



CASH & VOUCHER ASSISTANCE FOR HEALTH OUTCOMES



This position paper was prepared by the members of the Red Cross Red Crescent Movement technical sub-working group on CVA for health outcomes, sitting in coordination with the Movement cash peer working group (CPWG), in 2021. The current members of the CVA for health outcomes TWG are: IFRC, ICRC, British Red Cross, Canadian Red Cross, Danish Red Cross, German Red Cross, Norwegian Red Cross, and Swiss Red Cross. The technical working group is co-chaired by ICRC and Norwegian Red Cross.

The global health cluster task team on cash-based interventions has been consulted with respect to this paper.

AN OVERVIEW

The World Health Organization (WHO) constitution envisages “the highest attainable standard of health as a fundamental right of every human being.” There is a need to preserve the delivery of health services that are quality-assured, and as much as possible, free at the point of delivery, so patients can access a health service when needed without suffering financial hardship; this is known as Universal Health Coverage¹ (UHC). While the quality and accessibility of healthcare differs across countries, (humanitarian) crises have a profound impact both directly and indirectly on the health and well-being of affected populations, and the healthcare systems that they rely on.

Humanitarian and Development organisations have for decades supported and even substituted health systems in crises. However, the increase in use of cash and voucher assistance² (CVA) in humanitarian responses has led practitioners to explore the use of CVA to support healthier communities, including direct support to patients and carers, to complement existing support to health systems.

This paper explores how CVA, a form of demand-side financing, can be used to support health outcomes, as a complement to supply-side interventions, and highlights some of the key considerations when implementing CVA to improve health outcomes.

SUPPORTING SYSTEMS OR SUPPORTING PEOPLE?

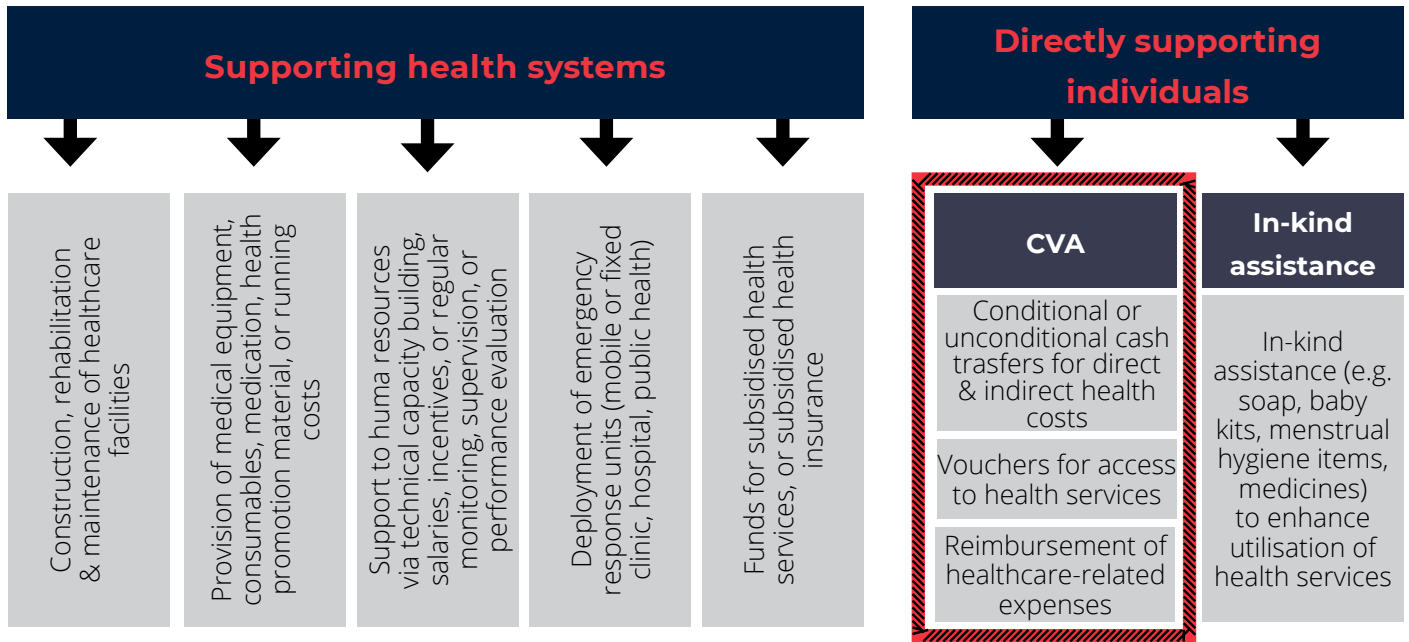
External support to mitigate the effects of a (humanitarian) crisis should as much as possible use and reinforce existing systems unless these systems are highly inefficient, become abused for political reasons, or are completely or partially unable to react to the excess health needs.

