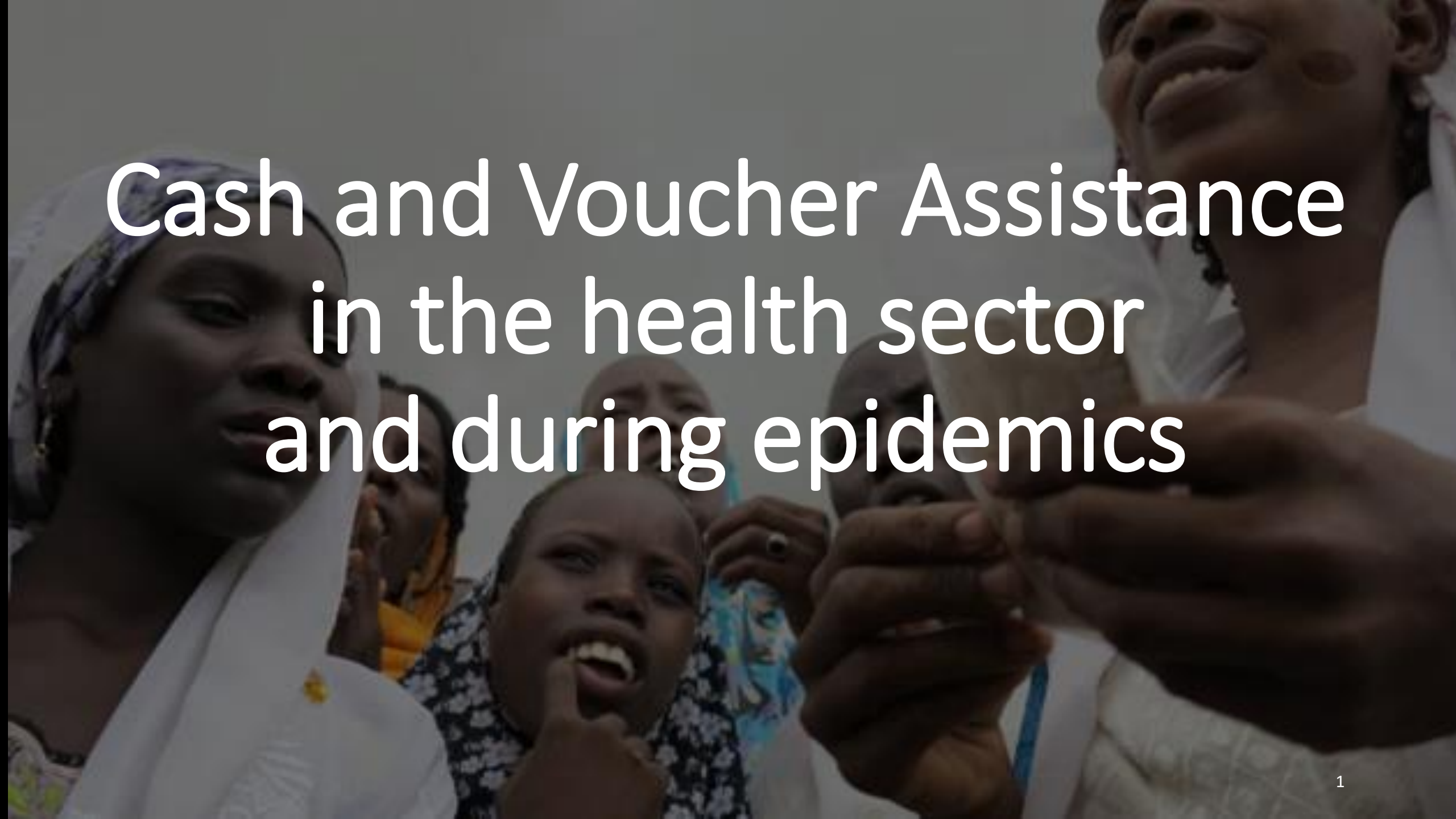


Cash and Voucher Assistance in the health sector and during epidemics

Essential health services during humanitarian crises should be free of charge at the point of delivery

