Technical Assistance Report

Project Number: 49278-001
Policy and Advisory Technical Assistance (PATA)
December 2015

Mongolia: Strengthening Hospital Autonomy

This document is being disclosed to the public in accordance with ADB's Public Communications Policy 2011.

Asian Development Bank

CURRENCY EQUIVALENTS
(as of 7 December 2015)

Currency unit	–	togrog (MNT)
MNT1.00	=	$0.000502
$1.00	=	MNT1,994.00

ABBREVIATIONS

ADB	–	Asian Development Bank
MOF	–	Ministry of Finance
MOHS	–	Ministry of Health and Sports
TA	–	technical assistance
PIU	–	project implementation unit

NOTE
In this report, "$" refers to US dollars.

Vice-President	S. Groff, Operations 2
Director General	A. Konishi, East Asia Department (EARD)
Directors	S. Penjor, Urban and Social Sectors Division, EARD
	R. Schoellhammer, Mongolia Resident Mission (MNRM), EARD
Team leaders	C. Bodart, Principal Health Specialist, EARD
	J. Altantuya, Senior Social Sector Officer, MNRM, EARD
Team member	J. Ghimire, Senior Counsel, Office of the General Counsel

In preparing any country program or strategy, financing any project, or by making any designation of or reference to a particular territory or geographic area in this document, the Asian Development Bank does not intend to make any judgments as to the legal or other status of any territory or area.

CONTENTS

		Page
POLICY AND ADVISORY TECHNICAL ASSISTANCE AT A GLANCE		
I.	INTRODUCTION	1
II.	ISSUES	1
III.	THE POLICY AND ADVISORY TECHNICAL ASSISTANCE	3
	A. Impacts and Outcome	3
	B. Methodology and Key Activities	3
	C. Cost and Financing	4
	D. Implementation Arrangements	4
IV.	THE PRESIDENT'S DECISION	5
APPENDIXES		
1.	Design and Monitoring Framework	6
2.	Cost Estimates and Financing Plan	9
3.	Outline Terms of Reference for Consultants	10

POLICY AND ADVISORY TECHNICAL ASSISTANCE AT A GLANCE

1. Basic Data — **Project Number:** 49278-001

Project Name	Strengthening Hospital Autonomy	**Department /Division**	EARD/EASS
Country	Mongolia	**Executing Agency**	Ministry of Health and Sports

2. Sector

	Sector	Subsector(s)	ADB Financing ($ million)
✓	Health	Health sector development and reform	1.10
		Total	**1.10**

3. Strategic Agenda

Strategic Agenda	Subcomponents
Inclusive economic growth (IEG)	Pillar 2: Access to economic opportunities, including jobs, made more inclusive

Climate Change Information

Climate Change impact on the Project	Low

4. Drivers of Change

Drivers of Change	Components
Governance and capacity development (GCD)	Institutional development Organizational development
Knowledge solutions (KNS)	Knowledge sharing activities Pilot-testing innovation and learning
Partnerships (PAR)	Bilateral institutions (not client government) Official cofinancing

Gender Equity and Mainstreaming

Some gender elements (SGE)	✓

5. Poverty Targeting

Project directly targets poverty	No

Location Impact

Nation-wide	High

6. TA Category: B

7. Safeguard Categorization Not Applicable

8. Financing

Modality and Sources	Amount ($ million)
ADB	**1.10**
Policy and advisory technical assistance: Technical Assistance Special Fund	1.10
Cofinancing	**0.00**
None	0.00
Counterpart	**0.10**
Government	0.10
Total	**1.20**

9. Effective Development Cooperation

Use of country procurement systems	No
Use of country public financial management systems	No

I. INTRODUCTION

1. The Government of Mongolia requested assistance from the Asian Development Bank (ADB) to strengthen public hospital autonomy. A fact-finding mission took place in Ulaanbaatar in August 2015, and ADB reached an agreement with the government on the impact, outcome, and outputs of the policy and advisory technical assistance (TA), as well as its cost and financing, the implementation arrangements, and outline terms of reference for consulting services. Concept clearance was obtained on 22 October 2015. The design and monitoring framework is in Appendix 1.[1]

