Q&A document

WFP / CaLP webinar series

Webinar #2: Health expenditures: what and how to include in MEB?

As presented during the webinar, you can find 3 approaches to calculate health expenditures for the MEB in the recently published guidance by the Global Health Cluster.

1. **Are there any mistakes or things that should not be done when doing health expenditure surveys.**

Household expenditure surveys simply reflect what people spend on health. The more questions we can ask to understand what they spend it on and where, the better we know how to provide better protection from catastrophic health expenditures, and reduce financial barriers to access essential services.

The mistake we can make is in the analysis, by interpreting the findings in the same way as for example for food related expenditures. This is well explained in the health and MEB paper.

The most common mistake seen in the health part of the MEB is when people choose 3-5 common drugs, or the top 5 diseases and priority services such as deliveries and their average 'market price', and then use this to calculate average household needs stating that every family has a need for these so many times per month. This shows lack of understanding of how the health sector and health needs work.

2. **How detailed would your expenditure survey dig to ensure that the response is not promoting poor or unacceptable health practices?**

When building the MEB it might be important to reflect on "what to cover and when", as Health expenditures are not regular as food or rent ones. This needs to be reflected as well in the way the expenditure survey is built, especially in terms of recalling period, i.e. while for food it makes sense to ask about the last month, as people likely eat the same food always (not considering seasonality here), for health it might be risky to register only the last month, as health expenditures have very irregular patterns.

So this is likely to depend on context. If there is widespread use of poor or unacceptable health practices, the expenditure survey could be as detailed as wider health data suggests there are poor practices. A limiting factor might be whether the practices are taboo - if they are, the expenditure data might not be reliable because you won't get honest answers from the respondent. If they are not taboo, a detailed survey would allow for a health component in the MEB that does not reflect expenditure on poor or unacceptable health practices. However, if you are running a MPCA program, how recipients spend the cash on is up to them, and they may spend the assistance on poor health practices even if the MEB health component does not include it - here, soft

conditionality or behavioral messaging might be a more useful design choice to minimise the promotion of poor health practices.

3. **Should the inclusion of Health in the MEB rather build on "perceived health needs" or calculated so to achieve specific "health outcomes"?**

There is a grey area between perceived and real health needs. Some have lower or higher thresholds for seeking a service than others, and you don't know if someone has something serious or not till they have seen a health worker. The 'needs' based method for MEB that starts from a package of services is largely built on an ability to seek an essential service when needed from a qualified health worker. Then adding indirect costs and for costs self medication. But would exclude costs to go to a traditional healer. The health expenditure based methods simply look at how much money households spend. And we then need to understand where they spend it and on what, so we could promote better health seeking behaviour.

The link between health expenditures and health outcomes is complex.

4. **How do we take into account basic health insurance coverages in our MEB calculations?**

If households have to pay their premium, the amount should be part of the MEB. Plus adding then additional expenditures for costs not covered under the insurance.

If someone else pays the premium for them, the amount is not included in MEB as not an expenditure for the household anymore. Clarify in the explanation that in this situation people have access to essential services as under the insurance, so that part of the basic health needs are covered. Then still include remaining health expenditures not covered by the insurance.

There is some further guidance on this in the health and MEB paper.

5. **When we have calculated MEBs as part of HEA analyses, we have looked at a "typical" household composition in the target area (based on the average number of children and adults in a typical household). We felt that this affected how to calculate the health sector basket value. Is this common practice elsewhere?**

Most CWGs are using the same approach, as the MEB is the reflection of 'average' needs among a target group in a target area. However, this can raise issues for specific sector needs that are usually using individual targeting. This is where a more comprehensive, global analysis of expenditures can help to find the right balance with a pile-up of sector-specific needs. As capacities on MEB increase across sectors, it can be possible to go into more detailed analysis and sophisticated approaches to better reflect actual needs of the group, which expenditure analysis does not necessarily reflect.

In Gaza, the MEB was calculated based on the costs for an average household, as was the transfer value. If the expenditure data is collected as part of a HEA / vulnerability assessment, how the size or composition of the household affects the percentage spent on health can be analysed, and the MEB and transfer value can be adjusted accordingly (e.g., provide a larger health component if the household has a large number of elderly dependents). As was discussed during the webinar, more detailed health expenditure data can be collected which can allow for a more nuanced health component that considers different health costs (for example, if the household has a high dependency ratio, increase the portion of the health component reserved for medicines and overnight hospital visits - this will follow from what the expenditure data suggests). When the Gaza MEB is revised, the transfer value will likely shift to reflect household composition, i.e. adults and dependents.

The expenditures for health can be calculated as average. But the underlying needs and individual needs are not average. We need to avoid drawing the wrong conclusions from the average amount. This is why the better response to provide financial protection for accessing essential health services aims to reduce direct payments for the service when someone is ill. So the better option is to pay the provider, next best option is to reimburse or pay the person who is ill at the time of receiving the service.

6. **In Iraq, we have regular requests for cash for health from IDPs, (e.g., to cover surgeries out of the country, expensive treatments) but it is an unsustainable activity and there is worry that such activities will be difficult to monitor. We have tried to coordinate with the local health authority to support such cases, but this is not something that can continue in this manner. Is there any advice on such situations?**

There are examples I think from refugee contexts, where they created a medical committee to consider such requests or needs for referral to (tertiary) services not available in the area or country. For example reconstructive surgery for cleft lips, or repairs of fistula for women. These need to be paid for from dedicated funds.