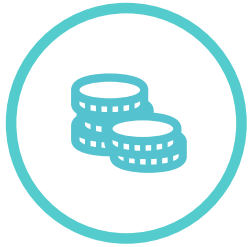
GHC position paper on user fees, 2010
Health financing in fragile settings, 2019

- Reduce reliance on user fees, as these always lead to barriers for accessing health services
- Protection against catastrophic health expenditures
- But often people still have direct and indirect healthcare expenditures

Adapt CVA to characteristics of the health sector

TARGETING:

RISKS VS AVERAGE NEED



TRANSFER VALUE AND FREQUENCY

QUALITY OF HEALTH SERVICES AND MEDICINES PURCHASED

ENSURE SUPPLY OF DRUGS AT HEALTH FACILITIES

OFTEN LOW DEMAND FOR PREVENTIVE CARE

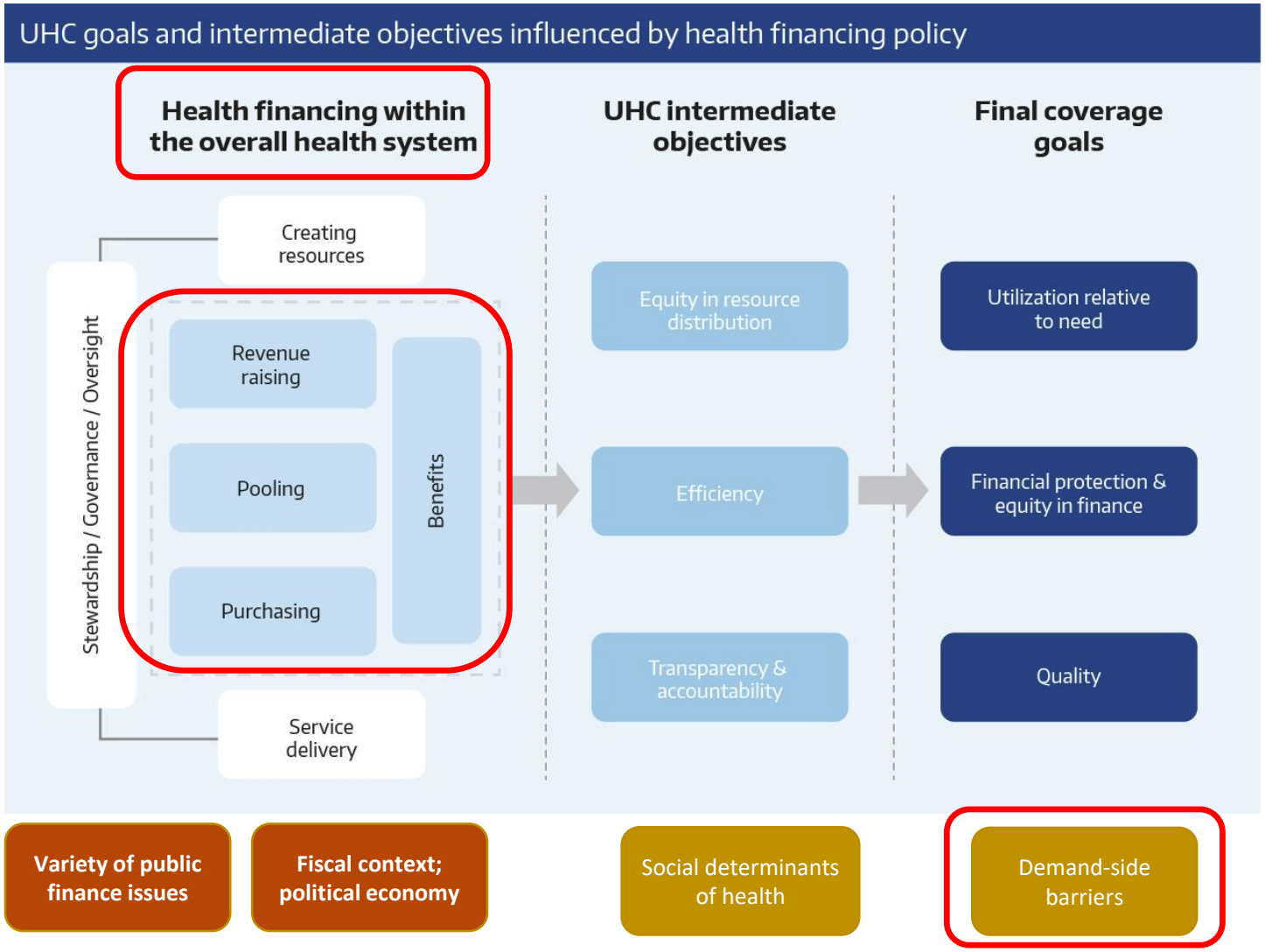
COMMON GOODS FOR HEALTH

CVA within Health financing for UHC

HEAVILY DRIVEN BY SUPPLY SIDE THINKING

ASSUMPTION THAT BY IMPROVING QUANTITY AND QUALITY OF SUPPLY, AND REDUCING "PRICE" AT THE POINT OF SERVICE USE, UNMET HEALTH NEEDS WILL BE REDUCED.

