ADB

Technical Assistance Report

Project Number: 47007
Capacity Development Technical Assistance (CDTA)
September 2013

Mongolia: Strengthening the Health Insurance System

(Financed by the Japan Fund for Poverty Reduction)

Asian Development Bank

CURRENCY EQUIVALENTS
(as of 2 September 2013)

Currency unit	–	togrog (MNT)
MNT1.00	=	$0.000631
$1.00	=	MNT1,584

ABBREVIATIONS

ADB	–	Asian Development Bank
TA	–	technical assistance

TECHNICAL ASSISTANCE CLASSIFICATION

Type	–	Capacity development technical assistance (CDTA)
Targeting classification	–	Targeted intervention (Millennium Development Goals)
Sector (subsector)	–	Health and social protection (health finance)
Theme (subtheme)	–	**Social development** (human development)
Location (impact)	–	National (high)

NOTE

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

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CONTENTS

I. INTRODUCTION

1. The Government of Mongolia requested support from the Asian Development Bank (ADB) to strengthen its social health insurance system. A fact-finding mission took place in Ulaanbaatar in January 2013, and ADB reached agreement with the government on the impact, outcome, outputs, costs and financing, implementation arrangements, and outline terms of reference for consulting services for the technical assistance (TA). Concept clearance was obtained on 14 February 2013. The design and monitoring framework is in Appendix 1.[1]

II. ISSUES

2. Since its establishment in 1994, the social health insurance system in Mongolia has demonstrated good achievements, including high coverage of over 90.0% of the population.[2] Health care delivery has also been sustained despite severe budget constraints in the early 1990s at the onset of the socioeconomic transition in Mongolia. However, those insured are increasingly dissatisfied with social health insurance because of poor service quality provided by hospitals and increasing out-of-pocket expenditures.

3. High out-of-pocket expenses have resulted from social health insurance reimbursement ceilings, exclusion of costly procedures and diagnostic services from reimbursement, limited reimbursement for medicines, enforcement of various forms of co-payments,[3] existence of informal payments, and the need to seek better quality care abroad. As a result, out-of-pocket payments for health services stood at 41.0% of total health expenditures in 2010,[4] while utilization of hospital services was lowest among the poor, raising concerns about the inclusiveness of growth. In 2009, 3.8% of total households (or 27,442 households) experienced catastrophic health expenditures,[5] and 1.8% of these households became impoverished due to health payments.[6]

4. The government subsidizes social health insurance for 58.0% of the population, but targeting is ineffective and does not take into account the ability to pay.[7] Ineffective targeting results in 15.0 % of the poor remaining uninsured (mostly the unemployed and herders). Government subsidies account for only 9.0% of social health insurance revenues as subsidies are set too low (currently about $5 per year per insured person) and are not indexed to the rising cost of care. As a share of revenue of social health insurance, total government subsidies have been declining. Of total social health insurance revenues, 86.0% are generated by the contributions paid by employees and employers in the formal sector, representing 28.0% of the insured population. The disparity between the proportion of formal sector workers who are insured (28.0%) and the contribution to social health insurance revenues (86.0%) has frustrated employers and made social health insurance unattractive to them. The remaining 5.0% of social health insurance revenues are contributions paid by self-employed and informal workers. Social health insurance was introduced in 1994 to mobilize additional financing for the health sector, but currently social health insurance funding represents only 21.0% of government health

[1] The TA first appeared in the business opportunities section of ADB's website on 14 February 2013.
[2] Social health insurance coverage peaked at 98.0% in 2011 due to blanket universal coverage paid for the uninsured by the Human Development Fund, which was discontinued in 2012.
[3] Co-payment between the patient and the hospital are applied for certain services.
[4] World Health Organization. *WHO Global Health Expenditures*. http://www.who.int/nha/expenditure_database/en/
[5] The World Health Organization defines catastrophic expenditures (illnesses) as expenditures that lead to nonfood household expenditures of more than 40.0%.
[6] World Health Organization. Forthcoming. *Financial Burden of Health Payments (6 Country Study)*. Manila.
[7] Government subsidies target certain categories of the population such as the elderly, children under 18, the disabled, students, and soldiers.

expenditures, while direct state funding, which is less effective, covers 76.0% of health expenditures.

