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Technical Note on the Inclusion of Health Expenditures in the Minimum Expenditure Basket and Subsequent Multi-Purpose Cash Transfer

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Cash Task Team
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Summary key messages

- The MEB is a concept to describe expenditures for average basic needs of households.
- Findings indicate that 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 always report having related expenditures, health expenditures should always be reflected in an MEB
- Unlike food and non-food items needs, however, health needs within a population vary between individuals and households over time. This means that the translation of the average household expenditures for health in response options is different compared to other needs reflected in the MEB that do apply regularly to all households in more or less the same way.
- Similarly – for food and non-food items (including Shelter and WASH items), the household expenditures often reflect the full costs of the items as they are sold in the market, whereas for health it tends to be more complicated, as the health expenditures for a household are not equal to the total costs for all the health services (including direct and indirect costs).
- We propose three methods to determine the health portion of the MEB: the average cost and the household contribution for a package of essential services; household expenditure surveys; and in the absence of data for these two methods, including health expenditure as a dynamic and optimal portion of the MEB.
- For each method we provide issues that need to be considered to understand their limitations and how to make informed corrections.
- Acknowledging health expenditures in the MEB only confirms that households have health related expenditures and does not mean that a subsequent inclusion of the same amount in an MPC is the preferred default response option to ensure financial access to essential health services.
- For using the heath part of the MEB to determine a transfer value for an MPC, we discuss the gap analysis method, to estimate 'unmet needs': the proportion of the MEB needs that is not met through a household's own income, nor by other forms of support from partners.
- As the objective in the health sector, in support of equitable access and protection from catastrophic health expenditures, is to reduce the reliance on user fees, expenditures related to health needs as reflected in the MEB should primarily be addressed through provider payment mechanisms, complemented by health sector specific CVA that can also address indirect costs.
- As these approaches should significantly reduce the need for households to pay for a health service when needed from their monthly income, the proportion of unmet need that remains should be low.
- If partners expect that these interventions may take time to be implemented with adequate coverage, the proportion of unmet need will initially be closer to the full health part of the MEB, and thus translate in an almost similar MPC transfer value for health.
- However, the latter should only be an interim solution, and while this may seem to be the 'easy and most efficient' option to address the 'unmet needs', this should be reduced as soon as the desired interventions (provider payment mechanisms and sector specific CVA) become effective.
- Subsequent expenditures surveys should then demonstrate that households do have reduced 'out of pocket' health expenditures, based on which the MEB part for health can be reduced.
- If this is not respected, the MPC would inadvertently contribute to a fee-charging culture for priority services, which would undermine financial protection for health and progress towards universal health coverage.

Contents

1. Objective and target audience

This technical note aims at providing a general guidance on how to reflect health expenditures in the design of the Minimum Expenditure Basket (MEB). We also include within the guidance how these health expenditures can be translated into an optimal mix of response options for health sector specific supply and demand side financing options for reducing financial barriers to access essential quality health services.

It is important to note that as health needs with subsequent health related expenditures are identified in an MEB, the optimal response is to reduce the user fees, therefore addressing the supply side, so as not to inadvertently contribute to a fee-charging culture for priority services, as this would undermine financial protection for health and progress towards universal health coverage. If after having introduced these responses households still report health related expenditures, these can then be included in a Multi-Purpose Cash (MPC) grant, or sector specific CVA.

This note, and thus the design of the health portion of the MEB and how to use the findings to inform the optimal mix of response options is premised on that logic, as outlined in the Health Cluster's Cash Task Team Working Paper for Considering Cash Transfer Programming for Health in Humanitarian Context.

The target audience for this document are both health and cash practitioners. We note in different sections of the note, who we think should take the lead in the design, but like all other planning of humanitarian interventions, the design of the health portion of the MEB should be a collaborative effort across all clusters.

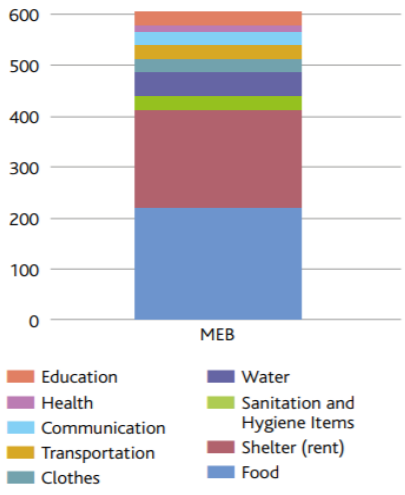
2. Basic MEB concepts

2.1 What is the Minimum Expenditure Basket (MEB)

According to the Cash Learning Partnerships, a Minimum Expenditure Basket (MEB) is a list of "basic needs items and services that can be monetized and are accessible in adequate quality through local markets and services. Items and services included in an MEB are those that households in a given context are likely to prioritize, on a regular or seasonal basis. An MEB is inherently multisectoral and based on the average cost of the items composing the basket. It can be calculated for various sizes of households"[1].