As such, most humanitarian interventions focus on supporting the supply side of existing health systems as the primary means of impacting health outcomes, through a combination of activities including financing and directly providing health items, as well as technical capacity building initiatives, as illustrated below. CVA should be considered complementary to such supply-side health strategies, and not aim to replace them.

More information on key terms used throughout this paper can be found in Annex 1.

1. Universal health coverage means that all people have access to the health services they need, when and where they need them, without financial hardship.
2. The term CVA can be used interchangeably with CBI “cash-based interventions”, CBA “cash-based assistance”, and CTP “cash transfer programming”. In 2018 the wider humanitarian sector took the decision to use the term CVA “cash and voucher assistance” as being the clearest descriptor of what this is all about. Individual Movement actors may use different terms, but collectively the Movement uses CVA to be in line with the wider humanitarian sector.

HEALTH INTERVENTIONS IN HUMANITARIAN CRISES



WHAT IS CASH & VOUCHER ASSISTANCE?

CVA in humanitarian assistance refers to all activities where cash transfers or vouchers for goods or services are directly provided to individuals, households or communities to enable them to meet their needs³. **In the context of healthcare, it means cash transfers or vouchers given directly to people requiring health services (a form of demand-side financing).** It does not include financial assistance given to health systems or health facilities (supply-side or input financing).

The diagram below expresses the general simplicity of basic CVA feasibility, where three key questions are asked. However, when it comes to healthcare it becomes more complex, as we cannot apply free market principles to healthcare.

In Lebanon, ICRC provided conditional cash transfers (CCT) to women with high-risk pregnancies. Each installment was conditional upon the attendance at prenatal care and the value was calculated based on the cost of the services, transport to reach the services, and a dietary top-up, enabling better nutrition.



In short, just because people previously used cash to purchase health services, that does not mean humanitarian actors should reinforce a poorly functioning system by enabling people to continue to pay for those services. It is important to analyse the health system to better understand its user fee system and assess its appropriateness. There may be a need to advocate with health authorities for a reduction in user fees and to collaborate to reduce other barriers to accessing health care. Supporting and reinforcing health systems is vital, and the quality of health services, the feasibility of CVA, the sustainability of the support and any (indirect) negative impacts all need to be considered. CVA as a standalone strategy does not fix issues related to accessing health care if other barriers are not addressed; it does, however, work well as a complementary tool to usual supply-side activities.

3. CaLP's definition of a voucher is: A paper, token or e-voucher that can be exchanged for a set quantity or value of goods or services, denominated either as a cash value (e.g. \$15) or predetermined commodities (e.g. 1 month supply of contraceptives) or specific services (e.g. 1 prenatal visit), or a combination of value and commodities. Vouchers are restricted by default, although the degree of restriction will vary based on the programme design and type of voucher. Although vouchers are included in CVA (given to individuals, households and/or communities), they will by default be reimbursed to a service provider (e.g. health facility, hospital, government facility).



WHAT IS CVA FOR HEALTH OUTCOMES?

Supply side interventions are the primary and preferred means of impacting health outcomes. However, this does not mean there is no role for CVA in achieving health outcomes. CVA for Health Outcomes is the use of targeted cash and voucher assistance to help improve health outcomes.