5. The present social health insurance system governance structure has led to tensions within government organizations (mainly the ministries of finance, health, and population development and social protection) and between the Health Insurance Organization and the Health Insurance Sub-Council.[8] There are no clear lines of accountability for social health insurance performance. Moreover, the current legal framework further fragments responsibilities by making the Ministry of Health instead of the Health Insurance Organization responsible for functions such as designing the benefit package, setting payment tariffs, and selecting service providers. There is also potential for serious conflicts of interest where the main service provider (i.e., the Ministry of Health) also sets payment tariffs and selects providers to be reimbursed by social health insurance. The social health insurance system also lacks mechanisms and an effective information system through which insured people can report complaints and provide feedback on social health insurance deficiencies; these are essential for informed decision making and accountability.

6. The Health Insurance Organization has limited capacity, particularly in terms of service costing, actuarial projections, contract negotiations, and monitoring of quality of services. It is merely one of the departments of the Social Insurance General Office and is subject to legal restrictions when it comes to staff and operational resource allotment. These circumstances have prevented the Health Insurance Organization from developing into a strong purchaser of health services on behalf of the insured population. Furthermore, for the Health Insurance Organization to act as a purchaser of care on behalf of the insured requires an effective health information system to monitor quality of services and financial autonomy of public hospitals to enter into negotiations with the Health Insurance Organization. In addition, all public hospitals are allocated social health insurance funds systematically regardless of performance, preventing the Health Insurance Organization from effectively selecting hospitals to contract with.

7. To address the deficiencies in paras. 2–6 above, Parliament is revising the Citizens' Health Insurance Law. The revision of the law is undergoing a broad consultation process, including with civil society organizations. It is envisaged that the revised law will introduce broad reforms to improve governance and financial sustainability; improve targeting of government subsidies, including for the poor; increase access to an essential benefit package; and strengthen the autonomy and operational capacity of the Health Insurance Organization. The revised Citizens' Health Insurance Law will give more weight to reforms that the Health Insurance Organization and the Health Insurance Sub-Council have started to implement with TA provided by German development cooperation through GIZ and ADB.[9]

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[8] The national insurance system is governed by the National Insurance Council, which has several sub-councils, including the Health Insurance Sub-Council. This Sub-Council acts as a multisectoral oversight body for the Health Insurance Organization, which at present is a department of the Social Insurance General Office. This office is an implementing agency of the Ministry of Population Development and Social Protection. The Health Insurance Organization, which included 65 staff nationwide at the end of 2011, is in charge of the day-to-day management of the social health insurance system, primarily reviewing claims from health providers, contracting with health providers, monitoring providers' performances, and managing social health insurance data. The Health Insurance Sub-Council includes representatives from the government, the Mongolian Employers' Federation, and the Confederation of Trade Union.

[9] ADB. 2003. *Technical Assistance to Mongolia for Health Sector Reform*. Manila; ADB. 2003. *Report and Recommendation of the President to the Board of Directors: Proposed Loan to Mongolia for the Second Health Sector Development Project.* Manila; ADB. 2007. *Report and Recommendation of the President to the Board of Directors: Proposed Grant to Mongolia for the Third Health Sector Development Project.* Manila. The support has

III. THE TECHNICAL ASSISTANCE

A. Impact and Outcome

8. The impact of the TA will be increased financial accessibility of health services, especially for the poor. The outcome will be improved performance of the social health insurance system.

B. Methodology and Key Activities

9. To improve the performance of the social health insurance system, the TA will strengthen the institutional and human resources capacity of the Health Insurance Organization and the Health Insurance Sub-Council.[10] It will assist in (i) developing financial tools for social health insurance; (ii) improving internal management of the Health Insurance Organization, including contractual tools and monitoring of quality of health services; and (iii) improving the governance structure of the social health insurance system.