II. ISSUES

2. Poor quality of health services in public hospitals is considered a major constraint. The public sector accounts for 78% of total hospital beds and 80% of total hospital admissions, and absorbs nearly 70% of the national health budget.[2] International experience and best practices tend to confirm that the lack of autonomy in decision making in public hospitals, especially in relation to financing, human resources management, and procurement, is an important determinant of poor health service delivery.[3] The Ministry of Health and Sports (MOHS) tends to micromanage public hospitals by defining the hospitals' strategies; allocating and regulating their budgets; appointing their executive management; managing their human resources; and handling the procurement of all major equipment, drugs, and supplies.[4]

3. Public hospitals are financed from the state budget, the health insurance fund, and user fees. Hospital managers are constrained by rigid financing procedures that lead to major inefficiencies. For instance, hospital managers are not allowed to reallocate resources between cost categories without obtaining permission from the Ministry of Finance (MOF), which can take considerable time and effort. Savings at the end of the fiscal year are automatically returned to the Treasury, discouraging hospital managers from becoming more efficient. Hospital managers also lack the means to reward staff for good performances since not even savings can be used to supplement salaries. This results in less motivated staff and low performance of public hospitals, including poor quality of services.[5] Public hospitals mostly serve poor and low-middle-income people, who make up about 60% of the total population (higher-income citizens tend to seek care from private hospitals or abroad), so improving public hospital management will primarily benefit the poorer and lower-middle-income groups.

4. The government has made some initial attempts to reform hospital management. The revised Health Law (2011) has provisions for the establishment of hospital management boards in state-owned, tertiary-level hospitals.[6] However, because of changing priorities and lack of

---

[1] The TA first appeared in the business opportunities section of ADB's website on 3 November 2015.

[2] Government of Mongolia, Ministry of Health and Sports. 2015. *Health Indicators 2014.* Ulaanbaatar.

[3] A. Harding and A.S. Preker, eds. 2003. *Innovations in Health Service Delivery.* Washington, DC: The World Bank. Poor performances of public hospitals are explained by the incentive system the hospital faces, in which autonomy of decision making plays an important role. Preker states that incentives result from, first, pressures originating from the external environment, and second, the hospital's managerial instruments. External pressures are government oversight, organized purchasing (e.g., health insurance), market pressures, and governance from the owners of the hospital. Managerial instruments are reflected in the authority or autonomy given to its managers, the market environment created by the provider payment mechanism and exposure to competition, the extent to which the hospital keeps its surpluses and is responsible for its losses and debts, accountability mechanisms, and the extent to which social functions of the hospital are explicit and fully funded.

[4] The Ministry of Health was renamed MOHS in December 2014.

[5] Government of Mongolia, Ministry of Health. 2005. *Health Sector Strategic Master Plan 2005–2015.* Ulaanbaatar.

[6] Tertiary hospitals are regional diagnostic and treatment centers located in *aimags* (provinces), and state general and specialized hospitals in Ulaanbaatar.

technical capacity of MOHS, no regulations and operational tools exist that would help improve governance and management of financial and human resources, and aid the implementation of hospital autonomy. Implementation of hospital autonomy in a few tertiary-level public hospitals in 2011 resulted in merely adding another administrative layer—the management board—which complicated hospital administration since hospitals continued to operate under the direct control of MOHS. MOHS ceased this attempt in 2013.

5. Overall, Mongolia is developing a policy environment to improve quality of health services through the introduction of competition and market elements in the management of public hospitals.[7] This objective is in line with the implementation framework of the Health Sector Strategic Master Plan, 2005–2015, to ensure transparency, accountability, autonomy, and appropriate delegation of authority in public hospitals.[8] In July 2015, the government submitted to Parliament a package of draft legislation proposals, which aims to improve governance (enhanced decision-making power) and management of public hospitals in a comprehensive way.[9] These new pieces of legislation will be closely interconnected with the revised Health Insurance Law (approved by Parliament in January 2015), which enables the health insurance organization to act as the main purchaser of health services. Autonomy of hospitals is a precondition to a sound purchasing process, since it allows hospitals to negotiate with the health insurance organization.

6. The capacity of MOHS and other central and local government agencies to engage in a broad hospital reform process needs to be strengthened. This will require a phased approach to hospital autonomy with built-in mechanisms to learn from the implementation process and readjust implementation tools as required. Senior hospital management staff, board members, and selected community representatives will require substantial capacity upgrades if they are to live up to their new responsibilities in managing autonomous facilities. The capacity of MOF to oversee and monitor hospital financing reform will also need to be reinforced.