CVA can support health outcomes when used in programmes that target health outcomes (exclusively), such as reducing financial barriers to access paid healthcare. For example, CVA can:

- Support targeted people when they need to use a defined essential health service (preventative and curative);
- Cover formal or informal fees, or medicines, tests or medical supplies (direct costs);
- Incentivise the use of preventive services and/or incentivise healthy behaviours;
- Support specific populations to buy key health commodities (e.g. baby kits).

When used well, CVA can support or promote healthy lifestyles, help reduce risks, prevent or reduce negative coping mechanisms, and reduce financial barriers to accessing essential health services.

CVA is often the best option to meet the indirect costs of healthcare. Ideally, CVA for health outcomes should be targeted to people when they need to use a service. The amount of the transfer should cover the actual costs for diagnosis and treatment (direct costs), as well as indirect costs. The purchasing of such services should be restricted to providers for which quality standards can be ensured by regular supervision or checks from health professionals. For example, costs such as:

- Transport (to health facilities) and meals at the hospital;
- Health care referrals;
- Carers or care facilities;
- Lost wages or income when hospitalised or not able to work during an extended period of time due to illness, rehabilitation, or temporary or lifelong disability.

CVA can support the key determinants of health to create healthier people and communities. The direct and indirect consequences of crises, endemic poverty, underfunded and underdeveloped health and education systems, and lack of knowledge regarding preventive care, and the financial barriers to accessing healthcare all contribute to poor health outcomes.

CVA can support communities' wider health and wellbeing. Cash transfers given to cover basic needs will contribute to improving the overall situation of a household, giving them money to buy food and hygiene items, pay rent, pay for schooling, etc. all of which contribute to better health (including mental health) outcomes. There is evidence that receiving cash assistance helps households diversify, and thus improve, their diets, contributing to better health outcomes.

CVA can also be used for risk reduction. For example, cash transfers given to 'at risk' groups such as civilian casualties or survivors of sexual violence can help them access safe shelter, or support them to engage in safe livelihood activities, thus preventing or reducing risky or negative coping mechanisms (unsafe work, reducing meals etc.). This in turn can improve health outcomes⁴.

4. In these cases, Multi-Purpose Cash (MPC) may be the most appropriate mechanism. Targeted MPC for health can be complementary to 'regular' MPC that covers basic needs (food, shelter, etc.). Targeted MPC can be given to people requiring additional, targeted support to access health services, including counselling; MHPSS; accessing diagnostics, treatment, or medications, etc.

Cash or vouchers?

Cash transfers are the provision of assistance in the form of money—either physical currency or e-cash—to recipients. Cash can be given in advance or as a reimbursement for the expenses recipients have already made. Cash is unrestricted as it can be spent in any way; as such it may not be preferred for some specific health outcomes. However, conditions can be added to cash transfers; these are prerequisite activities or obligations that a recipient must fulfil before receiving the cash. For example, conditional cash transfers (CCT) may be used to encourage specific health behaviours, such as payments following verified attendance at prenatal consultations with a verified provider.

Vouchers—paper or electronic—are by nature restricted. Commodity vouchers are exchangeable for a fixed quantity and quality of goods or services at a specific retailer or service provider. In contrast, value vouchers have a monetary value that can be used to buy any goods or services provided by that specific retailer or service provider. Conditions can also be added to vouchers. For example, a voucher may be used in exchange for medicines at a registered pharmacy.

The ethos of CVA is to give choice to recipients; therefore, for many humanitarian objectives unconditional cash transfers are preferred. Controlling or restricting recipients' everyday purchases goes against this ethos.



However, when there are risks related to life and health, it may make sense to prioritise vouchers or conditional cash transfers rather than unconditional cash. Therefore, Conditional Cash Transfers (CCT) or vouchers for *direct costs* of healthcare can be used as a means to ensure that the service is obtained from a qualified provider⁵. For *indirect costs*, Unconditional Cash Transfers (UCT) may be appropriate, though from a health perspective the preferred option is to link the transfer with the need to use a health service.