The MEB provides a better understanding both on how the households prioritize their needs, and in some cases which sectoral standards need to be met. It is therefore important to coordinate with all relevant sectors when assessing household priorities and spending patterns.

FIGURE 2. *Minimum Expenditure Basket from Syria Crisis: Lebanon*



There are different views on what constitutes an MEB, based on minimum consumption standards of essential goods and services.

[1] Cash Learning Partnership (2018), Glossary of terminology for cash and voucher assistance. [http://www.cashlearning.org/downloads/calp-glossary-english.pdf]

2.2 Purpose of the MEB

The MEB can be used to **inform program design** and can be a critical component in the design of cross-sectoral interventions, including a Multipurpose Cash (MPC) transfer, with transfer amounts calculated to contribute to meeting the needs as reflected in an MEB.

An MEB does not necessarily equate to all the essential needs of a household. While it aims to capture the whole of household essential needs, in reality it is limited to what can be purchased/obtained through the markets, and therefore does not capture *all* essential needs.

A **Minimum Expenditure Basket (MEB)** is an increasingly popular operational tool for calculating the transfer value of a MPC, but these are not the same thing. *See Part 3 how the MEB can be used for estimating transfer*

2.3 Designing an MEB

In a humanitarian crisis, the affected population are the best source of information to understand their minimum expenditure standards/requirements. These can be compared to minimum consumption requirements as defined by international standards. For this reason, it is important to consult and engage stakeholders in the development and design of an MEB, the first being the affected populations themselves.

Other stakeholders include humanitarian actors, such as clusters/sectors who will contribute to determining what is needed and what can be purchased by the populations. The government is also an important actor to consider, particularly when there are already existing social safety nets. This is also relevant when determining the gap analysis and the transfer value.

A. Determining the content of the MEB

Determining the content of the MEB is generally an exercise that includes several clusters and is done at the inter-cluster level. In most cases, it is led by an existing Cash Working Group (CWG), however it should include all sectors. In general, we can distinguish four main approaches to design an MEB:

a) **A right-based approach,** with a list of basic human rights as described in international treaties & humanitarian standards (such as Sphere standards for education, shelter, water, health and food).
b) **Needs-based approach:** the components of the MEB are identified by the affected population. With this method, the result can sometimes be different from the right-based approach as households may not see certain goods and services (e.g health prevention interventions or vector control) as part of their essential needs.
c) **Expenditure-based approach:** This method is based on the reported household expenditures per category of need.
d) **A mixed approach**: some needs will still be in the MEB even if households did not prioritize them or did not spent money on them.

Needs assessments are usually a good source of information on the household's priority needs, including for instance health or shelter expenditures. Secondary data can also be used, especially in an emergency context where an assessment is not feasible due to capacity or time-constraints.

Where possible, organizations should also engage the community in determining what to include in the MEB, mixing both a right-based and needs based approach because different communities will have different needs. For instance, refugee communities may have low health care expenditures, because services are subsidized, whereas the host community may have higher expenditures if

services for them have high user fees. Similarly, in informal camps, IDP's may not have shelter related costs, however other communities will.

While an MEB aims to capture the average recurring minimum essential needs for all households, it does not account for additional needs for vulnerable groups in individual households, including pregnant and lactating women, infants, the elderly, persons with disabilities, and those with chronic illnesses. It is important to reflect the differences in health needs between households and changes over time in the analysis as well as in the interpretation of the findings in response options, and not just focus on average needs.

Furthermore, changes by season (e.g. related to agriculture or education) or stage in the emergency response (needs, availability of goods and services), including winterization or summer items need to be considered.

Finally, the MEB differentiates between recurring costs (such as food, rent), and one-off cost. The needs assessments will be a good source of information on the populations' expenditures, including recurring costs, which almost always translates into priority needs.

B. Calculate the average cost per item of the MEB

By determining what should be in the MEB, we know which markets for goods and services should be considered for assessments. It allows us to quantify needs and therefore support effective gap analysis on both multi-sectoral and single sector programmes. This influences the design of and harmonizes the transfer values later in the response analysis process, and defines the coordination needs between sectoral programmes.

In many cases, the CWG facilitates the process for the cost of the minimum expenditure basket, including setting up price monitoring systems to ensure the MEB is updated according to market prices.

Items in the MEB are generally calculated on the average market unit prices, the amount or quantity of such units and the number of persons in a household.[2] The household size is generally determined during the MEB assessment or from demographic data sources, e.g registration data for refugees/IDP's or population consensus.