7. ADB has supported government efforts to improve sector governance and strengthen health financing and health insurance under the Third Health Sector Development Project and the ongoing TA for Strengthening the Health Insurance System, which resulted in a high consensus among stakeholders on key policy reforms in the health sector, including provider and purchaser split, autonomous status of providers, health insurance as a strong purchaser, and pooling of funds; and fair competition between public and private providers.[10] The Third Health Sector Development Project also assisted the government in identifying factors that influence hospital efficiency (i.e., lack of flexibility in financial management, centralized procurement, and high turnover of personnel) and supported the government in revising the Health Law (2011).

8. Based on this momentum, the government has requested ADB support to (i) further advance the regulatory framework for hospital autonomy, (ii) build capacity of the government and hospital staff to manage hospitals within the improved legal environment, and (iii) provide technical support for the gradual implementation of hospital autonomy.

---

[7] Government of Mongolia. 2012. *Government Action Plan, 2012–2016*. Ulaanbaatar.

[8] MOHS is in the process of updating the Health Sector Strategic Master Plan, 2005–2015 to adjust to the new sustainable development goals.

[9] The draft package of legislations includes a new draft law on medical care and the revision of the Health Law, the Budget Law, the State and Local Property Law, and the Civil Service Law.

[10] ADB. 2007. *Report and Recommendation of the President to the Board of Directors: Proposed Loan to Mongolia for the Third Health Sector Development Project*. Manila; ADB. 2013. *Technical Assistance to Mongolia for Strengthening the Health Insurance System.* Manila.

III. THE POLICY AND ADVISORY TECHNICAL ASSISTANCE

A. Impacts and Outcome

9. The impacts will be public hospitals' management performance improved, and autonomy of general and specialized hospitals in managing financial and human resources ensured. The outcome will be autonomy in pilot hospitals strengthened and decision to expand autonomy nationwide taken.

B. Methodology and Key Activities

10. An extensive review of international and national experiences will help in developing a conceptual framework and a strategic implementation plan for hospital autonomy based on extensive consultations with stakeholders. Readiness for implementation of hospital autonomy will be ensured through intensive development of institutional and human resource capacity. A phased action plan for hospital autonomy will be implemented in five selected facilities. Hospital performance will be monitored and evaluated, and lessons will serve for the formulation of policy recommendations for further improvements of hospital autonomy.

11. Key activities of the TA will be organized under four outputs:

(i) **Output 1: Regulatory environment for hospital autonomy analyzed and developed.** This output will support MOHS in consulting with stakeholders on the development of a conceptual framework and a strategic plan for phased implementation of hospital autonomy in Mongolia. This plan will be approved by the cabinet. The framework will include ownership, governance, management functions, financing, human resources, and social responsibility related to regulations on running public hospitals as enterprises, and will be based on an analysis of best international practices and careful selection of most suitable self-governing principles for Mongolia. Recommendations on policy and regulatory changes to increase the performance of autonomous hospitals will be developed. The activities of this output will follow a wide participatory approach, so a series of consultative and consensus-building meetings will be organized.

(ii) **Output 2**: **Institutional and human resource capacity for hospital autonomy strengthened.** This output will focus on strengthening institutional and human resource capacity based on a training needs assessment. Training programs for MOHS and other central and local government agencies will aim to strengthen their capacity for the new supervisory and regulatory tasks, while a series of management training sessions for hospital staff—including hospital board members, directors, managers, and selected community representatives—will focus on exercising the delegated decision-making rights in the areas of finance, procurement, human resources, and operational management. Training will follow a competency-based approach, which will include task analysis, defining training objectives, methodology, and development of training materials.

(iii) **Output 3: Hospital autonomy implementation piloted.** This output will pilot-test the implementation of the approved hospital autonomy framework. The pilot will be carried out in five selected hospitals, including secondary (*aimag* [provincial] and district general hospitals) and tertiary hospitals (regional diagnostic and treatment centers, and specialized hospitals). A time-bound action plan and monitoring and evaluation tool for hospital performance and operations will be developed for each of the selected hospitals to enable successful implementation of autonomy in the pilot phase. The pilot implementation process

will be supported by the proposed TA. Based on the lessons from implementing the output, additional recommendations to improve the policy design and for full implementation of the hospital autonomy framework will be provided.