10. Key activities of the TA will be organized under three outputs:

(i) **Output 1: Increased capacity for social health insurance financing.** This output will help the social health insurance system increase its capacity to determine costs of services, strengthen provider payment systems, and promote standardized care in hospitals for cost control and increased quality of services. It will also facilitate monitoring sustainability of the social health insurance fund and improve the efficiency of government subsidies to the social health insurance system, including enrolling the poor, identified through proxy means testing, in the social health insurance system.[11]

(ii) **Output 2: Improved performance through management systems and capacity development of the Health Insurance Organization.** This output will strengthen the management and organizational capacity of the social Health Insurance Organization, including its purchasing capacity through selective contracting and monitoring of the quality of health services. It will also update the medium-term strategy of the Health Insurance Organization and assist in institutionalizing the preparation of its business plan. The output will conduct

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resulted in (i) refining important aspects of the social health insurance system, including its governance; (ii) initiating the determination of cost estimates for health services; (iii) strengthening the provider payment; (iv) cabinet approval of the health financing strategy 2010–2014; (v) developing a health financing model, including single purchaser and pooling of funding from the state budget and the social health insurance fund; and (vi) introducing key inputs in drafting of the revised Citizens' Health Insurance Law.

[10] With the passage of the revised Citizens' Health Insurance Law, the Health Insurance Sub-Council could be elevated to a Health Insurance Council.

[11] The legal framework for enrolling the poor identified through proxy means testing is embedded in the amended Social Welfare Law of 2012, whose passage was assisted by the ADB-supported Social Sectors Support Program (ADB. 2009. *Report and Recommendation of the President to the Board of Directors: Proposed Loan and Grant and Technical Assistance Grant to Mongolia for the Social Sectors Support Program*. Manila). The ADB-funded Food and Nutrition Social Welfare Program and Project (ADB. 2008. *Report and Recommendation of the President to the Board of Directors: Proposed Grants to Mongolia for the Food and Nutrition Social Welfare Program and Project*. Manila) has supported implementation of a national proxy means test to identify poor households. The proxy means test was adopted by the National Statistical Office and the former Ministry of Social Welfare and Labour in 2010. The resulting database is being used to target social welfare programs such as the food stamp and medicard programs (supported by ADB) and will be used to enroll the poor in social health insurance. It is expected that the database will eventually support targeting of other programs, such as education or energy subsidies or access to employment and skills building programs.

training for staff of the Health Insurance Organization based on a thorough assessment of internal management procedures, including human resources management and information technology requirements.

(iii) **Output 3: Strengthened governance of the social health insurance system.** This output will strengthen the governance of the social health insurance system through capacity development of members of the Health Insurance Council on social consensus and policy on social health insurance. It will also help further develop and institutionalize a number of tools, such as satisfaction surveys and regular publications on the performance of providers and the Health Insurance Organization as well as on insured members' rights and obligations. Output 3 will design and assist in the implementation of a complaints and redress mechanism. The output will also organize and increase the capacity of the social health insurance system in media relations activities to market and increase the understanding of social health insurance. The work on hospital autonomy under the Ministry of Health to address the limited financial autonomy of public hospitals will be supported to ensure contracts can be negotiated and hospitals can be more accountable for the results of the contracts. The TA will recommend a step-by-step integration of state and social health insurance funding to turn the Health Insurance Organization into a single purchaser. A knowledge product will be prepared to capture the knowledge gained on policy practices, international experience, operational aspects, and recommendations to further develop the social health insurance system in Mongolia.

11. Potential risks are (i) the delayed passage of the revised Citizens' Health Insurance Law and (ii) the passage of a revised law that does not include all the expected reform elements. Both risks are considered manageable as the draft revised law is included for discussion in Parliament, and because there is wide consensus on major reform elements in Parliament.

C. Cost and Financing

12. The TA is estimated to cost $1,700,000, of which $1,500,000 will be financed on a grant basis by the Japan Fund for Poverty Reduction and administered by ADB. The government will provide counterpart support in the form of office accommodation, remuneration and per diem of counterpart staff, administrative support, and other in-kind contributions.