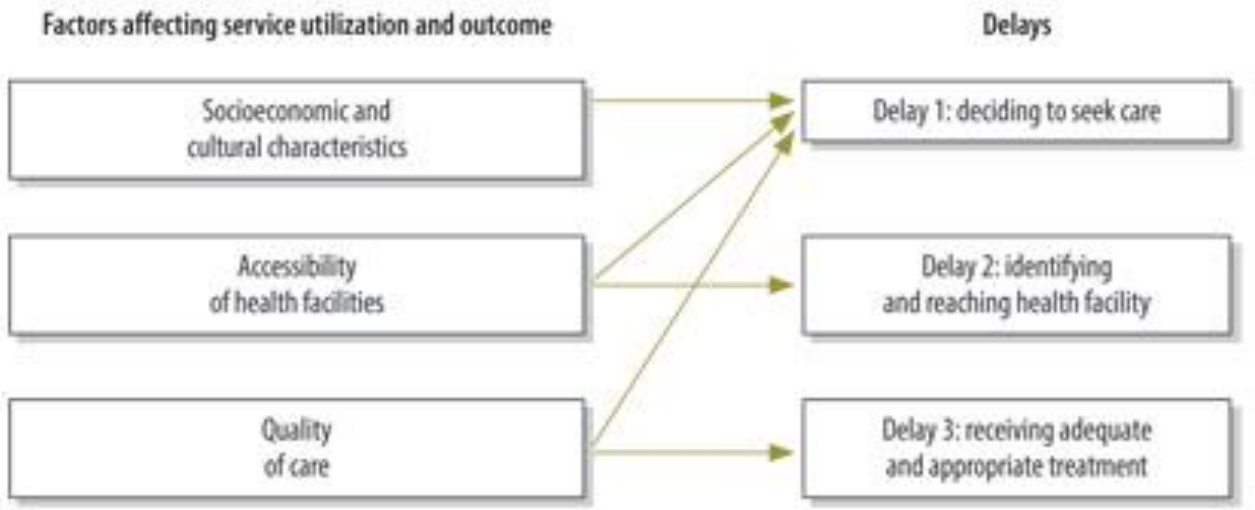
BROADLY THIS APPROACH HOLDS TRUE; BUT NOT ALWAYS AND ALONE IS NOT ENOUGH.



Various demand-side barriers exist

3-Delays model developed in the context of maternal mortality and emergency care; has broader relevance.

Coverage is **ineffective** when beneficiaries do not receive needed services/products even when legally entitled.



SOCIO CULTURAL

(attitudes to health/ treatment seeking behaviour)

COST

(time & money, direct and indirect, opportunity cost)

KNOWLEDGE

(poor understanding of entitlements; education, unclear/ complex benefits)

Need to understand the main demand-side barriers and underlying causes

https://www.who.int/bulletin/volumes/93/6/14-146571/en/

GHC Cash Task Team Working Paper on CVA for health in emergencies (March 2018)