(iv) **Output 4: Public awareness on hospital autonomy increased.** The TA will develop a plan and implement an advocacy campaign to increase public awareness on hospital autonomy with a specific focus on target groups. The TA will also prepare and implement a plan for community consultation and participation to monitor the activities of hospitals selected for implementation of hospital autonomy. A knowledge product and policy recommendations based on implementation results will be developed and disseminated at the end of project implementation.

12. The key risk is that the priorities of the government change after the 2016 election, lessening its interest in hospital autonomy. The implementation of the TA could also be hindered if Parliament delays the passage of the Medical Care Act and other supporting laws. Finally, central government officials' resistance to hospital autonomy could be another risk.

C. Cost and Financing

13. The TA is estimated to cost $1,200,000, of which $1,100,000 will be financed on a grant basis by ADB's Technical Assistance Special Fund (TASF-V). The government will provide counterpart support in the form of office accommodation for the project implementation unit (PIU) and other consultants, venues for meetings, counterpart staff and allowances, access to data, miscellaneous administrative expenses, and other in-kind contributions.

D. Implementation Arrangements

14. MOHS will be the executing agency of the TA and will designate a senior staff member as the TA focal point. MOHS will set up and chair a technical working group at the onset of TA implementation with participation of all key stakeholders (MOF, Ulaanbaatar City Health Department, Ministry of Population Development and Social Protection, Social Insurance General Office, Mongolian Hospital Association, and consumer representatives). The TA will be implemented over 24 months, tentatively from 1 April 2016 to 31 March 2018.

15. In dialogue with MOHS, ADB will recruit a consulting firm using quality- and cost-based selection with a ratio of 90:10 and a simplified technical proposal to provide 21 person-months of international and 20 person-months of national consulting inputs, including experts in hospital autonomy, governance, health and hospital management, and capacity building. In addition, two national consultants will be recruited individually to help develop and implement an advocacy plan and public campaign (2 person-months), and a community participation plan (4 person-months). A PIU will be set up to assist project implementation and day-to-day organizational and technical matters. A project coordinator (24 person-months) and an administration and finance coordinator (27 person-months), who will be part of the PIU, will be recruited as individual consultants by ADB and paid from TA funds. The consulting firm, national individual consultants, and coordinators will be hired in accordance with ADB's Guidelines on the Use of Consultants (2013, as amended from time to time). The terms of reference (Appendix 3) outline their tasks and reporting requirements.

16. The PIU will be responsible for procuring the office equipment under the supervision of MOHS in accordance with ADB's Procurement Guidelines (2015, as amended from time to time). MOHS will retain the equipment upon TA completion. TA funds will be disbursed in

accordance with the *Technical Assistance Disbursement Handbook* (2010, as amended from time to time). To assist implementation, ADB may establish an advance payment facility for the executing agency to support certain agreed cash expenditures, including workshops, training, seminars and conferences, and implementation of field work and survey activities, with details of the proposed activities, including cost estimates, submitted through the executing agency to ADB for approval. ADB may also make certain direct payments (e.g., for workshop venues).

17. TA achievements will be disseminated to policymakers, the private sector, civil society, and the media, for instance by means of workshops, publications, and through the local media. Advocacy activities and a plan for community consultation and participation to support hospital autonomy will be implemented. A final conference, with the participation of all stakeholders will be held and a knowledge product (policy brief) will be prepared to capture the policy recommendations for the government resulting from hospital autonomy implementation.

IV. THE PRESIDENT'S DECISION

18. The President, acting under the authority delegated by the Board, has approved the provision of technical assistance not exceeding the equivalent of $1,100,000 on a grant basis to the Government of Mongolia for Strengthening Hospital Autonomy, and hereby reports this action to the Board.