D. Implementation Arrangements

13. At present, the Health Insurance Organization is part of the Social Insurance General Office, an implementing agency under the Ministry of Population Development and Social Protection in charge of implementing social security programs. The Ministry of Population Development and Social Protection will be the executing agency for the TA and the Social Insurance General Office will be the implementing agency.[12]

14. The TA will be implemented over 36 months from 30 November 2013 to 31 October 2016. ADB will recruit a consulting firm using quality-based selection to provide 29 person-months of international and 56 person-months of national consultants, including experts in

[12] Depending on the outcome of the revised Citizens' Health Insurance Law, the selection of the executing agency could be revised. If the Health Insurance Organization becomes a regulatory agency independent of line ministries, the prime minister's office or deputy prime minister's office could be the executing agency.

social health insurance policy and management, governance, and capacity building.[13] The firm will be recruited in accordance with ADB's Guidelines on the Use of Consultants (2013, as amended from time to time). A national health insurance specialist (36 person-months) and a national administrative and finance assistant (36 person-months) will be recruited individually to facilitate day-to-day organizational and technical matters, liaise with the executing agency and other stakeholders, and monitor the outputs of the consulting firm. The national health insurance specialist will be responsible for procuring the TA equipment under the supervision of the executing agency in accordance with ADB's Procurement Guidelines (2013, as amended from time to time). The executing agency will retain the equipment upon TA completion. The outline terms of reference for consultants are in Appendix 3.

15. The proceeds of the TA will be disbursed in line with ADB's *Technical Assistance Disbursement Handbook* (2010, as amended from time to time). To facilitate 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).

16. Regular seminars will be held with representatives of government, social health insurance institutions, media, and civil society to discuss TA achievements and issues. Dissemination of TA achievements will be ensured through workshops, policy debates, printed publications, the local press, and during training activities with policy makers, the private sector, civil society, and the media. Information campaigns will be organized during TA implementation to disseminate information and market social health insurance. A final conference will be held with broad participation from the public and private sectors and civil society to present and discuss the knowledge product and the manual prepared for the social partners (the Mongolian Employers' Federation, and the Confederation of Trade Union) involved in overseeing the social health insurance system.

IV. THE PRESIDENT'S DECISION

17. The President, acting under the authority delegated by the Board, has approved ADB administering technical assistance not exceeding the equivalent of $1,500,000 to the Government of Mongolia to be financed on a grant basis by the Japan Fund for Poverty Reduction for Strengthening the Health Insurance System, and hereby reports this action to the Board.

[13] Quality-based selection is used as (i) the social health insurance reform is highly specialized, and (ii) the quality of the services is of overriding importance for the outcome of the project.

DESIGN AND MONITORING FRAMEWORK

Design Summary	Performance Targets and Indicators with Baselines	Data Sources and Reporting Mechanisms	Assumptions and Risks
Impact Increased financial accessibility of health services, especially for the poor	By 2018: Decreased percentage of catastrophic illnesses from 3.8% in 2009 to 2.8%[a] Decreased percentage of impoverishment due to cost of treatment from 1.8% in 2009 to 1.0% Decreased difference in utilization rates of hospital services between the poor and the better-off from 5.0% in 2009 to 2.0%	National Statistical Office – Household Socio-Economic Survey	**Assumption** Mongolia's economic growth is able to create employment leading to increased and sustained enrollment in and contributions to the social health insurance system
Outcome Improved performance of the social health insurance system	By 2017: Percentage increase in social health insurance coverage, including within the poor and informal sector, from 83.0% in 2010 to 96.0% Social health insurance fund revenues for the citizens' whose contributions are subsidized by government increase from 9.0% in 2011 to at least 30.0% Percentage increase in insured members' satisfaction level with social health insurance from 2013 to 2017 Percentage of out-of-pocket expenditures has not deteriorated from 41.0% in 2010	Health Insurance Organization Health Insurance Organization Pre-post survey (baseline in 2013) World Health Organization statistics	**Assumption** The revised Citizens' Health Insurance Law and its related regulations mandate (i) increased autonomy of the Health Insurance Organization; (ii) increased and indexed government subsidies for social health insurance; and (iii) a dedicated national social health insurance council with balanced power among the government, the Employers' Federation, and the Confederation of Trade Unions
Outputs 1. Increased capacity for social health insurance financing	By 2016: Increased percentage in social health insurance coverage among the 5.0% poorest households identified through proxy means testing, from 85.0% in 2010–2011 to 98.0%[b] A set of tools to monitor sustainability of the social health insurance fund is available and used Costs of key hospital procedures and services are available	Ministry of Population Development and Social Protection statistics Project report Health Insurance Organization and	**Assumptions** The revised Citizens' Health Insurance Law and its related regulations include (i) measures to ensure sustainability of the social health insurance fund, (ii) an essential package of benefits, and (iii) selective contracting of health providers A financial and

