WORKING PAPER FOR CONSIDERING CASH TRANSFER PROGRAMMING FOR HEALTH IN HUMANITARIAN CONTEXTS

Global Health Cluster and WHO
Cash Task Team
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Key messages:

- Cash Transfer Programming (CTP)[1] can be useful to improve access to and utilisation of health services in humanitarian settings, by reducing direct and indirect financial barriers and/or by incentivising the use of free preventive services.
- Health prevention and promotion interventions, and other public health functions such as preparedness and response to epidemics, cannot be assured through demand side financing.
- Health systems that rely on direct out of pocket payment by patients when they are ill as a main source of funding tend to be inequitable and ineffective due to several market failure issues. The optimal response option to address household health expenditures, when health services are available with adequate capacity and quality but user fees are applied, is through provider payment mechanisms. CTP for health should always be considered complementary to such supply side health financing strategies, and not aim to replace these.
- As health needs are mostly unpredictable, expenditures are not average and health services and medicines should only be obtained from providers that meet minimum quality standards, CTP to purchase health services should in principle be targeted to patients when they need to use a priority service, the amount of the transfer should cover to the direct and indirect costs of seeking treatment, and only be obtained from pre-selected providers that meet minimum standards for effectiveness and quality.
- Following the commitment on the use of cash transfers from the Grand Bargain, all health cluster/sector coordination should consider CTP systematically in the health response options analysis, and we need to build their capacity to do so.

[1] CaLP glossary 2017: Cash Transfer Programming refers to all programs where cash or vouchers for goods or services are directly provided to beneficiaries. In the context of humanitarian assistance the term is used to refer to the provision of cash transfers or vouchers given to individuals, household or community recipients; not to governments or other state actors. CTP covers all modalities of cash based assistance, including vouchers. The term can be used interchangeably with Cash based Interventions, Cash Based Assistance, and Cash and Voucher Programming.

- Evidence on CTP for health from development contexts cannot always be extrapolated to humanitarian contexts. As there is very little evidence for the use of CTP in humanitarian settings, we need to promote research and start documenting current practice for learning.

1. INTRODUCTION

Cash Transfer Programming (CTP) is a rapidly expanding modality for the delivery of humanitarian assistance. The ODI High Level Panel Report 2015 on Humanitarian Cash Transfers '*…urge[s] the humanitarian community to give more aid as cash, and to make cash central to future emergency response planning*'. Commitments under the Grand Bargain recommend that '*cash should be considered equally and systematically alongside other forms of humanitarian assistance, and where cash is considered feasible, it should be the preferred and default modality*'. However, no single modality (cash, in-kind, support to service delivery or technical support), is sufficient for meeting humanitarian health objectives to achieve public health outcomes and mitigate the impacts of future disasters. The preferred option for supporting access to health care services, when these are available with appropriate capacity and quality but when user fees are applied, is through provider payment mechanisms, with CTP complementing these. In addition, health prevention and promotion interventions, and other public health functions such as preparedness and response to epidemics cannot be assured through demand side financing.

The purpose of this paper is to discuss the potential added value of CTP to achieve health outcomes and/or health sector specific objectives. It discusses pros and cons of different types of cash transfer modalities complementary to health financing options, and alongside other response interventions to support access to quality services. This will assist the systematic and appropriate consideration of CTP in the health sector response options analysis and strategic planning. The document is not meant as operational guidance how to do CTP. As we learn from experiences, this paper will be updated and additional guidance and tools will be developed.

2. HEALTH IS MARKET FAILURE

Most of the current experience with CTP comes from the food-security sector, and response options for cash and/or in-kind support are framed within market based programming approaches. While it is acknowledged that CTP can assist in overcoming barriers to access healthcare, health systems that rely on direct out of pocket payment (by patients when they are ill) as a main source of funding tend to be inequitable and ineffective. For this and other imperfect health market features as discussed below, external interventions are always required in both financing and delivery of health services. While all markets have imperfections, the healthcare market has all of the possible failures combined.

One of the more important failures is due to the unpredictable nature of illness/injury and the broad range in costs to seek care, so that when people

have to pay for health services at the time of use they are exposed to financial hardship that can lead to catastrophic levels of spending, inability and/or delays to purchase services. This is often more so the case for the most vulnerable in society, whereby it is not atypical that for example 5% of the population incurs 50% of the health expenditures.[i] Other market dysfunctions are related to the need for high quality of services and treatments, unequal knowledge between patients and providers with potential for unfair practices with substandard quality, and low demand for preventive health services or commodities.

Health systems have also other public health functions such as health prevention and promotion interventions, or the organisation of early warning and response systems for epidemics, which cannot be assured through market-based-principles or demand side financing.

External interventions by governments in health are often based on the principles of equity, risk sharing, pooling of funds through taxation and other forms of compulsory prepayment, strategic purchasing and regulation of services for meeting population health needs and quality standards.[ii] In a well-functioning health system, equity in health financing is achieved by reducing the reliance on user fees, aiming at levels of out-of-pocket payment to less than 15% of the total health expenditures. These systems are predominantly funded by pooled revenues through taxation or social health insurance with greater purchasing power to use appropriate provider payment mechanisms in combination of complementary demand side financing if necessary.

3. EXTERNAL HEALTH ASSISTANCE DURING CRISES

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 unable to react to the excess health needs.

Many countries affected by humanitarian crises have however poorly developed health systems, some already from before the crises, and their functionality often further degrades as the crises develops. High levels of out-of-pocket spending, poor accessibility, interrupted supply lines, inequity and poor quality of care from unregulated providers are some of the characteristic for many of these contexts.