DESIGN AND MONITORING FRAMEWORK

Impacts the TA is Aligned with

Public hospitals' management performance improved (The Implementation Framework of the Health Sector Strategic Master Plan, 2006–2015)[a]

Autonomy of general and specialized hospitals in managing financial and human resources ensured (The Government Action Plan, 2012–2016)[b]

Results Chain	Performance Indicators with Targets and Baselines	Data Sources and Reporting	Risks
Outcome Autonomy in pilot hospitals strengthened and decision to expand autonomy nationwide taken	a. Strategic plan for the nation-wide and phased implementation of hospital autonomy approved by March 2017 (baseline 2015: NA) b. At least 50% of selected hospitals operating autonomously with improved financial management, human resources and patient satisfaction based on approved assessment criteria by March 2019[c] (baseline 2015: 0)	a. Government resolution, cabinet b. Project completion report, MOHS	Central government officials resist hospital autonomy
Outputs 1. Regulatory environment for hospital autonomy analyzed and developed	1a. Hospital autonomy conceptual framework developed and approved by Q1 2017 (baseline 2015: NA) 1b. Regulatory, organizational, and managerial reform for hospital autonomy approved by Q2 2017 (baseline 2015: NA)	1a. Government resolution, cabinet 1b. Ministerial order, MOHS	Delayed passage of the Medical Care Act by the Parliament Change in priorities of the government following the 2016 election reduces interest in and support for implementing hospital autonomy
2. Institutional and human resource capacity for hospital autonomy strengthened	2a. Institutional and human resource capacity-building program developed by Q1 2017 (baseline 2015: NA) 2b. More than 50% of participants in institutional and staff capacity development under the project are women (baseline 2015: NA)	2a–2b. Project progress report, MOHS	

Results Chain	Performance Indicators with Targets and Baselines	Data Sources and Reporting	Risks
3. Hospital autonomy implementation piloted	3a. 100% of selected hospitals have functional management boards with client representation by Q1 2018 (baseline 2015: 0) 3b. Management boards of at least 50% of selected hospitals execute their decision rights with respect to financial and human resources by Q1 2018 (baseline 2015: NA) 3c. Executive management of at least 50% of selected hospitals appointed by hospital management boards and have performance contracts by the end of 2017 (baseline 2015: NA)	3a–3c. Project progress report, MOHS	
4. Public awareness on hospital autonomy increased	4a. Policy brief on hospital autonomy prepared and approved by Q1 2018 (baseline 2015: NA) 4b. Final conference on policy recommendations' dissemination carried out by Q1 2018 (baseline 2015: NA)	4a. MOHS and ADB 4b. Project final report, MOHS	

Key Activities with Milestones

1. **Regulatory environment for hospital autonomy analyzed and developed**

1.1 Describe and analyze best international practices in hospital autonomy applicable to a Mongolian context (Q2 2016).
1.2 Conduct an extensive desk review of legal, policy, regulatory, organizational, and management-related documents governing the operations of public hospitals in Mongolia (Q2–Q3 2016).
1.3 Develop and recommend a conceptual framework for hospital autonomy (ownership, governance, and executing and operational management functions with special emphasis on strategy development, social responsibility, financing, human resource management, and procurement) based on extensive consultations with stakeholders (Q3–Q4 2016).
1.4 Develop a strategic plan for implementation of hospital autonomy through a wide participatory process (Q3–Q4 2016).
1.5 Develop policy and regulations to fill any gaps in the implementation of the framework (Q4 2016–Q2 2017).
1.6 Conduct a series of consultative meetings to build consensus on the hospital autonomy conceptual framework, strategy plan, and other related issues (Q3 2016–Q2 2017).

2. **Institutional and human resource capacity for hospital autonomy strengthened**

2.1 Conduct a training needs assessment to undertake institutional and human resource development for the implementation of hospital autonomy (Q4 2016–Q1 2017).

2.2 Design a training curriculum and program to build institutional and human resource capacity (Q3 2016–Q1 2017).
2.3 Implement training programs to build institutional and human resource capacity for policymakers and operational staff (Q2 2017–Q1 2018).

3. Hospital autonomy implementation piloted
3.1 Develop selection criteria and select five hospitals to pilot-test autonomy at different levels of the health-care system (Q2–Q3 2016).
3.2 Develop a phased action plan based on the strategic plan for implementation of hospital autonomy (Q4 2016–Q1 2017).
3.3 Conduct training to enhance hospital management practices in selected hospitals (Q4 2016–Q4 2017).
3.4 Provide policy and advisory technical assistance during pilot implementation, including development of an M&E framework and assessment criteria (Q4 2016–Q1 2018).
3.5 Monitor and evaluate the hospital operations and performance based on the M&E framework (Q4 2016–Q1 2018).
3.6 Provide policy recommendations based on lessons learnt from the pilot for further improvements of hospital autonomy implementation (Q4 2017–Q1 2018).