BOX 1: Sample MEB calculation table based on market prices for North-east Syria[1]

Item	Unit	Quantity	Price per unit	Total Cost (SYP)
Food Items				
Bulgar	Kg	15	198	2,970
Rice	Kg	19	431	8,189
Bread	Kg	37	123	4,551
Dried Pulses	Kg	15	398	5,970
Ghee/Vegetable Oil	Kg	7	747	5,229
Sugar	Kg	5	390	1,950
Salt	Kg	1	63	63
Fresh seasonal vegetables	Kg	12	131	1,572
Chicken	Kg	6	843	5,058
Eggs	Kg	6	992	5,952
Tomato Paste	Kg	6	565	3,390
NFIs				
Individual Soap	Pieces	12	166	1,992
Laundry/Dish Soap	Kg	3	362	1,086
Toothpaste	Pieces	2	183	366
Sanitary Pads	Pack of 10	4	230	920
Water and Sanitation				
Drinking Water	Liter	4500	.54	2,430
Other services				
Internet	1 GB	1	550	550
Gas Tank	Liter	25	278	6,950
Total				59,188

[2] It is worth nothing that an MEB can be more accurate if defined on an average individual level rather than average HH size.

Different clusters/sectors feed into the cost of the items of the MEB. See examples in **Box 1.** For instance, the Food Security Cluster will have the cost of the food portion of the MEB, based on the 2,100 Kcal.

Other MEBs can include for instance, shelter, children's clothing, and in many cases winterization items. The WASH cluster will provide the cost of a hygiene kit.

Price monitoring, as well as Post-distribution monitoring data are then used to update any changes in the cost of the MEB to ensure these are reflected accurately, as well any changes of availability of items within the MEB.

3. Health and MEB

3.1 Access to a package of essential quality health services as a basic need

Health needs are among the basic needs that households have and are considered a survival need. Household surveys consistently indicate that health care is among the top three priority needs.

Unlike food and non-food items needs, the occurrence of illness and the need to utilize a curative or preventive health service varies between individuals and households over time. Subsequent health expenditures also vary between the type and duration of the illness, and the different levels of severity or complications that may occur.

While at population level we can estimate average household health expenditures, the application to single households or individuals is not appropriate. This means that the translation of the average household expenditures for health in response options is different compared to other needs reflected in the MEB that do apply regularly to all households in more or less the same way and can thus be addressed largely by MPCs. Moreover, some diseases have seasonal trends, *i.e*. malaria cases increase during the raining season.

There are also other health needs that are considered Common Goods for Health (CGH).[3] Common Goods for Health are population-based functions or interventions that require collective financing, either from the government or donors based on the following conditions:

- Contribute to health and economic progress
- There is a clear economic rationale for interventions based on market failures.

They include for instance health risk reduction measures, such as vector control or preventive programs, such as vaccination for measles. Certain diseases, such as TB, are considered public health risks, and control programs are publicly funded. Epidemic preparedness and response are also a CGH, including disease surveillance. As such, benefitting from CGHs should not lead to direct household expenditures, and thus, do not need to be reflected as a need in the MEB. Households may contribute however indirectly, for example trough taxation. For a summary of health-related needs that should and should not be considered in the MEB, see **Box 2.**

It is also important to note that whereas for example, for food items the household expenditures often reflect the full costs of the items as they are sold in the market, the household expenditures for health are not equal to the total costs for all the health services. These are called the Total Health Expenditure (THE), and this is always a combination of public funding (contributions from government, donors and

[3] https://www.who.int/health-topics/common-goods-for-health#tab=tab_3

obligatory health insurance), and private funding (out of pocket payments)[4]. When a substantial proportion of the THE is out of pocket, this inevitably leads to inequity for access, due to financial barriers and increase the risk for catastrophic health expenditures.

Therefore, **the aim of health financing is to provide a social safety net to ensure access to an essential package of quality health services for citizens when they are in need to use a service, without suffering financial hardship.** There is consensus among both development and humanitarian health partners that such services should be provided for free at the point of delivery, by reducing reliance on user fees (private funds) and thus by increasing the public funding proportion of the THE to finance access to health services. Even more so in humanitarian contexts, there should be no user fees, for consultations, diagnostic test or treatments, charged by health service providers. However, this policy is often not fully implemented, and, in many cases, households still have expenditures related to health (see **Box 2**).

Similar to the market approach, the humanitarian health response should strive to make services available and accessible through the existing providers in the health system but based on general principles for health financing for UHC[5]. When quality services are available with adequate capacity for a humanitarian target group, partners should use pooled funds from humanitarian donors to purchase services from existing qualified providers (public or private) against a prioritized package of health services.

3.2 Household Health Expenditures in the MEB

Household expenditure surveys and Post-Distribution Monitoring (PDM) reports consistently reflect that household expenditures for health are frequently the third or sometimes even the second highest expenditure category, with often a substantial proportion of the households reporting health expenditures of more than 10% or 25% of their total household expenditures.[6] [7] These are thresholds for having catastrophic health expenditures. Moreover, lack of funds is frequently mentioned as a barrier for accessing essential health services in negative coping strategy surveys.

