on Aging. *Aging in Place: Growing Older at Home*). See: aging in place
home care	Help with personal care (see activities of daily living) and basic household tasks (see instrumental activities of daily living) such as light housekeeping, laundry, basic shopping, meal preparation, household management; and reminders for personal care and medication (Joint Commission Resources and Joint Commission on Accreditation Health. 2012. *Standards for Home Health, Personal Care and Support Services, and Hospice: 2012*. Illinois: Joint Commission Resources. p. 168). Alternatives: domiciliary care or home help (usually involves less personal care)
hospitality services	Refers to services such as meal services, housekeeping services, laundry services, social and recreational opportunities, and a 24-hour emergency response system (The Community Care and Assisted Living Act of Canada. 2002. Definition).
impairment	A loss or abnormality in body structure or physiological function (including mental functions); in this report, abnormality is used strictly to refer to a significant variation from established statistical norms (that is, deviation from a population mean within measured standard norms) (WHO 2015). See: disability

independent living	Housing for seniors that may or may not provide hospitality services. In this living arrangement, seniors lead an independent lifestyle that requires minimal or no extra assistance (J. R. Pratt. 2016. *Long-Term Care: Managing Across the Continuum*. 4th ed. MA: Burlington. p. 180).
informal care	Care provided by spouses and partners; other members of the household; and other relatives, friends, and neighbors. Informal care is usually provided at home and is typically unpaid and not part of an organized service delivery system (OECD. 2005. *Long-term Care for Older People*). See: formal care
institutional care	Long-term residential care provided within an institutional setting, usually a nursing home, care home, or, less commonly, a hospital or hospice. Institutional care comprises 24-hour care and accommodation and may include the provision of meals, personal care and supervision, and nursing care (OECD. 2007. *Health at a Glance 2007, OECD Indicators*).
instrumental activities of daily living (IADL)	Activities that support independence but are not fundamental to survival; including housework, meal preparation, shopping, accounting, medication management, and transportation.
integrated care	A concept bringing together inputs, delivery, management, and organization of services related to diagnosis, treatment, care, rehabilitation, and health promotion. Reflects a concern to improve patient experience and achieve greater efficiency and value from health delivery systems (O. Groene and M. Garcia-Barbero. 2001. Integrated Care: A Position Paper of the WHO European Office for Integrated Health Care Services. *International Journal of Integrated Care*. 1 June). See: care coordination
international classification of functioning, disability, and health	A classification of health and health-related domains that describe body functions and structures, activities, and participation; the domains are classified from different perspectives: body, individual, and societal; because an individual's functioning and disability occur within a context, this classification includes a list of environmental factors (WHO 2015).
intrinsic capacity	The composite of all the physical and mental capacities that an individual can draw on (WHO 2015).
long-term care	Long-term care is defined by WHO in the *World Report on Ageing and Health* (2015): Long-term care is "the activities undertaken by others to ensure that people with or at risk of a significant ongoing loss of intrinsic capacity can maintain a level of functional ability consistent with their basic rights, fundamental freedoms and human dignity."

out-of-pocket expenditure	Payments for goods or services that include (i) direct payments, such as payments for goods or services that are not covered by any form of insurance; (ii) cost sharing, which is a provision of health insurance or third-party payment that requires the individual who is covered to pay part of the cost of the health care received; and (iii) informal payments, such as unofficial payments for goods and services, that should be fully funded from pooled revenue (WHO 2015).
palliative care	An approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual (WHO definition).
pay-as-you-go	A financing model where contributions (through social insurance or specific tax) are collected and then used to pay for current expenditure rather than saved for future expenditure (i.e., not fully funded schemes).
person-centered approach	An approach to care that consciously adopts the perspectives of individuals, families, and communities, and sees them as participants as well as beneficiaries of health care and long-term care systems that respond to their needs and preferences in humane and holistic ways; ensuring that people-centered care is delivered requires that people have the education and support they need to make decisions and participate in their own care; it is organized around the health needs and expectations of people rather than diseases (WHO 2015).
personal care	Assistance that helps an older person to remain independent. May be provided formally or informally and may be related to (iii) activities of daily living; eating, mobility, dressing, grooming, bathing, or personal hygiene; (iv) medication; distribution of medication, administration of medication, or monitoring of medication use; (v) maintenance or management of the cash resources or other properties of a resident or person in care; or (vi) monitoring of food intake or of adherence to therapeutic diets. (The Community Care and Assisted Living Act of Canada. 2002. Definition.) Alternative: personal assistance
private-pay	Services that are paid for completely by elderly care service users.
public–private partnership	A government service or private business venture that is funded and operated through a partnership of government and one or more private sector companies (Sawhney, U. 2014. Chapter 9: Public Private Partnership for Infrastructure Development: A Case of Indian Punjab. In U. Hacioğlu and H. Dinçer. *Globalization and Governance in the International Political Economy*. Panjab University, Chandigarh, India).

publicly subsidized	Service users with higher incomes pay up to a maximum amount based on comparable private services. Service users who receive income assistance may pay a predetermined set rate (Government of British Columbia. *Publicly Subsidized or Private Pay Services*).
rehabilitation	A set of measures aimed at individuals who have experienced or are likely to experience disability to assist them in achieving and maintaining optimal functioning when interacting with their environments (WHO 2015).
residential care	Refers to a wide range of housing options aimed at older persons; including nursing and care facilities (other than hospitals) and senior housing. Typically for older persons with care needs who require frequent personal care or close access to support. In some countries, the term residential care is used to cover institutions that essentially provide shelter to people without the economic means or family support to live independently. See: assisted living
resilience	The ability to maintain or improve a level of functional ability in the face of adversity through resistance, recovery, or adaptation (WHO 2015).
self-care (or self-management)	Activities carried out by individuals to promote, maintain, treat, and care for themselves, as well as to engage in making decisions about their health (WHO 2015).
social care	Assistance with the activities of daily living (such as personal care, maintaining the home) (WHO 2015).
social pension	Noncontributory cash income given to older persons by the government). May be universal (cash income given to all older persons, regardless of their socioeconomic status) or means-tested (solely for the poor and are conditional on the level of income). Some countries use alternate terms such as "old age allowance" or "social assistance," reserving the term "pension" for civil servant pensions and contributory schemes.
transitional care	Refers to the coordination and continuity of care during a movement from one care setting to another or to the home.
universal design	Broad-spectrum ideas for producing buildings, products, and environments that are inherently accessible to older persons, and to people with and without disabilities. Principles of universal designs are equitable use, flexibility in use, simple and intuitive, perceptible information, tolerance for error, low physical effort, and size and space for approach and use (National Disability Authority. *What is Universal Design*). Alternative: inclusive design

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Country Diagnostic Study on Long-Term Care in Mongolia

This publication presents findings of a study on the availability and provision of long-term care (LTC) in Mongolia including the need for and supply of LTC, regulatory and policy frameworks, service provision, quality management, human resources, and financing. Analysis, conclusions, and recommendations for the development of LTC systems in Mongolia are also included. It contributes to the development of an in-depth knowledge base on LTC policies, programs, and systems. It is one of six country diagnostic studies—the others on Indonesia, Sri Lanka, Thailand, Tonga, and Viet Nam—prepared under the Asian Development Bank technical assistance 9111: Strengthening Developing Member Countries' Capacity in Elderly Care.

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