Multi-purpose cash or targeted cash assistance?

CVA for health outcomes can take the form of a multi-purpose cash grant (MPC) or it can be sector specific, targeting a specific health intervention, such as maternal and newborn health outcomes, sexual and reproductive health and rights, tuberculosis management, immunisation, etc.

MPC is designed to cover basic needs (the essential goods and services required by a person) through an appropriate transfer value. The transfer value of the MPC will be based on a “Minimum Expenditure Basket” (MEB), a list of “basic needs items and services that can be monetized and are accessible in adequate quality through local markets and services”⁶. The Global Health Cluster has outlined specific guidance for how to consider health in the MEB and MPC⁷.

While there is less evidence for CVA and health outcomes in humanitarian settings, there is relevant evidence from development settings. Indeed, there is growing evidence of the effectiveness of combining health promotion and disease prevention counselling, education and training with targeted and complementary CVA to affect health outcomes. For example, conditional cash transfers or vouchers for access to prenatal care be complemented with a top-up (in cash or voucher)—for baby kits, delivery in a health facility by a skilled birth attendant, to cover costs for complications during the delivery when indicated, or any other related costs⁸—encourages the recipient not only to use those health services during the programme cycle but can also support behaviour change in the long term once recipients recognise the benefits of such regular visits.

5. Patients will not know the quality of health provider in settings where regulation is poor, or where drugs are available on normal markets or from unlicensed outlets

6. CaLP Network Glossary of terminology for cash and voucher assistance <https://www.calpnetwork.org/wp-content/uploads/2020/03/calp-glossary-english.pdf>

7. [Technical Note on the Inclusion of Health Expenditures in the Minimum Expenditure Basket and Subsequent Multi-Purpose Cash Transfer](#)

8. Although in many places prenatal care may be free, there may be other costs such as to reach a facility, or hidden costs such as informal contributions to carers

EXAMPLES OF CVA FOR HEALTH OUTCOMES

Situation	Solution
Meeting people's essential needs	Multi-purpose cash gives maximum flexibility to access the exact food, hygiene, and other goods/services according to their specific needs (e.g. dietary requirements)
Ensuring access to pre- and post-natal care	Conditional Cash Transfer (CCT) can be given in instalments, based on progression of pregnancy, and combined with health promotion messages and commitment to adherence. For paid services, CCT can cover the cost of services, transport, etc. When relevant services are free, CCT can cover the cost of transport only. (Both packages could include additional cash for recipients to improve their diet.)
Medicines for chronic illness and preventive checks	CVA programme can reimburse providers or pharmacies providing the care, and health commodities such as diagnostic tests or medicines, against a monthly specified invoice. This is based on a contract for 'Diagnosis Treatment Packages' and, if necessary, cash provided directly to the patient when visiting the provider to address the patient's indirect costs.
Routine immunisation and child growth monitoring	Conditional cash transfer can incentivise utilisation of routine immunisation and other preventive childhood health services. The service is free, so cash is intended for basic needs and to compensate for indirect costs.
Transportation for referral and hospitalisation	Cash can be provided to the patient or caretaker, given when arriving at the referral hospital, or as a voucher/token with a taxi company.
Basic routine health costs	Some basic health costs can be built into multi-purpose cash, see guidance from GHC on inclusion of health needs in the minimum expenditure basket, and in MPC.
Purchase of Long Lasting Insecticidal Nets (LLIN)	Commodity vouchers can be exchangeable for a fixed quantity and quality of health-related item, such as an LLIN.
Purchase of medicines	A value voucher can be provided to recipients to ensure purchase of medicine from a specific licensed pharmacy.
Non-CVA Financial Support To Improve Health Access	
Health facilities not fully functional	Inputs or input-based financing can be provided to a health facility covering, for example, incentives for staff, running costs, and medications and medical supplies.
Improving access to health insurance	Humanitarian actors can subsidise health insurance coverage for a target population under an existing health insurance fund.
Community funds for covering (unanticipated) health costs	Community solidarity groups where members financially contribute a small amount every month and then can borrow funds when they need to access healthcare, e.g. for high costs (e.g. childbirth) or unexpected costs (e.g. surgery after an accident). This can be achieved, for example, through a revolving fund supported by an NS, to ensure the poorest communities, that will be the least able to contribute, are included.