Health care costs can also be one of the main reasons for households incurring medium to high debts.[8] Unfortunately, health data in PDMs is often not broken down into categories of what the health-related expenditures are, where they are incurred, for what, and whether they are direct or indirect costs, as outlined in **Box 2** below (see also 3.2).

These findings indicate that households will always have some level of health expenditures, even when policies are in place for priority services to be provided free of charge in public facilities. This implies that such policy is not always fully implemented, and patients still have to pay for services not included and thus subsidized in a high priority package and/or there may be informal fees charged by

[4] In humanitarian contexts, a significant proportion of the Total Health Expenditure (THE) for the humanitarian target group will be financed by humanitarian partners and donor governments. These are thus also considered public funds. The gap is then paid by households as out of pocket payments (private funds).
[5] See Health financing policy in fragile and conflict affected situations. https://www.who.int/publications-detail/health-financing-policy-in-fragile-conflict-affected-situations/
[6] Wagtaff A et all. Progress on catastrophic health spending in 133 countries: a retrospective observational study. The Lancet, Volume 6, ISSUE 2, e169-e179, February 01, 2018.
https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(17)30429-1/fulltext
[7] Cylus J et al. Catastrophic health spending in Europe: equity and policy implications of different calculation methods. Bulletin of the World Health Organization 2018;96:599-609
https://www.who.int/bulletin/volumes/96/9/18-209031/en/
[8] Whole of Afghanistan Assessment, 2019

public providers. It may also be that there is an issue of the quality of the service, driving patients to seek a private provider or traditional medicine. Furthermore, in many situations patients report having to buy medication from private pharmacies, as public providers that should have provided the medication for free have stockouts.

People may also purchase non-prescription drugs for common illnesses and/or incur indirect costs (see Box 2 for examples). Given that access to essential health services is a basic need and that households always have some level of health expenditures related to seeking health services, their expenditures for health therefore should always be reflected in the MEB.

BOX 2: Health related expenditures	
Health needs that may lead to household health expenditures that should be considered in the MEB	**Other health needs that are Common Goods for Health, and should not require direct expenditures for households, and thus not part of the MEB**

• Direct costs at public health facilities:
  ○ Formal or informal fees for services, outpatient, or inpatient
  ○ Fees for diagnostic tests
  ○ Fees for medication or medical supplies
  ○ Fees for medical assisted devices
• Services from private health providers, including traditional healers.
• Purchasing prescription or non-prescription drugs from unregulated drug outlets, or private pharmacies.
• Indirect costs related to transport or for a caretaker (also related to utilize free preventive programmes).
• Health commodities as baby kits, female hygiene kits, or mosquito nets.
• Other health commodities that are advised to purchase in health promotion programs (nutrition good for diverse diet, soap for hygiene).
	• Preventive health programmes, as immunization and growth monitoring, antenatal and post-natal care
	• Risk reduction measures, as vector and rodent control, or monitoring quality of drinking water.
	• Treatment of diseases that are of public health concern, as TB, or HIV.
	• All hazard emergency and disaster risk management for health.
	• Epidemic disease control, and treatment of epidemic case load.
	• Surveillance and early warning systems.

NB: Acknowledging health expenditures in the MEB only confirms that households have health related expenditures and does not automatically mean that a subsequent inclusion of the same amount in a MPC is the most appropriate or preferred default response option to ensure financial access to essential quality health services. See for more information on this in Part3.

3.3 Determining the health expenditures in the MEB

When considering current household health expenditures in the MEB, such an amount cannot not be seen as static. This is because it is inter-dependent with possible changes in government contribution to the total health expenditures and external funding from humanitarian donors and partners that aim to make the household health expenditure as low as possible. Or partners who aim to shift from making the payment when a health service is needed, to collecting and pooling public revenue for health through obligatory pre-payment into a social health insurance, or general taxation. There will often be a mix of the above and their contribution to the total health expenditures will change over periods of time.

Taking these factors into account, we propose the following methods to estimate a reasonable amount or proportion of the MEB for household health expenditures. Where possible, different methods could and should be applied for triangulation, to arrive at the optimal estimate for the MEB. This exercise is best done by health practitioners internally within the health cluster, in collaboration with the cash expert leading the MEB estimates.

A. Expenditures for a Package of Essential Health Services

This is the equivalent of the market approach described above, as it is informed by a health system assessment, which should then lead to the definition of the essential services that are needed and the average costs for it. The difference with markets in other sectors is that in the health 'system, there is almost always a mix of public and private (for profit and not for profit) providers, as well as traditional medicine.

In principle, patients should go to health facilities with health providers whose services are supported with public funds, including support from humanitarian partners. This should ensure minimum quality and limited, or no fees being charged. In practice, however, many people also seek services from non-regulated and/or private-for-profit providers, based on perceptions of quality or linked with health seeking behaviours.