4. Public awareness on hospital autonomy increased
4.1 Conduct advocacy activities to support hospital autonomy implementation in selected hospitals (Q3 2016–Q4 2017).
4.2 Prepare and implement a plan for community consultation and participation of selected hospitals (Q2–Q4 2017).
4.3 Prepare a knowledge product (policy brief) and policy recommendations based on implementation results (Q4 2017).
4.4 Organize a final conference on dissemination of outputs and policy recommendations (Q1 2018).

Inputs
ADB: $1,100,000

Note: The government will provide counterpart support in the form of office accommodation for the project implementation unit and other consultants, venues for meetings, counterpart staff and allowances, access to data, miscellaneous administrative expenses, and other in-kind contributions.

Assumptions for Partner Financing

Not applicable.

ADB = Asian Development Bank, MOHS = Ministry of Health and Sports, M&E = monitoring and evaluation, NA = not applicable, Q = quarter.
[a] Government of Mongolia, Ministry of Health. 2007. *The Implementation Framework of the Health Sector Strategic Master Plan, 2006–2015*. Ulaanbaatar.
[b] Government of Mongolia. 2012. *The Government Action Plan, 2012–2016*. Ulaanbaatar.
[c] Assessment criteria will be developed and approved during implementation.
Source: Asian Development Bank.

COST ESTIMATES AND FINANCING PLAN
($'000)

Item	Amount
Asian Development Bank[a]	
1. Consultants	
a. Remuneration and per diem	
i. International consultants	470.0
ii. National consultants	220.0
b. International and local travel	60.0
c. Reports and communications	5.0
2. Equipment[b]	15.0
3. Training, seminars, and conferences	
a. Facilitators and resource persons	10.0
b. Training program	120.0
c. Publication and distribution of training materials, advocacy activities	50.0
4. Surveys	50.0
5. Miscellaneous administration and support costs[c]	25.0
6. Representative for contract negotiations	5.0
7. Contingencies	70.0
Total	**1,100.0**

Notes:
1. The technical assistance (TA) is estimated to cost $1,200,000, of which contributions from the Asian Development Bank are presented in the table above. The government will provide counterpart support in the form of office accommodation for the project implementation unit and other consultants, venues for meetings, counterpart staff and allowances, access to data, miscellaneous administrative expenses, and other in-kind contributions. The value of government contribution is estimated to account for 8% of the total TA cost.
2. TA funds for budget line items 2–5 will be administered by the executing agency, and advance payment facility may be used.

[a] Financed by the Asian Development Bank's Technical Assistance Special Fund (TASF-V). To be turned over to the executing agency upon completion of TA activities.
[b] Computers, printers, photocopier, and other small office equipment.
[c] Includes interpretation and translation costs.

Source: Asian Development Bank estimates.

OUTLINE TERMS OF REFERENCE FOR CONSULTANTS

1. The Asian Development Bank (ADB) will engage a consulting firm for the duration of the technical assistance (TA) in accordance with ADB's Guidelines on the Use of Consultants (2013, as amended from time to time). The firm will provide consulting services on hospital autonomy, governance, health and hospital management, and capacity building. The firm will be recruited using the quality- and cost-based selection procedure (quality–cost ratio of 90:10 and a simplified technical proposal). In addition, two national consultants will be recruited individually to help develop and implement an advocacy plan and public campaign, and a community participation plan. A project implementation unit (PIU), comprising a project coordinator and an administration and finance coordinator, will be established to assist project implementation and day-to-day organizational and technical matters and is recruited individually by ADB.