Design Summary	Performance Targets and Indicators with Baselines	Data Sources and Reporting Mechanisms	Assumptions and Risks
2. Improved performance through management systems and capacity development of the Health Insurance Organization	Percentage increase in providers selected for reimbursement based on contract evaluation, from 0.0% in 2013 to 30.0% in 2016	Ministry of Health Health Insurance Organization report	economic management unit is set up to serve the Health Insurance Organization
	Midterm strategy is updated and business plan is prepared for the Health Insurance Organization by 2015	Ministerial Order of the Ministry of Population Development and Social Protection	**Risks** Passage of the revised Citizens' Health Insurance Law is delayed
	A set of tools to improve the purchasing and monitoring capacity of the Health Insurance Organization is available and used by 2016	Project report	The revised Citizens' Health Insurance Law does not include all the desired reform elements
3. Strengthened governance of the social health insurance system	A complaints and redress mechanism for the insured is developed and operational by 2015	Ministerial Order of the Ministry of Population Development and Social Protection	
	A set of governance tools is designed and implemented by 2016	Order of the Health Insurance Council and project report	
	Percentage increase in knowledge and understanding on social health insurance among nongovernment stakeholders seen from 2013 to 2016	Pre-post survey (baseline in 2013)	

Activities with Milestones	Inputs
1. Increased capacity for social health insurance financing 1.1 Provide capacity building to the Health Insurance Organization to (i) determine cost of services to set realistic reimbursement levels, (ii) strengthen provider payment systems, and (iii) control cost of care by enforcing standardized care in hospitals (January 2014–December 2015) 1.2 Develop the tools and capacity within the Health Insurance Organization to monitor the sustainability of the social health insurance fund and advise the social health insurance council (January 2014–December 2014) 1.3 Improve level and targeting of government subsidies (including covering the poor identified through proxy means testing) and train the Health Insurance Organization and council for better decision making on coverage of the informal sector and the poor (March 2014–June 2016) **2. Improved performance through management systems and capacity development of the Health Insurance Organization**	**Japan Fund for Poverty Reduction: $1,500,000**

Item	Amount ($'000)
Consultants	
International (29 person-months)	650.0
National (128 person-months)	360.0
International and local travel	90.0
Reports and communications	15.0
Equipment	15.0
Workshops, training, seminars, and conferences	170.0
Surveys	45.0

Activities with Milestones	Inputs
2.1 Update the organizational and managerial assessment of the Health Insurance Organization (January 2014–March 2014) 2.2 Improve contracting (i.e., contracting types and process, quality of contracts at entry, contract monitoring capacity, and evaluation of contracts) (March 2014–June 2016) 2.3 Develop the tools and select providers based on contract evaluation (March 2014–February 2015) 2.4 Standardize care, especially for chronic patients, as the basis for contract evaluation and reimbursement (March 2014–June 2016) 2.5 Update the medium-term strategy of the Health Insurance Organization and institutionalize the preparation of regular business plans (March 2014–March 2015) 2.6 Perform a detailed analysis of internal management and human resources procedures and recommend improvements, including required information technology aspects (March 2014–September 2014) 2.7 Conduct training for staff on internal management procedures and develop a continuous education program for the Health Insurance Organization (September 2014–September 2016) **3. Strengthened governance of the social health insurance system** 3.1 Develop and prepare the institutionalization of governance tools: financial risk surveys, satisfaction surveys, and regular publications on the performance of providers and the Health Insurance Organization as well as on insured members' rights and obligations (January 2014–March 2016) 3.2 Design and assist in the implementation of the complaints and redress mechanism for insured members (January 2014–March 2016) 3.3 Organize and provide capacity development on information campaigns, public debates, and regular media relations activities to promote social health insurance (January 2014–June 2016) 3.4 Ensure sufficient authority is granted to providers to negotiate and manage their contracts (hospital autonomy) (January 2014–December 2015) 3.5 Recommend a step-by-step integration of the state and social health insurance funding to turn the Health Insurance Organization into a single purchaser (March 2016) 3.6 Conduct training and produce a manual for members of the National Health Insurance Council on social consensus and key social health insurance concepts and policies on social health insurance (April 2014–September 2016) 3.7 Prepare a knowledge product to capture all the essential knowledge gained, policy practices, international experience, and recommendations to further develop the social health insurance system in Mongolia (September 2016)	Miscellaneous administration and support costs 50.0 Representative for contract negotiations 5.0 Contingencies 100.0 Note: The government will provide counterpart support in the form of office accommodation, remuneration and per diem of counterpart staff, administrative support, and other in-kind contributions.