BOX 3: Health system assessment

Sources of information: Needs assessment, household surveys, health facility assessments, national health policy documents, etc.
Examples of key questions, relevant for health MEB:

- What is the burden of disease?
- How are health services provided and by whom? What is the mix of public and private providers, for profit and not-for-profit?
- What services are available from which type of provider, where and at what cost, and with which quality?
- Are private pharmacies and drug-outlets regulated?
- When people need a health service, where do they seek this, why?
- What are the key bottlenecks in the health system for the delivery of services?
- What are the barriers to seeking care?
- What is the health expenditure patterns?
- How much do people spend on indirect costs, such as transport or costs for the caretaker?
- What proportion of households has catastrophic health expenditures?
- Is there a package of essential health services, including a high priority package adapted for populations in fragile, conflict and violence (FCV) settings? Is it costed?
- Does the government have a health financing strategy, with protection for the poor?
- What are the formal policies on user fees and are there exemption schemes for the poorest or most vulnerable, including for example IDPs?

Most countries have defined and costed essential packages of quality health services, based on its burden of disease and the availability of effective interventions. Humanitarian programs then often select a subset from this to agree on a High Priority Package (HPP), such as the Minimum Service Package in Yemen.[9] In humanitarian contexts, such national packages are also adapted by taking into account specific health needs that could result from a crisis, and by adapting the mix of service delivery platforms to take into account the different operational and security contexts in such settings.[10]

Such adapted HPP can then be costed, and thus translated in an average cost per person per year, which would give a reference for the total costs to deliver these packages for a humanitarian target population (the equivalent to the concept of Total Health Expenditures, applied to a specific target population). Deducting the contribution from the government (for example salaries for health workers which may be paid by the MoH) leaves an amount that could then be included in the MEB (because it is assumed that is the cost that households will incur if access is not subsidized by donors and/or humanitarian partners).

Such amount, however, does not include indirect health expenditures, such as transportation or accommodation for a caretaker. It would also not account for the fact that people may need services not covered in the package, and/or prefer to seek services from private providers or traditional medicine, or purchase medicines from private pharmacies and/or non-regulated drug outlets. The latter is often required when public providers have stock-outs, or when their quality is perceived to

[9] http://yemenhc.org/?wpdmpro=minimum-service-package-guideline

[10] e.g. by delivering certain services through mobile teams or task-sharing by supervised community health workers, when it is not possible to support a fixed primary care facility.

be lower than the private sector. For this reason, more detailed household health expenditure survey is needed to better understand health expenditure patterns, including direct and indirect health, in which case the MEB should be adapted to reflect these costs.[11]

In countries that have a social health insurance system, the Ministry of Health together with the insurance fund that acts as purchasing agency design a benefit package that includes services at primary, secondary and tertiary care levels. Based on its costing at population level, a premium for households' contributions is then estimated which is then ideally to be collected through obligatory pre-payment. The premium would be the amount then to include under the MEB, plus any indirect costs related to health care. When a humanitarian partner pays directly the premium for households in a target population to the insurance fund, then the premium no longer needs to be included in the MEB.

Additional issues to consider when using a costed high priority package as reference for the MEB:

- When there is only private insurance for the formal sector as reference (e.g. for employees of large companies and government) the amount of the premium would be an underestimate of a population- based-premium that would also include health needs of households with informal livelihoods and the poor, as people enrolled are usually healthier and in less need of services compared to the national average.
- Health commodities are often not included in an HPP for health services and should be taken into account when estimated the health component of the MEB. These include baby kits, female hygiene kits, mosquito nets, etc.

What does this look like in practice:

- The Minimum service package that was adopted by the Yemen Health cluster, was costed in 2017 with a baseline cost estimate, calculated for full-service coverage and standard staff productivity, of a per capita cost between $21 USD and $23 USD only for running costs. This was about the total government health expenditure in the period preceding the current conflict. Different scenarios of staff productivity and service coverage produce per capita costs ranging from $9 USD (low coverage and reasonable productivity) and $29 USD (high coverage and low staff productivity) with a perhaps more realistic one of $14 USD (low coverage and low staff productivity).
- UNHCR, in countries where this was feasible, has paid the premium for enrolment of refugees under a national social insurance fund, such as in Sudan, Iran, etc. When they pay directly to the fund, the amount should not be included in the MEB of the refugees. The premium amount can be taken though as reference for non-refugee humanitarian target populations.

B. Household Expenditure Surveys

The health component of household expenditure surveys can reflect the real expenditures that households have related to health. Beside estimating the average expenditure for health, the data can also be used to calculate the proportion of households with catastrophic expenditures (>10% and >25%, respectively of the total household expenditure related to health).

Such surveys are done for the National Health Accounts (NHA), and usually provide information on health needs, health seeking behaviour, barriers to accessing health, and expenditures. Expenditures are often disaggregated for inpatient and outpatient services, medicines, and diagnostics, with a breakdown between wealth quintiles and subnational or urban/rural differences. The NHA household

[11] It is important to ensure that the right questions are asked on the health-related expenditures, as well as the right data collection tools are in place for this, see section 3.2.

health expenditure surveys, however, do not generally include indirect costs, such as transportation, or costs for the caretaker, or health commodities.

