21st October 2020 Cash Hub Webinar Summary Points

Topic: CVA for Health

Speaker	Summary Takeaways
Mark James Johnson, Health and Care Department IFRC, Geneva	The aim of this discussion is to cover key concepts and definitions which will be important for the rest of this webinar. We need to speak the same language. **Health Statistics** According to the WHO, more than half of the world's population do not have access to all of the essential services they require. With many millions of people around the world facing financial barriers to the access health services. Data from the World Bank and WHO reports: • 930 million people spend at least 10% of their household budgets on health expenditure • 210 million people spend at least 25% of their household budgets on health expenditure The consequence of these health expenses for people are that we see people being pushed into various levels of poverty. An estimated 90 million people are pushed into extreme poverty due to health expenditure, defined as living below $1.90 per person per day. Furthermore, just less than 99 million people are pushed below the threshold of $3.20 per person per day. The point to emphasize here is that issue of poverty, financial barriers and access to services are all intrinsically linked, and they often mutually reinforce one another. **Cash and health, two worlds collide** For CVA there are the Grand Bargain commitments, which state that "cash should be considered equally and systematically alongside other forms of humanitarian assistance, and be used where feasible". The IFRC have committed to this as an institution and it is the responsibility of both cash and technical colleagues to uphold these commitments. Within Public Health there is the Universal Health Coverage agenda, arguably the sector's central agenda. This is founded on the belief that everyone, everywhere should have access to the health services that they need, and crucially that individuals are not subject to undue financial hardship when accessing these services. Within the health sector the focus has always been on service provision and access. Of course, the financial side of public health is nothing new, but here it is intrinsically tied together in the policy agendas that we as humanitarian or development actors have signed up to. What does this mean in practice and what are we aiming to do?

	• Look at how humanitarians contribute to reducing the reliance on out of pocket payments in all contexts, particularly as out of pocket payments are often regressive [placing more burden on the poor than the rich]. • The consensus within humanitarian settings and public health is that essential services should be free at the point of delivery, however the reality is often very different. Where possible, we should have an interest in protecting individuals from these out of pocket expenses and catastrophic health expenditures. • In order to do this, we need to look at accounting for direct and indirect financial barriers to access health services, commodities or other aspects of health care as appropriate. **Definitions** 'Cash and voucher assistance (CVA) 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.' (CaLP, Movement definition) Therefore, 'CVA for health outcomes is the use of cash and/or voucher assistance to help achieve health outcomes.' – cash is a means to meet sector objectives, not a sector itself. **Demand side** Support can be provided directly to recipients through CVA in a range of ways these can be: service/commodity vouchers (e.g. voucher to a pregnant woman to buy a malaria net); value vouchers (e.g. NHS in the UK provides various levels of value vouchers for glasses and lenses, these are means-based with eligibility relying on the income level of the individual); unconditional and conditional cash transfers (e.g. conditional cash for antenatal and postnatal care services); and multipurpose cash (e.g. the WHO have begun to incorporate health cost calculations in minimum expenditure baskets). **Supply side** Supply side includes support provided to those who supply health care services, which are not CVA programmes. These include subsidising coverage under health insurance schemes, contracting providers to deliver prioritised services, and direct external assistance. Important to understand that there is a hierarchy of preferred financing options. Demand must be seen as complimentary to the preferred options on the supply side, including our normal work around service provision. As with all cash assistance, we must ensure the market is functioning, which in this case is the health system. Therefore, cash and vouchers will play a complimentary role alongside the service provision and supply side work of the humanitarian sector. A set of overview questions being focused on within the CVA and Health technical working group:

	1) Quality, quality, quality 2) The unpredictable nature of illness/injury 3) Health as a dysfunctional system 4) Unequal knowledge between patients and providers 5) Small, but growing evidence base (we want to hear from you about the work that you are doing).
Ansa Masaud Baloch Jørgensen, Cash and Health Coordinator, Norwegian Red Cross	**Health Care Costs: What are they?** Framing the issue: - Health care recovery happens in a context, health care choices are based on a range of factors with costs and fees being one, although not the only key dimension. - Understanding health care costs and expenditures should inform CVA costs coverage and programming. - Recognise that health expenditures are not even, they are unpredictable (with both illness and injury) and there are differing spending levels between different groups (including the socioeconomic status of households and groups). - Health care costs are not uniform costs for all, expenditure varies in both income and health seeking behaviours and this needs to be considered when planning CVA programmes. - For cash transfer programming experts an understanding of health care costs is key to their implementation of their CVA programming. **Health care costs can be split into direct and indirect costs** Direct costs include user fees for accessing the healthcare, admission and registration fees, diagnosis and test fees, hospitalization and bed charges, operational and surgery costs, costs for drugs and medicines, vaccination costs, costs for medical supplies, and costs for hygiene products. Indirect health costs and opportunity costs include non-medical healthcare costs (e.g. accommodation or food costs), transport costs, social and family (e.g. costs of care for children and dependents), and the financial effects of income loss whilst undergoing treatment. Both direct and indirect costs can be significant, often the direct costs are higher financially, but the hidden indirect costs can also result in great financial strain for households. **Conclusion** - It is important to understand that health care costs and household expenditures will vary per household and this needs to be taken into account when designing CVA options. - There are regulated and unregulated fees, which needs to be considered when designing response options and completing market assessments. - It is important to take indirect costs into account, as they can hinder an individual's access to health care.