A. Consulting Firm

2. **Senior health sector reform specialist and team leader** (international, 11 person-months). The specialist should preferably have an advanced qualification in health and hospital management from a recognized institute with at least 10 years of international experience in health sector and health system reform in several countries. The specialist will help conceptualize and guide the implementation of hospital autonomy in five selected hospitals, which are to serve as pilot facilities. The specialist will provide the technical lead and will conduct extensive technical and/or consultative discussions and consensus meetings with various counterparts to reach the best possible decisions that cover all potential concerns. The team leader will report to the Ministry of Health and Sports (MOHS), the PIU, and ADB. In close coordination with MOHS and ADB, the consultant will:

(i) review international literature and analyze best international practices in hospital autonomy applicable to a Mongolian context;
(ii) conduct an extensive desk review of legal, policy, regulatory, organizational, and management-related documents governing the operations of public hospitals in Mongolia;
(iii) develop and recommend a conceptual framework of the hospital autonomy (ownership, including public–private partnership models, governance, and executing and operational management functions with special emphasis on strategy development, social responsibility, financing, human resources management, and procurement);
(iv) assist in the development of a strategic plan for the implementation of hospital autonomy;
(v) assist MOHS in organizing consultative and/or consensus meetings with various counterparts to reach the best possible decisions that cover all potential concerns about hospital autonomy implementation;
(vi) prepare policy and regulation recommendations to address existing gaps in the implementation of the framework;
(vii) provide ongoing policy and technical advice to MOHS and the selected hospitals during implementation; and
(viii) monitor and evaluate the implementation of hospital operations and performance based on the developed monitoring and evaluation framework.

3. **Health sector reform specialist** (national, 10 person-months). The specialist should preferably have a postgraduate degree in medical science with at least 5 years of relevant experience in health and hospital management. The specialist should be fluent in English and

work in tandem with the international senior health sector reform specialist to assist in all tasks under the international expert's terms of reference. In addition, the specialist will:

(i) prepare a peer-reviewed study report on international experience with hospital autonomy, including broad policy recommendations;
(ii) review and analyze national, legal, policy, regulatory, organizational and management-related documents governing the operations of public hospitals in Mongolia;
(iii) carry out field visits to selected hospitals for monitoring and progress evaluation of project implementation;
(iv) review and report to the team leader on project implementation; and
(v) act as interpreter and translate documents as required.

4. **Senior capacity-building specialist** (international, 10 person-months). The specialist should preferably have an advanced qualification in the medical, business administration, or a related field and at least 10 years of relevant work experience in health organizational capacity development strategies and human resource capacity development programs and training. The specialist will report to the team leader, the PIU, and ADB and will perform the following tasks:

(i) evaluate existing capacity of selected hospitals to increase their operational responsibility;
(ii) carry out a training needs assessment based on task analysis for undertaking institutional and human resource development for implementation of hospital autonomy;
(iii) identify capacity-building needs and prepare a capacity-building plan for the selected hospitals, including but not limited to planning, delivery of services, administration, monitoring and evaluation;
(iv) define training objectives, methodology, and design of an institutional and/or organizational capacity-building training curriculum and program;
(v) define training objectives, methodology, and design of a human resource competency-based training curriculum and program;
(vi) develop appropriate training materials, manuals, and guidelines;
(vii) arrange and carry out training for policymakers and operational staff in exercising the delegated decision-making rights in the areas of finance, procurement, human resources, and operational management; and
(viii) provide ongoing technical advice on developing organizational and human resource capacity to the selected hospitals during implementation.

5. **Capacity-building specialist** (national, 10 person-months). The specialist should preferably have a postgraduate degree in business administration and/or medical science and at least 5 years of relevant work experience in health, human resources, and capacity development training. The specialist should work closely with the international senior capacity-building specialist to assist in all tasks under the international expert's terms of reference. In addition, the specialist will:

(i) review and analyze organizational and management-related documents governing the operations of public hospitals;
(ii) consolidate inputs and recommendations for the training component of the capacity-building design during consultative meetings and workshops;
(iii) liaise with the local training provider, the National Center for Health Development, on training programs and facilitate training sessions under the guidance of the international expert;
(iv) monitor attendance and conduct a performance evaluation of the training participants;

(v) provide feedback collated on the participants' assessment of each of the sessions along with other information that is useful to improve the training program;
(vi) carry out field visits to selected hospitals to follow up with the training participants and provide in-service assistance and support; and
(vii) act as interpreter and translate documents as required.