Household expenditure surveys are also coordinated by Cash Working Groups, as part of Basic Needs Assessments or PDM surveys, and can include information on health expenditures though not always detailed.

Furthermore, additional information on how health expenditures may pose barriers to accessing essential services can be gathered from surveys on negative coping mechanisms. Related to health this could include questions such as whether a household was unable to seek a service when they needed it, as they prioritized other needs, or due to other then financial barriers[12] whether the household resorted to selling assets or incurring debt, or deprioritized another need to meet a health need.

Issues to consider:

- Health expenditure surveys do not necessarily reflect the real need for utilization of health services. Often households in the lower wealth quintiles with usually higher health needs have less expenditures, as they can afford less and often delay seeking care or in some cases, do not seek it when there is a health care need. The amount for their health expenditures reflected is thus often an underestimate of their real needs.
- In cases where household expenditure surveys indicate that households have on average more than 10% health expenditure, this is a very strong indication that more investments are required on the supply side to reduce user fees, in particular for high hospitalization costs.
- When household health expenditures remain high, even above 10%, despite the introduction of supply side financing and sector specific CVA, it needs to be looked into further. Depending for example on where these expenditures are made (still in health facilities supported by humanitarian partners, or in the private sector), additional non-financial interventions, such as support to health facilities, are required on both the supply and demand side to address the underlying causes of these high expenditures.

Taking all these factors into account, the amount for health expenditures estimated through household expenditure surveys provide a practical reference for its inclusion in the MEB. The amount in the MEB needs to be adjusted when new interventions are introduced, for instance supply side interventions and/or health specific CVA, which in turn should reduce the out of pocket expenditures. This ideally should then be reflected in lower average health expenditures in subsequent expenditure surveys.

What does this look like in practice:

	Urban	Rural
Rent	2,149	1,965
Food	5,125	5,525
Health	3,152	3,375
Education	408	453
Transport	813	1,470
Comm.	284	324
Water	316	98
Fuel	1,441	1,455
Debt	1,270	1,114
Shelter	913	N/A

In Afghanistan in October 2019, PDM surveys, completed for the Emergency response Mechanism reported the following results:

[12] Such as knowledge/awareness, socio-cultural, security, quality, or distance etc.

Average household expenditures in month prior to the PDM	
Rural areas: household health expenditure was $42.96 USD in the month prior to PDM (3,375AFN, representing 21% of the total household expenditure of 15,777AFN)	**Urban areas**: household health expenditure was $43.72 USD (3,152AFN, representing 20% of the total household expenditure of 15,870AFN) Not specified what costs are included.

The report didn't indicate average household size in this survey/target population; however, the Afghanistan 2015 DHS gave an average household size of 8 persons. This would make an average per capita of health expenditure to **$5.4 USD per person per month.**

C. Health Expenditure as Optimal and Dynamic Proportion of the MEB

A mixed method approach is the most suitable, however when this is not possible, then it is recommended to add a reasonable amount for health in the MEB. But this should be the least preferred option.

Within a health system financing strategy, the aim is to keep households 'out of pocket' expenditures for health as low as possible. When households spend more than 10% or more than 25% of their total household expenditures on health, these become catastrophic, leading to negative coping for health and other needs.[13]

From a program design perspective, this would mean that the proportion of the MEB for health should be less than 10% of the total MEB. Its important to also take into account other planned provider payment mechanisms or purchasing of services through contracting (based on inputs, outputs or performance), Health Equity Funds, complemented with additional health sector specific CVA interventions.[14]

Depending on the extent that these will be effective in reducing user fees, one could argue that then the estimated proportion for health expenditures in the MEB would range between 3% and 9%. Taking a higher or lower proportion depending on the extent to which essential services are provided for free with adequate coverage and utilization. If it is estimated that introducing systems for provider payment mechanisms or health sector specific CVA assistance would take several months, then initially a higher proportion would be included in the MEB, with the aim to adjust it once the preferred financing interventions are implemented with adequate coverage that reduce household health expenditures.

The reason to still keep a low proportion of for example 3%, would be to acknowledge that households still have expenditures, such as for over the counter self-medication for common illnesses, indirect costs, and expenditures on health commodities.