KEY ISSUES AND UNANSWERED QUESTIONS

1 Free healthcare versus the reality of healthcare costs

There is a need to preserve the delivery health services that are quality-assured, and as much as possible, free at the point of delivery. However, the reality is that many healthcare systems rely on user payments (whether formal or informal fees), and part of the salaries of healthcare staff are often made up of user fees (whether explicitly or not). For example, when formal salaries are below the minimum liveable wage, health staff may ask for informal user fees, and might refuse care or provide inadequate care if these fees are not paid. Additionally, the indirect costs of accessing healthcare may make otherwise affordable or free health services inaccessible to many.

2 Healthcare facilities and services owned by RCM partners

Some National Societies in different regions have been heavily involved in providing essential health and medical services through their own structures. These services may include operating primary, secondary, or tertiary healthcare facilities, act as main ambulance service providers in their countries, blood banks services, First Aid programs, and some specialised services e.g. eye hospitals/clinics. The National Societies, in special cases, apply fees on some services for cost recovery. Partners (PNS, UN partners, or other agencies) , through their support to these services, may waive or cover the cost for all beneficiaries or for specific vulnerable groups.

3 Health as a 'dysfunctional' market system

Health systems that rely on direct out-of-pocket payment by patients seeking health services as a main source of funding tend to be inequitable and ineffective. While all markets have imperfections, the healthcare market has all of these possible failures combined:

- The unpredictable nature of illness/injury and broad range in costs mean people can be exposed to financial hardship which leads to debt, catastrophic levels of spending, or inability and/or delays to purchase services.
- The need for regulations for quality of services and treatments.
- Unequal knowledge between patients and providers with potential for unfair practices and/or substandard quality.
- Low demand for preventive health services or commodities.
- Health systems have other public health functions such as disease prevention and health promotion interventions, or the organisation of disease surveillance and response systems for epidemics, which cannot be assured through market-based-principles or demand-side financing.

4 Quality Control

Quality control is critical in all activities, but when it comes to CVA in the health sector, quality control may need to be addressed differently; there are real risks to life and health if people are supported to access poor quality health services. As an example, patients who buy unregulated medicines run the risk of them having no impact on the progression of their illness, or in the worst-case scenario, of worsening their health or causing their death. When it comes to CVA for health, there is a difference between quality control and the need to be in control. When quality control risks are related to life and health, for example where health systems are weak, it makes sense to prefer vouchers instead of cash for access to healthcare. However, the humanitarian sector should be more comfortable with letting go of the control of how recipients use the resources we give them. Further discussion is needed on how best to proceed and some "red lines" must be defined specific to CVA for health.

CONCLUSION

The use of CVA for health outcomes is a growing field, and one which is gaining increased attention across the humanitarian sector, both within the Movement and amongst our partners.

With the continued focus placed on Universal Health Coverage, and therefore the interdependent nature of ensuring access to quality services and protection from undue financial hardship, there is increased recognition of the role of both supply- and demand-side interventions to affect health outcomes across many contexts.

Health will continue to be somewhat of a special case due to the complexities concerning the sector's "market" dysfunctions and the need to preserve the delivery of services that are quality-assured and, as much as possible, free at the point of delivery. However, growing evidence is highlighting the complementarity of CVA to positively contribute to these efforts.

There is increasing evidence to support the use of health sector specific CVA, but partners must become familiar with the approach and better understand when CVA adds value to improve health outcomes. These approaches should be identified based on factors including health seeking and barriers surveys or key informant interviews, and a basic health system assessment of how services are provided and by whom, at what quality, and with what formal or informal payment mechanisms, among other considerations.