	- Health expenses are not even, and they cannot be calculated as an average or blanket amount for households in need in CVA programmes. **Upcoming resources:** Thematic series from Norwegian Red Cross will focus on health care costs, access to and utilization of health care, and CVA in nutrition and maternal care.
Sophia Peponi, Director of Programmes Department, Cash Transfer Programming Coordinator, Hellenic Red Cross	**Conditional Cash for Health** The conditional cash for health programme is part of the HRC's National Plan for COVID19 under the Health Pilar 6: 'maintain access to essential health services (clinical and paramedical)' This programme will aim to fill a two-fold gap in the national health system for vulnerable individuals or those on low-incomes addressing: - Contribution to patients' medicines and diagnostic test expenses - Health care follow-up, consultation and personal contact This programme will support 500 vulnerable individuals with underlying chronic diseases with CVA, supplementing their medical and pharmaceutical expenses and assisting them to take better care of their own health conditions. The objective of the programme is to support these at-risk individuals so that they are less prone to infections, including COVID19. **Intervention and targeting** The programme will deliver conditional cash grants of 130 EUR a month for 6 months, which will be fixed for all beneficiaries. The total budget for this programme is 438,652 EUR which includes 390,000 EUR of cash grants. 500 individuals will be targeted, those with underlying chronic diseases from vulnerable social and economic contexts in two regions of North Greece. The minimum expenditure basket takes into account costs for pharmacy expenses, diagnostic test, transportation to hospital and HRC Branches, and data expenses (from electronic prescriptions). This programme is planned to begin in the 1st quarter of 2021 and is currently waiting for confirmation of funding requests. **Selection Criteria** Selection criteria includes both context specific criteria related to those vulnerable to COVID19, standard vulnerability criteria and annual income criteria. 1) Context specific criteria (meets at least 2 in this category) Chronic Obstructive Pulmonary Disease (COPD), individuals 65+ who have been hospitalized with Covid19 (potential complications, special needs, after hospitalization, etc.), diabetes, hypertension, heart disease, obesity. 2) Vulnerability criteria (meets at least 1 in this category)

	Lonely elderly 65+, family members of single headed families or large families (6+), persons with a serious health condition (life threatening), people with disabilities, unemployed (long term or due to Covid19). 3) Annual income criteria, using thresholds (indicative) 6,500 EUR for lonely elderly or 9,000 EUR for single headed family with at least one member with disability or chronic disease. **Cooperation with HRC Health Sector** HRC nurses will be working with beneficiaries to prepare individual health care plans; follow up on implementation of these plans; visit and see beneficiaries twice a month for personalised care; provide health and hygiene promotion activities; and verify plans each month with cash programming team in order to trigger the next instalment of the cash grant. **Conditionality** This the first time the HRC have designed and implemented a conditional CVA programme. Beneficiaries will need to follow their individual health care plans set by the HRC nurses in order to be entitled to the next monthly instalment. The aim of the conditionality is to encourage beneficiaries to adopt a healthier lifestyle and take care of their health so that they become less vulnerable to contracting COVID19. **Exit Strategy** The provision of services will continue at the end of the programme and where possible group sessions with tailor made thematics will be held within Branch Health Clubs. The HRC will also make referrals of beneficiaries to social pharmacies and social services, aiming to prepare individuals and signpost to other support systems available. In addition, the HRC will inform beneficiaries of Social Solidarity Income, their eligibility and how to apply.
Jan van Zoelen, former Cash and Markets Specialist, DR Congo, ICRC **Jo Burton**, Global Cash and Markets Lead, ICRC	**DR Congo Case Study** This programme began in Eastern DRC in 2020 and was initially requested by the surgical team as they found many of the weapon-wounded patients they were seeing at the hospital had other needs which were not being addressed. These needs, for example loss accommodation or loss of bread winner due to violence, were affecting health outcomes as discharged patients were not able to cover their basic needs. A CVA programme was launched to address these needs. Unconditional cash grants were given in order to enable beneficiaries to use the funds for a variety of needs, including shelter, medicine and basic needs, aiming to improve their overall health outcomes. The programme was inspired from the needs that weapon-wounded patients have, but it at expanded to include at risk patients being treated by the mental health department, patients being treated by the physical rehabilitation programme, as well as some protection cases.