- CVA can be useful **to improve access to and utilisation of health services**, by reducing direct and indirect financial barriers, and/or incentivise utilisation
- When **health services are available** with **adequate capacity and quality but user fees are applied**, the **preferred response option is through provider payment mechanisms**, with **CVA to be considered complementary** to such supply side health financing strategies, **and not aim to replace these**.
- **CVA to purchase health services** should in principle be targeted to patients when they need to use a priority service, **the amount of the transfer** should cover to the **direct and indirect costs of seeking treatment**, and only **be obtained from pre-selected providers** that **meet minimum standards for effectiveness and quality.**

Multi-purpose cash transfers to meet basic needs for vulnerable households does improve their ability to access health services

But MPC should not inadvertently contribute to a fee-charging culture for priority services

- Reasons to engage with MPC assistance and CWGs:
  - Households surveys always indicate that they use a proportion of the MPC for health
  - Though no effect on catastrophic expenditures
  - Household surveys for Basic Needs Assessment (that also look at health needs, health seeking behaviour, barriers and health expenditures)
  - Reflect health expenditures in MEB
  - Use results from Post Distribution Monitoring (proportion of MPG used for health, changes in negative coping mechanisms for health, etc)

CVA and the COVID-19 pandemic

Response to COVID-19, including treatment of patients, is a Common Good for Health, and should be free of charge

When the COVID-19 is declared a national emergency, governments should consider suspending user fees for essential health services by all providers for the duration of the crisis

- Financing options to compensate the loss of revenue and cope with increased expenditures include front-loading budgets and pre-funding public and private providers.
- Or through contracting and reimbursement mechanisms, including health emergency equity funds or voucher systems.
- Complemented by targeted cash assistance to patients and caretakers for indirect health care related costs
- MPC to meet basic needs for vulnerable households that have lost income due to the lockdown measures, or because they are quarantined and/or otherwise caring for a sick household member, will improve their ability to access health services.

To prevent transmission in programs and among staff that continue to work in vital sectors, or from staff to clients and beneficiaries, they are all expected to implement the basic preventive measures:

Physical distancing
Hand hygiene
PPE and IPC for staff
Disinfecting surfaces
Stay at home with mild COVID-19 symptoms

Public health measures applied in the delivery of humanitarian goods and cash

- If assistance is provided through cash or vouchers, organisations should ensure that beneficiaries can access basic items safely, and not putting them or their staff at further risk.
- Where feasible use mobile, or electronic contact less payments, to reduce the risk of transmission.
- Surface of ATM machines should be regularly disinfected, 1.5 meter distance between users.
- Sensitization of both clients (beneficiaries) and financial service providers on safe transaction measures
- Vouchers for disinfectants, soap?

Evidence on CVA for health from development contexts cannot always be extrapolated to humanitarian contexts.

As there is very little evidence for the use of CVA in humanitarian settings, we need to promote research and start documenting current practice for learning.

- Evidence from development settings on CVA and health indicates that it does add value
- Initial evidence on CVA and health in humanitarian settings indicates it can be done

- Have CVA consistently considered in health strategies in HRPs
- Develop more practical guidance
- Collect case studies
- Managing risks

Thank you for your attention!

Any questions?

Annex 1 to consider selecting preferred financing options, including cash transfer modalities for health, based on the comparative advantages

1. Subsidised coverage under national health insurance
2. Purchasing prioritised services through contracting, possible health emergency pooled fund

If not (yet) possible:

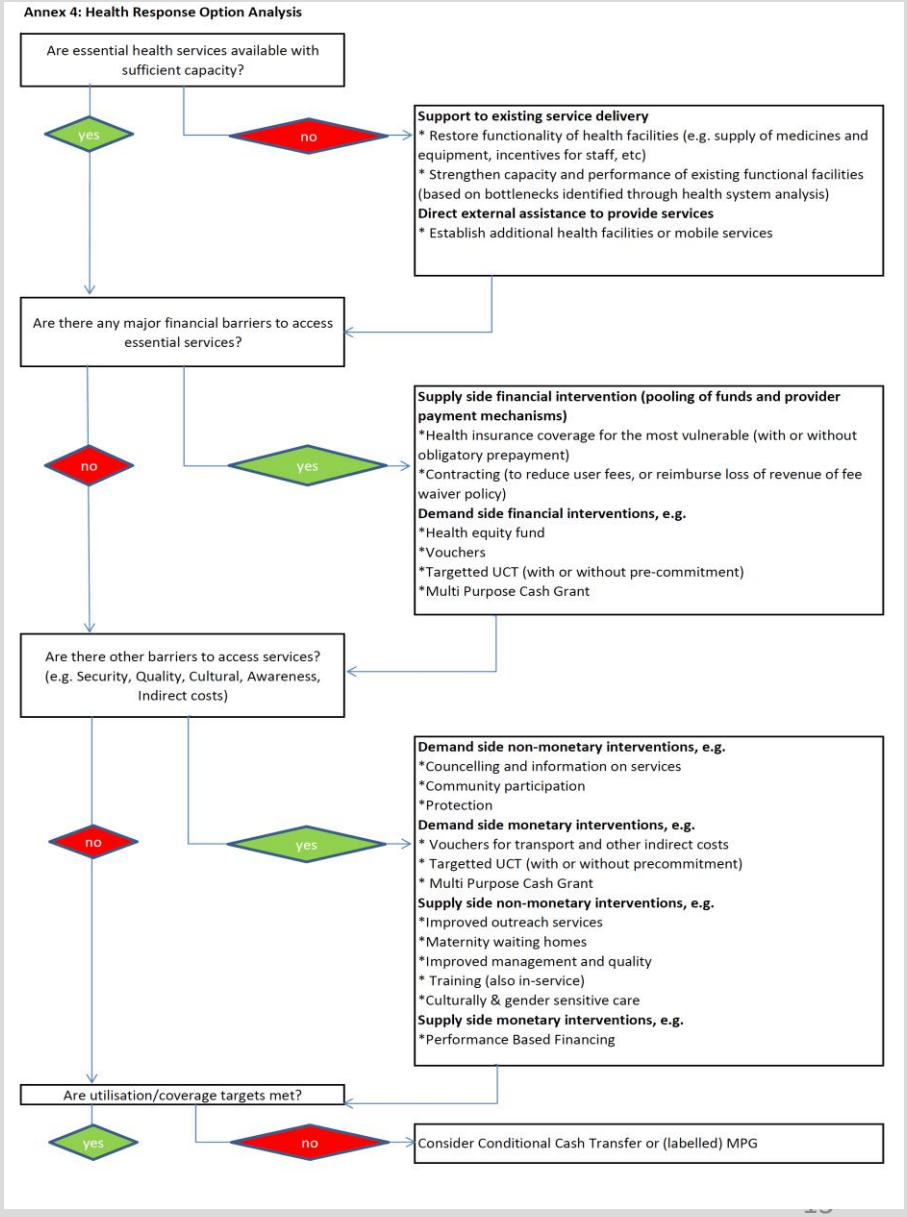
3. Service or commodity vouchers
4. Value vouchers for people with predictable health needs
5. Unconditional cash for a defined health need with pre-commitment to seek the service from a qualified provider
6. Add amount for health expenditures to MPC

Giving unrestricted and unconditional cash for health is easiest and most efficient, but has worst characteristics for equity and financial protection, and people may access poor quality services

Annex 4: Simplified decision tree

Key questions to see if CTP can be appropriate:

- Are essential health services to address the main causes of morbidity and mortality available with sufficient capacity?
- Are there any major financial barriers to access essential services?
- Are there other barriers to access services?
- Are utilisation/coverage targets met?



Suggested resources

- **General resources**

Cash Learning Partnership: http://www.cashlearning.org/

ODI (2016), Cash transfers what does the evidence say?

ODI (2018), The Grand Bargain Annual Independent report

- **Specific to Cash and Health:**

Global Health Cluster: http://www.who.int/health-cluster/about/work/task-teams/cash/en/

UNHCR (2015), CBI for health in refugee settings: a review

ODI (2011), Rethinking cash transfers to promote maternal health

UNDP (2014), Cash transfers and HIV prevention

- **Online trainings:** https://kayaconnect.org/local/search/

➢ Cash Transfer Programming-the fundamentals (Level 1&2)

➢ Coordinating multisector CTP

➢ CTP and social protection