Multi-purpose cash (MPC) can affect health outcomes, with the challenge of calculating the amount a household would need to meet their various health needs; generally, households receiving CVA support report more use of health service and better access to medication, but evidence is missing as to what extent these are obtained from qualified, rather than unqualified, providers.

Generally, there is still a lack of evidence on whether CVA for health outcomes — be it through UCT, CCT, MPC or adherence to a national health scheme — has a longer-term wellbeing effect or if it can encourage behaviour changes such an increase in use of preventive health services.



ANNEX 1: KEY DEFINITIONS

Supply-side financing



Financing Insurance (Coverage under a health insurance fund)

Subsidising coverage for a humanitarian target population under an existing health insurance fund has been applied in several countries, mostly so far for refugees (e.g. in Lebanon, Iran, Ghana), although pilots seeking integrated solutions for returnees, IDPs and vulnerable households by subsidising their coverage under a National Health Insurance Fund are being tested.

Health insurance is a system for the financing of medical expenses by means of contributions or taxes paid into a common fund to pay for all or part of an individual's health services specified in an insurance policy or the law. The key elements common to most health insurance plans are advance payment of premiums or taxes, pooling of funds, and eligibility for benefits based on contributions, employment or needs-based characteristics⁹. Health insurance schemes can be delivered by responsible public authorities, or through a combination of actors, including government ministries, private sector companies and, in some contexts, humanitarian and development actors. Indeed, many countries across numerous contexts utilise a mixed system with regards to health financing¹⁰.



Contracting providers to deliver prioritized health services (provider payment mechanisms)¹¹

Contracting for services can be done with non-state providers as well as within a public provider system. This builds on current practice through which humanitarian agencies support existing health providers and reduce fees through their inputs of supplies and resources (which may be for the general population or a specific group such as refugees). Paying incentives to health workers is also a form of contracting.

Contracts for payment are either based on inputs (e.g. staffing and running costs), on outputs of services delivered (fee per service, reimbursing the costs of hospitalization of patients referred), or sometimes with additional incentives based on reaching performance targets or milestones.

For example, Canadian Red Cross has considered an output-based approach where they cover, by fixed standard rate, the cost of normal and cesarean deliveries for vulnerable women at Syrian Arab Red Crescent (SARC) hospital in Homs.



Financial support to health provider or facility

Input based financing describes financial support given directly to a health provider/facility to enable them to purchase equipment, consumables etc. that are needed (rather than humanitarian agencies procuring and providing the inputs in kind).

For example, in Libya, ICRC has provided input-based financing to health facilities, to enable them to procure essential PPE locally for their COVID-19 response. This was brokered for Health teams by local Cash Specialists who were able to propose innovative delivery mechanisms as traditional bank to bank transfer was not possible.

If the humanitarian agency has a contract with the health provider/facility whereby the latter doesn't charge patients directly, but invoices the humanitarian agency, then it would be categorized as input-based contracting.



9. Reference source: Britannica encyclopaedia

10. WHO website on health financing

11. WHO: Provider Payment Mechanisms https://www.who.int/health_financing/topics/purchasing/payment-mechanisms/en/

Demand-side financing



Cash and Voucher Assistance (CVA)

Cash and voucher assistance is the provision of cash and/or vouchers to individuals, households or communities to enable them to access the goods and services that they need.



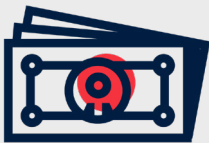
Cash transfers

Cash transfer is the provision of assistance in the form of money—either physical currency or e-cash—to recipients. This can be cash in an envelope handed over by Movement partners, cash given over the counter at a bank or remittance company, mobile money, cash through ATM cards, in fact any type of ways you can think of! Cash transfers are by nature unrestricted and recipients can use cash for any purpose.