	The provision of the assistance was delivered by the staff working directly with the beneficiary (staff from health, mental health, physical rehabilitation and protection departments), therefore providing one consistent focal point for the beneficiary. The programmes tools, procedures and transfer value ($150) were all designed by the ICRC Cash and Markets specialists. A Cash and Markets specialist continues to support the programme technically. **Implementation and evaluation of the programme** The programme began in February 2020 and to date 118 beneficiaries have been assisted, including 30 mental health beneficiaries, 15 weapon-wounded patients and 4 patients from the physical rehabilitation programme. A formal evaluation is currently ongoing; however, initial reports show that it has supported individuals in recovering from their surgery post discharge from hospital, protecting and improving some of their original health outcomes. The programme's beneficiaries use the cash payments for both direct and indirect costs e.g. payment of food, medicines, follow up treatment, travel to health facilities. This programme provides only short-term support to beneficiaries, for some that will be sufficient; however, for others who need further support, they may be eligible for further ICRC/British Red Cross cash for livelihoods programme, which has been implemented since 2015. This programme provides business training for individuals, supporting them to become autonomous and consequently be able to pay for any health or medical expenses they may have. **ICRC Global Overview CVA for Health** In ICRC we started conversations with our Health colleagues several years ago, about how we could use CVA to support Health Outcomes. ICRC works with health services at different levels, and has 5 categories of intervention, and often we provide a combination of interventions including direct support for the supply of goods and services, rehabilitation and construction of infrastructure, capacity building and training, organizational support around systems and approaches and advocacy around health rights and their protection, medical ethics etc. When it comes to CVA, which is money given to individuals not financial support given facilities – so from a health perspective to patients and their families or at risk individuals – ICRC recognizes that there are both direct and indirect costs of healthcare; so this is how we frame our work. One major indirect cost is transport. We often give CVA (normally cash), for example in South Sudan to support a referral for services where a patient then has to travel long distances to access those services, so giving them cash to cover that cost. We also support other indirect costs. In Ukraine, we give civilians casualties cash to compensate a lack of

	income due to their injury, until they can get back to work, so enabling them to cover their basic needs during the recovery period where they can't work, thus protecting their health outcomes and the well being of their family. CVA can support communities' wider health and wellbeing. ICRC gives cash transfers to cover basic needs (multipurpose cash) which will contribute to improving the overall situation of the household, giving them money to buy food, hygiene items, pay rent, pay for schooling etc. all of which contributes to better health (including mental health) outcomes. For example, there is evidence that shows that receiving cash helps households diversify their diets, improving nutritional outcomes, and contributing to better health outcomes overall. ICRC also uses CVA for risk reduction, where cash transfers are given to 'at risk' groups to help prevent or reduce risky or negative coping mechanisms (unsafe work, reducing meals etc.), which in turn can improve health outcomes. We do this in DRC, South Sudan and others. When it comes to provision of healthcare itself, CVA can only ever complement work done with health facilities, it cannot replace it. We are not trying to monetize healthcare or encourage people to pay for services that should be free at the point of use. So, for example in Lebanon, where healthcare does need to be paid for, we have provided conditional cash transfers to pregnant women to help them access ante natal, delivery and post-natal care. We did this because research showed that two of the three main barriers facing women was the cost of the care itself (so the fees for the services) and the cost of the transport to reach the services. On the contrary, in Somalia, our team asked me about providing CCT for access to maternal health services, but when they examined the root problem, it was not a financial barrier like in Lebanon…it was a knowledge barrier. In short women who went to the 1st ANC visit and had a 'normal' checkup, didn't think they needed to go back for any more visits. So here the problem was not financial and cannot then be solved with CVA. These two examples, really underline the need for strong analysis of the health system, its functioning, the quality of services, and to understand any systems of user fees (whether formal or informal), but most importantly to understand the barriers and root causes that prevent people from accessing healthcare. We must be clear: CVA can only solve financial barriers of accessing healthcare. It cannot address other barriers including lack of quality services (or lack of services altogether), knowledge barriers, cultural barriers etc. Whilst in ICRC, CVA targeted at generally improving the living conditions and wellbeing of communities and reducing risk for specific target populations will continue, 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) as well as indirect costs, such as transport. Enabling people to purchase such services should be restricted to providers from which quality standards can be ensured by regular supervision or checks from health professionals.

Prepared by Cara Wilson based on what was said in the Webinar and the takeaways may not reflect the top takeaways of the speaker as they see them.