[a] The World Health Organization defines catastrophic expenditures (illnesses) as expenditures that lead to nonfood household expenditures of more than 40.0%.

[b] The legal framework for enrolling the poor identified through proxy means testing is embedded in the amended Social Welfare Law (January 2012). Proxy means testing is an established targeting method used by several welfare programs.

Source: Asian Development Bank.

COST ESTIMATES AND FINANCING PLAN
($'000)

Item	Total Cost
Japan Fund for Poverty Reduction[a]	
1. Consultants	
a. Remuneration and per diem	
i. International consultants (29 person-months)	650.0
ii. National consultants (128 person-months)	360.0
b. International and local travel	90.0
c. Reports and communications	15.0
2. Equipment[b]	15.0
3. Workshops, training, seminars, and conferences	170.0
4. Surveys	45.0
5. Miscellaneous administration and support costs[c]	50.0
6. Representative for contract negotiations	5.0
7. Contingencies	100.0
TOTAL	**1,500.0**

Notes:
1. The total cost of the technical assistance (TA) amounts to an equivalent of $1,700,000, of which contributions from the Japan Fund for Poverty Reduction are presented in the table above. The government will provide counterpart support in the form of office accommodation, remuneration and per diem of counterpart staff, administrative support, and other in-kind contributions. The value of government contribution is estimated to account for 12.0% of the total TA cost.
2. TA funds for budget line items 2–5 will be administered by the executing agency; an advance payment facility may be used.

[a] Administered by the Asian Development Bank.
[b] Computers, printer, photocopier, and other small office equipment.
[c] Includes translation.

Source: Asian Development Bank estimates.

OUTLINE TERMS OF REFERENCE FOR CONSULTANTS

1. The technical assistance (TA) will be implemented over a period of 36 months from 30 November 2013 to 31 October 2016. The TA will finance consulting services, workshops, training, surveys, and equipment. It will require an estimated 157 person-months of consulting services (29 person-months of international consultants and 128 person-months of national consultants).

2. All consultancy services will be recruited in accordance with the Guidelines on the Use of Consultants (2013, as amended from time to time) of the Asian Development Bank (ADB). A firm providing specialized consultancy services in health insurance, governance, and capacity building will be recruited through quality-based selection with a simplified technical proposal. A national health insurance specialist and a national administrative and finance assistant will be recruited individually to facilitate day-to-day organizational and technical matters, liaise with the executing agency and other stakeholders, and monitor the outputs of the consulting firm. The national health insurance expert will be responsible for procurement of the TA equipment in accordance with ADB's Procurement Guidelines (2013, as amended from time to time). The executing agency will retain the equipment upon TA completion. The proceeds of the TA will be disbursed in line with ADB's *Technical Assistance Disbursement Handbook* (2010, as amended from time to time).

A. Firm

3. **Senior health insurance specialist and team leader** (international, 12 person-months). The specialist should have a postgraduate degree in health care financing with a concentration in health insurance, with at least 10 years of experience in developing social health insurance schemes in middle- and high-income countries, including human resources management and provision of training. The specialist will perform the following tasks:

- (i) Act as the team leader of the group of international and national consultants.
- (ii) Be responsible for the timely submission and quality of all outputs prepared by the team.
- (iii) Advise the government and social health insurance institutions on all aspects of the terms of reference.
- (iv) Develop methodologies, systems, tools, and capacity building materials, and extend training to the staff of the social health insurance institutions on:
  - (a) determining cost of services, strengthening provider payment systems, and controlling cost through standardizing care;
  - (b) monitoring the sustainability of the social health insurance fund;
  - (c) improving the level and targeting of government subsidies, including covering the poor identified through proxy means testing;
  - (d) covering the informal sector and the poor with social health insurance;
  - (e) improving contracting (i.e., contracting types and process, quality of contracts at entry, contract monitoring capacity, and evaluation of contracts);
  - (f) selecting providers based on contract evaluation; and
  - (g) standardizing care, especially for chronic patients, as the basis for contract evaluation and reimbursement.
- (v) Provide input and recommendations to the Ministry of Health's initiative to ensure that sufficient authority is granted to providers to negotiate and manage their contracts (hospital autonomy).

(vi) Provide inputs and recommendations on a step-by-step integration of the state and social health insurance funding to turn the Health Insurance Organization into a single purchaser.
(vii) Analyze the financial viability and sustainability of the future social health insurance system, and recommend the insurance system's appropriate investment model, given the actuarial probability of claims by its members.
(viii) Prepare best international practices on all aspects of the terms of reference.
(ix) Prepare a knowledge product to capture all the essential knowledge gained, policy practices, international experience, and recommendations to further develop the social health insurance system in Mongolia (outline to be agreed on with the executing agency and ADB).
(x) Prepare quarterly progress reports for the executing agency and ADB (outline to be agreed on with the executing agency and ADB).

4. **Senior organizational development specialist** (international, 8 person-months). The specialist should have a postgraduate degree in organizational development with strong expertise in management, with at least 10 years of experience in strengthening social health insurance organizations in middle- and high-income countries, including human resources management and provision of training. The specialist will perform the following tasks:

(i) Using a participative approach, (a) update the organizational and managerial assessment, (b) update the medium-term strategy, and (c) prepare the business plan of the Health Insurance Organization.
(ii) Perform a detailed analysis of internal management and human resources management procedures and recommend improvements, including required information technology aspects.
(iii) Develop methodologies and capacity building materials, and extend training to the social health insurance institutions on (a) business plan development; (b) human resources management, including development of a continuous training program for staff; (c) internal management procedures; and (d) information technology to support improved internal management procedures.
(iv) Prepare best international practices on all aspects of the terms of reference.
(v) Advise the government and social health insurance institutions on all aspects of the terms of reference.

5. **Senior governance specialist** (international, 9 person-months). The specialist should have a postgraduate degree in governance with expertise in social health insurance and health systems management, with at least 5 years of experience in strengthening social health insurance organizations in middle- and high-income countries. The specialist will perform the following tasks:

(i) Develop and prepare the institutionalization of governance tools: financial risk surveys and satisfaction surveys, and regular publications on the performance of providers and the Health Insurance Organization as well as on insured members' rights and obligations.
(ii) Design and assist in the implementation of the complaints and redress mechanism for insured members.
(iii) Organize and provide capacity development on information campaigns, public debates, and regular media relations activities to promote social health insurance.

(iv) Advise the government and social health insurance institutions on all aspects of the terms of reference.
(v) Prepare best international practices on all aspects of the terms of reference.
(vi) Develop methodologies and capacity building materials, and extend training to the social health insurance institutions on (a) newly introduced governance tools; (b) the complaints and redress mechanism for insured members; (c) media-related activities; and (d) social consensus and key social health insurance concepts and policies for members of the national social health insurance council, including development of a manual.

6. **Health insurance specialist** (national, 24 person-months). The national specialist will have a postgraduate degree in medical or public health sciences with expertise and 8 years of experience in health financing and social health insurance. The specialist will assist the senior health insurance specialist in delivering the outputs of the TA, provide interpretation and translation services for the team leader, and arrange meetings as required. The national specialist will perform the following tasks:

(i) Assist in developing methodologies, systems, tools, and capacity building materials, and extend training to the staff of the social health insurance institutions.
(ii) Assist in providing input to the Ministry of Health's initiative to ensure that sufficient authority is granted to providers to negotiate and manage their contracts (hospital autonomy).
(iii) Assist in providing inputs and recommendations on the step-by-step integration of the state and social health insurance funding to turn the Health Insurance Organization into a single purchaser.
(iv) Assist in preparing a knowledge product to capture all the essential knowledge gained, policy practices, international experience, and recommendations to further develop the social health insurance system in Mongolia (outline to be agreed on with the executing agency and ADB).
(v) Assist in preparing quarterly progress reports for the executing agency and ADB (outline to be agreed on with the executing agency and ADB).