[13] Wagtaff A et all. Progress on catastrophic health spending in 133 countries: a retrospective observational study. The Lancet, Volume 6, ISSUE 2, e169-e179, February 01, 2018.
https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(17)30429-1/fulltext

[14] For further details on provider payment mechanisms, see GHC and WHO Cash TT working paper for considering cash transfer programming for health in humanitarian settings, March 2018.
https://www.who.int/health-cluster/about/work/task-teams/working-paper-cash-health-humanitarian-contexts.pdf?ua=1

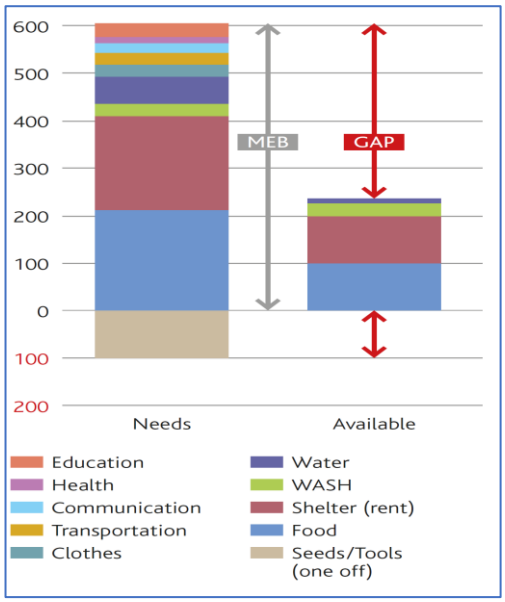
4. Using the MEB for estimating a transfer value

Although an MEB is a critical factor when determining transfer values, transfer values are closely dependent on the capacity of the households to meet their needs with their own resources, other assistance received, and gaps, as well as the ability of the international community to fill that gap. Expenditure amounts in the MEB can be supported through different interventions, and different transfer modalities. Transfer value calculation often requires coordination and coherence between programs. Transfer values consider project objective/needs, projected duration of needs, available resources at household level, cost of the goods and services, transaction costs, price variation and seasonality and financial capacity of humanitarian agencies.

4.1 Calculating an MPC transfer value using the MEB and gap analysis method

As previously noted, the multipurpose cash transfer value is not automatically equivalent to an MEB. The transfer value is generally used to cover the "unmet needs," of the MEB, for some of the needs listed in the MEB may be provided by other actors, either through in-kind, or direct support to existing services providers so they provide services for free, or met by households' own resources (e.g. income from livelihoods activities, food production etc.).

The calculation of the MPC transfer value, the gap analysis, is based on the cost estimate of the gap between the met and unmet needs. Gap analysis measures the extent of the unmet needs in monetary terms (see below). The transfer values are therefore theoretically meant to cover that gap, or unmet needs. There are however many other factors that contribute to the decision how much of the gap can be financed, , including resources constraints, national policies and or donor regulations. It is worth noting that the MPC transfer values rarely meet all the unmet needs.



Gap analysis: The remaining needs to cover are calculated as follows: [15]

The left column represents the minimum expenditures basket per household in a given context. An average monetary value is estimated for each category of need. The numbers in red represent the average level of debt per household.

Total need (or MEB)

−

Needs met by affected population
+
Needs met by other actors

=

Gap in needs

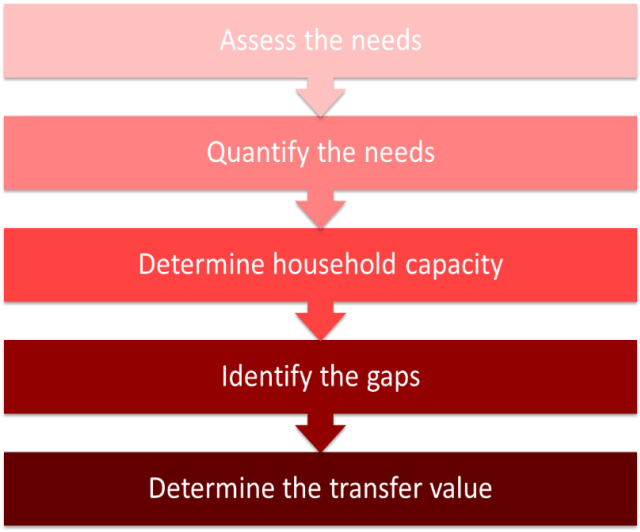
CaLP has outlined the following steps in Gap Analysis:

1. **Assessing the needs**, including all basic needs.
2. **Quantify the needs**: As previously noted above, this is the MEB. This is the process of quantifying the needs or monetizing the items in the MEB.

[15] Operational Guidance and Toolkit for Multipurpose Cash Grants - 2015

3. **Determine the household capacity**: This is also done during the needs assessment. It should also capture the other support that households receive (including government social safety nets, but also direct support from humanitarian partners to address a need) and what households produce for themselves. For example, households may grow some of their own food. Also, households may earn income from various sources or receive gifts or assistance from others. Quantifying these helps determine how much of the total need the household is able itself to meet.
4. **Identify the gaps:** The Gap, also sometimes referred to as the unmet need = Total Need – Household Capacity and – other types of (humanitarian) support to meet a need
5. **Calculate the transfer value:** Measuring the un-met need. However, there are many other factors to consider that then determine the actual MPC transfer value, including for example available budget from humanitarian donors, national and government policies, and government restraints, leaving some proportion of needs unmet.[16]