6. **General responsibilities of the consulting firm.** The consulting firm, in addition to the terms of reference specified above, shall bear the following general responsibilities to facilitate project implementation:
(i) ensure continued dialogue and transfer of experience to MOHS and the government team, to help strengthen team skills and capacity, and to ensure maximum quality of the TA outputs;
(ii) prepare reports, including but not limited to the inception report, interim report, draft final and final reports, and quarterly progress reports; and
(iii) prepare and assist dissemination of the required reports, including the final TA report and the final policy recommendations, to MOHS and other relevant counterparts.

B. Individual Consultants

7. **Community consultation and participation specialist** (national, 4 person-months, intermittent). The specialist should preferably have a postgraduate degree in public relations or other relevant social sciences with relevant work experience in public and/or community engagement and community mobilization activities. The specialist will report to the PIU. In close coordination with MOHS and ADB, and under the supervision of the project coordinator, the expert will:
(i) review international literature on community participation in public hospitals in the context of hospital development and management, and analyze successes and failures of the process of community participation;
(ii) develop standard practices and policies with regards to community consultation and participation in public hospital administration;
(iii) prepare and conduct patient satisfaction surveys to evaluate and assess communities' expectations and the impact of selected hospitals with granted autonomy;
(iv) develop a community awareness program to monitor the activities of selected hospitals throughout the life of the project using patient reports and community score cards; and
(v) develop and recommend terms of reference for community representatives on the hospital management boards (e.g., general requirements, criteria for eligibility of community representatives).

8. **Advocacy plan development specialist** (national, 2 person-months, intermittent). The specialist should preferably have a postgraduate degree in public relations or other relevant social science fields with at least 5 years of relevant work experience in development, communications, advocacy, and/or media. The specialist will report to the PIU. In close coordination with MOHS and ADB, and under the supervision of the project coordinator, the expert will:
(i) determine the most appropriate strategies for communicating with different stakeholder groups (target group for lobbying, patients, community) to communicate the hospital autonomy concept;

(ii) develop a communication and awareness plan to promote governance of public hospitals and boost trust in the reform of public hospitals;
(iii) develop advocacy messages for various target groups (e.g., politicians, policymakers, program managers, and local communities);
(iv) assist MOHS in the implementation of the communication, public awareness, and education campaign; and
(v) provide effective monitoring to ensure that actions taken are effective.

C. Project Implementation Unit

9. The TA will provide coordination and administrative and financial support by establishing a PIU with two national consultants who will be hired individually by ADB.

10. **Project coordinator** (national, 24 person-months). The project coordinator should preferably have a postgraduate degree in medical science and/or public health with at least 5 years of experience in project management. The project coordinator will report to MOHS and ADB, and will:
(i) assist the recruitment of consultants in accordance with ADB policies and procedures;
(ii) finalize a TA implementation work plan in close consultation with the TA team members, and assist in finalizing work plans for individual consultants;
(iii) ensure smooth implementation of the TA;
(iv) manage and coordinate day-to-day TA activities;
(v) monitor the implementation of work plans, including timely submission of deliverables and the holding of events;
(vi) liaise with all counterparts—especially with MOHS, hospitals, and consultants, as required by TA activities—to optimize TA implementation;
(vii) authorize expenditures related to the implementation of the TA in line with ADB policies and procedures;
(viii) procure equipment in accordance with ADB policies and procedures;
(ix) report to ADB on new legal and regulatory orders and guidelines related to the TA;
(x) arrange for ADB reviews (e.g., of schedules, meetings, venues, documentation); and
(xi) report to ADB and MOHS on the progress of TA implementation quarterly and annually.

11. **Administration and finance coordinator** (national, 27 person-months). The expert should preferably have a graduate degree in administration or related field (e.g., public or business administration, accounting) with at least 5 years of experience in administering an office. Good command of computer skills is a must. The coordinator will report to the project coordinator and will:
(i) maintain comprehensive and clear accounts, and monitor PIU expenditures and fund flows;
(ii) prepare advances, liquidation, and reimbursement;
(iii) keep financial records of the PIU;
(iv) submit quarterly and annual financial progress reports to MOHS and ADB;
(v) handle administrative issues related to the TA;
(vi) assist in preparing the TA inception report, interim report, draft final and final reports, and quarterly progress report;
(vii) file project documents in accordance with ADB guidelines;

(viii) provide secretariat support as required; and
(ix) assist MOHS and ADB in all activities related to the closure of the TA.