Minimum Expenditure Basket (MEB)

A Minimum Expenditure Basket requires the identification and quantification of basic needs (items and services) that can be monetized and are accessible through local markets and services. Items and services included in an MEB are those that households in a given context are likely to prioritise, on a regular or seasonal basis. An MEB is inherently multisectoral and based on the average cost of the items or services comprising the basket. It can be calculated for various sizes of households. The Global Health Cluster has outlined specific guidance for how to consider health in the MEB and multi-purpose cash¹².



Multipurpose cash (MPC)

Multipurpose Cash Transfers (MPC) are transfers—either periodic or one-off—corresponding to the amount of money required to cover, fully or partially, a household's basic and/or recovery needs. The term refers to transfers designed to address multiple needs, with the transfer value calculated accordingly. MPC transfer values are often indexed to expenditure gaps based on a Minimum Expenditure Basket (MEB), or other monetised calculation of the amount required to cover basic needs. All MPC are unrestricted in terms of use as they can be spent as the recipient chooses. The Global Health Cluster has outlined specific guidance for how to consider health in the MEB and MPC¹³.



Vouchers

Paper or electronic vouchers are exchanged for a specific quantity or value of goods or services. Vouchers are by nature restricted, as they can only be exchanged for specific goods or services with specific retailers or service providers. In the health sector, these can include Government health service providers or preselected qualified private providers (including faith based).

Commodity vouchers are exchangeable for a fixed quantity and quality of goods or services at a specific retailer or service provider. **Value vouchers** have a monetary value and can be used to buy any goods or services from that specific retailer or service provider. A gift card is also a type of value voucher (but has a different procurement process).

In Jordan, UNHCR switched from a health contracting system to cash assistance to provide access to normal and caesarian deliveries for refugees. Under the contracted system they were charged the unified rate (the foreigner's rate) which is several times the Jordanian rate that Syrian refugees would be charged if they paid directly for services. Thus, it was more cost effective to support refugees with cash assistance to pay for themselves when they access Ministry of Health services. For example, a normal delivery is charged at 50 Jordanian Dinars (JDs) under the non-insured rate but 250 JDs under the unified rate and a caesarean section under the uninsured rate is 300 JDs but 650 JDs under the unified rate. Thus, cash assistance meant the limited referral budget can be used to serve more refugees (see references).

12. GHC: Technical Note on the Inclusion of Health Expenditures in the Minimum Expenditure Basket and Subsequent Multi-Purpose Cash Transfer
13. Idem

ANNEX 2: REFERENCES & USEFUL RESOURCES

1. Global Health Cluster (GHC)
 - [Cash webpage](#)
 - [Working paper for considering CVA for health in the humanitarian context](#)
 - [Paper on including health in the MEB](#)
 - [Role of Cash & Voucher Assistance for health outcomes: Using the Health Barriers Framework to determine the appropriate response](#)
2. Cash Learning Partnership (CaLP)
 - [Cash for health webpage](#)
 - Improving health through CVA: Tutorial series
 - [CVA for health outcomes: seeking complementarity](#) (video)
 - [Inclusion of health in the minimum expenditure basket \(MEB\)](#) (video)
 - [Barrier analysis framework for assessing potential CVA for health outcomes](#) (video)
 - [How can we use cash and voucher assistance to support universal health goals?](#) (podcast)
3. GOAL
 - [A global mapping of GOAL's cash, vouchers, and social protection interventions linked with health](#)
4. UNFPA
 - [Philippines case study: Cash assistance to access sexual and reproductive health services and reduce maternal deaths](#)
 - [Philippines Case Study: Cash for protection for survivors of gender-based violence \(GBV\) and women at risk of GBV](#)
5. IFRC
 - [Cash and voucher assistance for health outcomes: a summary of the evidence base](#)
6. UNHCR
 - [Cash for health: Key learnings from a cash for health intervention in Jordan](#)
7. WHO
 - [Health financing website](#)

For up-to-date information about the Red Cross Red Crescent Movement's approach to cash for health outcomes, visit:

www.cash-hub.org/resources/cash-and-health/

or contact the co-chairs of the cash for health outcomes technical subworking group:

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