It is also important to emphasize that **there are multiple options other than multipurpose cash to close this gap, and it should not be considered as the only and default intervention to ensure that affected populations can access essential needs**. In many cases, multi-purpose cash may not be the suitable option, but more targeted CVA to meet a specific health need (transportation, or specific type of treatment, or vouchers to access health services) Humanitarian actors often choose a mixed approach of in-kind and cash assistance, or for health needs, health provider payment mechanisms complemented with sector specific cash or voucher assistance. These are often complemented with interventions to build capacities or ensure adherence to quality and safety standards



4.2 Identifying the health gap of the MEB

The first question for the health partners should be, how health needs and the household expenditures for health as reflected in the MEB, can best be met. This is also taking into account quality and financial protection, in addition to other non-financial barriers identified on the provider and demand side through the health sector assessments. Annex 1, an adaptation from Annex 4 in the GHC/WHO Cash Task Team 'Working paper for considering cash transfer programming for health in humanitarian contexts' [17] provides a simplified decision tree for choosing the most appropriate modality or mix of modalities to do so, through both financial and non-financial interventions.

Once health expenditures are identified, the next step is to define how to address the expenditures, while also identifying how to address the subsequent un-met health needs.[18] **The optimal response option for reducing direct health costs, is first to explore provider payment mechanisms that will reduce the application of user fees (such as enrolment under an existing social health insurance, or humanitarian donor and partner funding support to input or output based contracting).**

[16] CaLP: Operational Guidance and Toolkit for Multi-purpose Cash
[17] https://www.who.int/health-cluster/about/work/task-teams/working-paper-cash-health-humanitarian-contexts.pdf?ua=1
[18] Ibid. Annex 1 in the working paper proposes a hierarchy in selecting the preferred financing options, including demand side financing through CVA.

The next response option is then to consider health sector specific CVA interventions for utilization of health services, or for indirect costs related to accessing health services.

After having implemented these preferred options that will reduce the household health expenditures for health as identified in the MEB, and that are then part of the 'needs met by others' category of the gap analysis, the household health expenditure that then still remains should be considered as part of the "unmet needs", and therefore a subsequent portion for health in the transfer value for the MPC grant.

Initially, before interventions are effectively in place to reduce user fees and out of pocket payments, the proportion of the 'unmet need' for health as referenced against the health expenditure part of the MEB is likely to be high, and thus the transfer value for health in an MPC would also be relatively high. While this may seem to be the 'easy and most efficient' option to address unmet needs, this should only be seen as a temporary stopgap measure till the appropriate interventions to reduce 'out of pocket' health expenditures (provider payment and health specific CVA) are in place and should never be used as argument to delay their implementation.

Otherwise, the MPC would inadvertently contribute to a fee-charging culture for priority services, which would undermine financial protection for health and progress towards universal health coverage. **The MPC transfers with the inclusion of health are thus only to address unmet needs that remain after implementing provider payment mechanisms and sector specific CVA interventions,** based on health financing principles to deliver quality essential health services and make progress toward UHC.[19]

While at the start of the humanitarian interventions, it may not be clear yet how much out of pocket health expenditures as reflected in the MEB will then remain to consider for the MPC transfer value, the initial proposed amount of the unmet need for health will be an informed estimate. Subsequent household surveys will provide additional data on the remaining household health expenditures, including both direct and indirect costs. This should then guide the expected reduction in health expenditures in the MEB, and subsequent reduction in unmet need for which an MPC transfer can be considered.

Changes in the proportion of households with catastrophic health expenditures and negative coping for health will provide additional feedback on the effectiveness of financial protection on the provider side and the complementary CVA targeted to patients. It is also worth noting that just because an MEB and then MPC is calculated in a certain way, that doesn't mean that all households will spend as such, hence the flexibility of the MPC. Household expenditure patterns will differ from the original calculation, as they prioritize their needs, but also whether someone will be ill or not in the family.

What does it look like in practice:

If in the initial assessment for the MEB household health expenditures were on average 9%, and this can be reduced with 4% through supply side interventions and CVA for health (done by the Health Cluster), the remaining 5% would be reflected in the gap.

When the premium of a social health insurance fund was used to estimate the MEB, in a context where the humanitarian target population is not covered by such insurance and they have to pay when ill,

the premium amount would be included in the unmet needs part of the MPC, but then ideally combined with a policy of enrolment into the insurance fund with obligatory prepayment of the premium to obtain the insurance card and coverage.

Alternatively, the total amount to support enrolment of a humanitarian target group under such social insurance fund (average premium per person times the total target population to be covered) should be kept at the source (by the donors or through a humanitarian partner) and directly paid to the insurance fund. The premium amount is then deducted from the unmet needs, as it is now, 'met by others'. This then leaves other health expenditures as explained above not covered by an insurance, in particular indirect costs, still to be considered for health sector specific CVA options, or finally under the unmet needs and subsequent MPC transfer value.

Annex 1: Health Response Options Analysis