

# HOW TO CONSIDER HEALTH ASPECTS WHEN DESIGNING AN MEB

## UNDERSTANDING HEALTH EXPENDITURES

Households will always have some level of health expenditures, even when policies are in place for health services to be provided free of charge in public facilities. As the ability to use a health service when needed is a basic need, and households frequently report having related expenditures, **health expenditures should always be reflected in an MEB.**

Nonetheless, while we know that households always have some level of health-related expenditure and we have evidence from cash monitoring surveys which normally show that health is one of the most important expenses for households, calculating health needs for an MEB is complicated. While access to healthcare comes with both **direct expenditures** (e.g. costs for consultations, admission, diagnostics, medicines, etc.) and **indirect expenditures** (e.g. costs for transport or caretakers) that can be included in an MEB as average at population levels, it is much more difficult to conceptualise these expenditures at household level because health needs are individual and mostly unpredictable, and not equally distributed between individuals or households, or constant over time.

The unpredictability and unequal distribution of health needs and subsequent expenditures is also affected by poverty levels, as well as by different types of service providers, public and private. Thus, trying to extrapolate health costs for inclusion in an MEB from the expenditure patterns of vulnerable people – who are only just able to meet their needs – will not accurately reflect their health needs. If we unpack this, it is clear that there are several reasons why this is the case. Poor individuals and households may not be able to afford quality healthcare and either go without treatment or seek treatment when a problem is advanced and therefore harder and costlier to treat – so their expenditure does not reflect their health needs or appropriate costs. Nor is it easy to average the cost of services since these may vary considerably from treatment to treatment, but also depend on where people seek the service, as public health providers will often be subsidised or supported to provide essential services for free, whereas private providers will always charge the full costs plus a profit margin. Current average expenditure will not take into account catastrophic expenditures (expenditures that a household really cannot afford – usually estimated to be 10% and 25% of monthly expenditures) from e.g. accidents or sudden and serious health crises. Health expenditures are also made on different

types of treatment, including those that should not be supported, such as buying potentially substandard medicines from the market, or getting services from traditional healers or unregulated providers.

So, to ensure financial protection and reduce financial barriers to access essential quality health services, the objective should be to **first design mechanisms to pay healthcare providers for a package of prioritized health services.** This financing mechanism targeting health service providers can be complemented with sector-specific CVA targeted at patients for their remaining costs of services from qualified providers, including indirect costs.

This means that in fact we aim to reduce and minimise the health expenditures in the MEB, as most costs should primarily be covered through the approaches above that reduce direct 'out of pocket' expenditures. Or, when there is a possibility to enrol target groups into a health insurance fund, to link health expenditures in the MEB to the level that reflects the premium for obligatory prepayment into such insurance fund, and then adding expenditures for costs for services not covered, indirect costs, some health commodities and self-medication.

## DIFFERENT WAYS TO CALCULATE HEALTH EXPENDITURES ACCORDING TO THE GLOBAL HEALTH CLUSTER:

- If households have to pay a health insurance premium, this amount should be part of the MEB, with additional expenditures for costs not covered under the insurance such as transport (normally health insurance also covers high infrequent costs and so risks for potentially catastrophic expenditures can be shared). If the premium is covered by an agency or NGO, this amount should be excluded from the MEB. This is the optimal response. This approach is equivalent to the rights-based method for constructing an MEB, as it is based on access to a package of prioritised services from preselected qualified providers when needed, including related to hospitalisation.
- Household expenditure surveys can also be used. In the absence of existing data on the method above, this is the preferred methodology, as these surveys indicate how

much households currently spend on health, what the expenditure was on and from which provider. The surveys should also present the proportion of households that spend more than 10% or more than 25% of their total household expenditures on health, as these percentages are thresholds for catastrophic expenditures, leading to negative coping mechanisms for health and other needs.

- If there is little or no data available and a rough estimate on health expenditures is needed, it is advisable to estimate that between 5% and 10% of total household expenditures are devoted to health, and then adapt toward the lower or higher estimate based on PDM data and feedback from health partners on the extent to which services and indirect costs are progressively subsidised.

## TOP TIPS ON CONDUCTING HEALTH EXPENDITURE SURVEYS

- Make sure to see what information health actors, Ministries of Health and/or National Bureaus of Statistics have already collected, including health needs, behaviours and expenditure patterns.
- The more specific the questions, the better information is provided on financial barriers to accessing quality essential services. Expenditures should ideally be disaggregated between direct and indirect costs, and also by the type of provider at which the costs were incurred (Ministry of Health facility, private clinic, unregulated drug outlet, traditional medicine provider, etc.).
- When building the MEB, it is also important to reflect on what to cover and when, as health expenditures are not as frequent and regular as food or rent. This needs to be reflected in the way the expenditure survey is built, especially in terms of recall period. While for food it makes sense to enquire about the previous month, as people likely eat the same foods consistently (not considering seasonality), for health it might be risky to gather information on the previous month only, as health expenditures tend to have very irregular patterns.
- If expenditure data is collected as part of an HEA/vulnerability assessment, the size or composition of the household will affect the percentage of total expenditure spent on health, for example when there are family members with a chronic illness or disability. Again, in addition to the average proportion of HH expenditure on health as needed for the MEB, the proportion of HHs with more than 10% and more than 25% of their income on health should be calculated,

as these are indications of the level of financial protection against catastrophic health expenditures.

- When possible, reported health expenditures should also be disaggregated as specified above. This information will help to choose the most appropriate option to reduce reliance on user fees (i.e. reduce out of pocket health expenditures and thus reduce HH health expenditures), through provider payment mechanisms, complemented by health-specific CVA. The remaining gap would inform the transfer value for MPC ([see Inclusion of Health Expenditures in MEB](#)).

## AVOIDING COMMON MISTAKES AND CHALLENGES IN THE DESIGN OF THE HEALTH COMPONENT OF THE MEB

- A mistake often made is to interpret basic needs for health using a bottom-up approach, in the same way as for food-related expenditures. MEB designers may, for example, find out the average 'market price' of 3–5 common drugs, of treatment for the top 5 diseases, and/or of priority services such as deliveries, and then use this to calculate average household needs, stating that every family has a need for these items and services X times per month. This does not reflect the fact that not all households will need every month, nor the fact that in most contexts people can access services supported and subsidised by MoH and/or humanitarian partners. A challenge is that people report having made expenditures for services from unregulated or traditional service providers, or from private providers for which they have to pay even when free or subsidised services and supported by humanitarian partners are available. The cost to go to a traditional healer or a private for-profit health facility, should in principle not be considered as a basic need, but as long as such health seeking behaviour is not influenced, they represent a need from the perspective of the households, and can't be ignored or subtracted from the MEB.

Note: When using health expenditure data in the MEB to design a transfer value for an MPC programme or a response to reduce out-of-pocket payments for health, please see the [Inclusion of Health Expenditures in MEB](#) paper and Health Response Options Analysis. p.18.

## RESOURCES



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

Global Health Cluster Cash Task Team and WHO (2020) [Inclusion of Health Expenditures in the MEB | Cash Learning Partnership](#) ([calpnetwork.org](http://calpnetwork.org))

Global Health Cluster Cash Task Team and WHO (2021) [Role of Cash & Voucher Assistance for health outcomes: Using the Health Barriers Framework to determine the appropriate response](#)

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](#)