7. **Organizational development specialist** (national, 12 person-months). The specialist will have a postgraduate degree in related fields (medical, public health) with at least 5 years of experience in organizational development and social health insurance development. The specialist will assist the international organizational development specialist in delivering the outputs of the TA, provide interpretation and translation services for the team leader, and arrange meetings as required. The national specialist will perform the following tasks:

(i) Assist in (a) updating the organizational and managerial assessment, (b) updating the medium-term strategy, and (c) preparing the business plan of the Health Insurance Organization.
(ii) Assist in performing a detailed analysis of internal management and human resources management procedures, and recommend improvements, including required information technology aspects.
(iii) Assist in developing methodologies and capacity building materials, and extend training to the social health insurance institutions on (a) business plan development; (b) human resources management, including development of a continuous training program for staff; (c) internal management procedures; and (d) information technology to support improved internal management procedures.

8. **Governance specialist** (national, 20 person-months). The specialist will have a postgraduate degree in a relevant field (e.g., medicine, public health) with at least 5 years of experience in organizational development and social health insurance development. Specific experience in the field of governance is preferred. The specialist will assist the international organizational development specialist in delivering the outputs of the TA, provide interpretation and translation services for the team leader, and arrange meetings as required. The national specialist will perform the following tasks:

(i) Assist in developing and preparing the institutionalization of governance tools: financial risk surveys; satisfaction surveys; and regular publications on the performance of providers and the Health Insurance Organization as well as on insured members' rights and obligations.
(ii) Assist in designing and preparing the implementation of the complaints and redress mechanism for insured members.
(iii) Assist in organizing and providing capacity development on information campaigns, public debates, and regular media relations activities to promote social health insurance.
(iv) Assist in developing methodologies and capacity building materials, and extend training to social health insurance institutions on (a) newly introduced governance tools; (b) the complaints and redress mechanism for insured members; (c) media-related activities; and (d) social consensus and key social health insurance concepts and policies for members of the national social health insurance council, including development of a manual.

B. Individual Consultants

9. Two national consultants will be hired for the duration of the project to compose the project implementation unit.

10. **Social health insurance specialist** (national, 36 person-months). The specialist will have a postgraduate degree in a relevant field (e.g., medicine, public health) with at least 5 years of experience in social health insurance development. Specific experience in the field of governance or organizational development and capacity development will be preferred. The specialist will perform the following tasks:

(i) Review and assist in finalizing the semiannual and yearly work plans submitted by the international firm.
(ii) Monitor the implementation of work plans, including the timely submission of deliverables and holding of events.
(iii) Assess the quality of the capacity development activities of the firm.
(iv) Liaise with all project stakeholders, especially with the executing and implementing agencies and the firm, as required by TA activities to monitor client satisfaction and optimize TA implementation.
(v) Authorize expenditures related to the implementation unit in line with ADB policies and procedures.
(vi) Procure equipment in accordance with ADB policies and procedures.
(vii) Report to ADB on new legal and regulatory issuances and guidelines related to the TA.
(viii) Report to ADB and the executing and implementing agencies on the progress of TA implementation on a quarterly basis using the prescribed format.

11. **Administrative and finance assistant** (national, 36 person-months). The assistant will have a graduate degree in administration or a 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 assistant will report to the social health insurance specialist and will perform the following tasks:

(i) Closely work with the firm to ensure that financial transactions related to capacity development activities are executed promptly and accurately.
(ii) Keep the financial records of the implementation unit.
(iii) Liaise with all project stakeholders as required and requested by the national health insurance specialist.
(iv) Handle administrative issues related to the TA that fall outside the firm's responsibility.
(v) Assist in preparing the quarterly TA progress report in the prescribed format.
(vi) File project documents in accordance with ADB guidelines.
(vii) Provide secretarial support as required.