Acknowledging the financial barriers imposed by user fees in any emergency context, there is consensus that essential health services during a humanitarian crisis should be provided free of charge at the point of

delivery.[iii] But the reality is that in many cases people still have direct as well as indirect health expenditures.

Support to existing health services and systems

When existing services are unable to cope with increased needs and/or are of insufficient quality, the following elements are usually part of the response to restore or strengthen existing capacities: supply of quality medicines and equipment, incentives to health workers and in-service training, supervision of quality and managerial support, bringing in extra technical capacity such as laboratory, and/or strengthening community case management through Community Health Workers.

Whenever existing services don't have the capacity to address the excess or new health needs (e.g. mental health, Sexual and Gender Bases Violence, malnutrition, disease outbreaks), this modality has a comparative advantage over others.

Direct external assistance to provide services

When capacity of existing services and systems cannot be scaled up or restored and/or needs are overwhelming, this aid modality is indicated. A typical example is establishing new health facilities in camps for refugees or Internally Displaced Persons, though in most cases nowadays before considering this option the first choice is to strengthen an existing nearby facility. Another example is through the temporary deployment of International Emergency Medical Teams.

Purchasing services from existing providers

In contexts where health services have adequate capacity and quality, but where patients are charged for these services, humanitarian actors can support access at different levels of the health system by purchasing these services for the target population. For example contracts can be made with existing public and private health service providers to pay for services, such as through reimbursing the costs for deliveries or referral to secondary care, the costs for essential medicines and/or the user fees at primary care level.

4. DIFFERENT AID-MODALITIES TO OVERCOME FINANCIAL BARRIERS AND PROVIDE PROTECTION AGAINST CATASTROPHIC HEALTH EXPENDITURES, AND THEIR COMPARATIVE ADVANTAGES

While CTP has the potential to influence multiple aspects of performance of service delivery and different barriers to access, an important characteristic is to address financial barriers. As such it is important to discuss CTP from a health financing perspective. Annex 1 proposes a hierarchy in selecting preferred financing options, including cash transfer modalities for health, based on the comparative advantages described below.

4.1 Demand side financing through CTP

When seen from a health financing perspective, CTP can help to improve access to and utilization of health services in humanitarian settings, by reducing barriers to access from indirect costs (e.g. transport or accommodation costs), and direct costs (e.g. charges for consultation, diagnostic tests and/or medicines, or for preventive commodities as bednets). CTPs may also incentivize the use of free preventive services, such as immunization or Ante Natal Care.

While CTP as demand side financing has potential to complement supply side financing of health care, direct out of pocket payment modalities should however not be a main source of funding for the health system for reasons explained previously. Therefore, the potential effectiveness and efficiency of CTP options should be assessed complementary to provider payment mechanisms, and not aim to replace these.

Ideally, a cash transfer for health should be targeted to patients when they need to use a service, the amount of the transfer should cover the actual costs for diagnosis and treatment and indirect costs, and the purchasing of such services should be restricted to providers from which minimum quality standards can be ensured.

Cash transfer modalities are classified (see annex 2) by having conditions (requirements to receive assistance; activities or obligations that have to be fulfilled ***before*** receiving assistance) and/or restrictions (requirements or limitations, if any, on the use of assistance received; what a transfer can be spent on ***after*** the beneficiary receives it):[2]

[2] http://www.cashlearning.org/downloads/ctp-terminology-diagram-of-key-terms-august-2017.pdf

1. Unconditional and restricted
2. Conditional and unrestricted
3. Unconditional and unrestricted
4. Conditional and restricted

Each cash transfer modality has different characteristics[iv] (see annex 3), and based on the identified problem or gap that it is meant to address, the appropriate modality or mix of modalities can be selected. Partners should only use cash or vouchers where this is consistent and coherent with their obligation to ensure the quality of the service and/or medicines provided.

Depending on the purpose as well as the time it may take to implement different responses, including the different financing and cash transfer modalities, they may be more or less appropriate for the acute phase. However, it is not possible to indicate that certain financing and/or cash transfer modalities are only appropriate in a certain phase, as this also depends on capacities and mechanisms that existed prior to the crisis, or if such options have been included in preparedness plans.

4.1.1 Unconditional and restricted cash transfers

Unconditional and restricted cash transfers (e.g. vouchers) can have all of the characteristics in support for equitable health financing mentioned above if well designed and targeted. They have been most commonly applied to improving access to reproductive health services such as family planning and safe deliveries, or to improve access to medicines. They can also be used to cover indirect costs, such as for transport, accommodation and/or meals. There is robust evidence that vouchers increase utilisation of health goods and services. However it is unclear if voucher programmes are more efficient than other health financing strategies.[v]

- Service or commodity vouchers can be issued when someone is ill, they can be designed to cover a selection or range of essential services and medicines, and conditions can be negotiated with selected health service providers and pharmacies through contracts with regards to the quality and price of the services selected under the voucher scheme.
- Service vouchers can be used to cover high costs that otherwise would lead to catastrophic health expenditures, such as for admission to a hospital or surgical and obstetric procedures.
- Commodity vouchers can be used for preventive items such as bed nets, from providers that can guarantee their quality.
- Commodity vouchers for medicines should only be issued if the patient has a prescription from a licensed health worker.
- Value vouchers are usually distributed to all people in a target group, but as the amount is average and health needs and its costs are not, this modality scores low on equity and does not protect against catastrophic

expenditures. They have the same assurances for quality as service and commodity vouchers.
- Vouchers can be linked to reporting requirements from providers, and may thus contribute to strengthening of the Health Information System.
- Voucher programs typically require a capacity to contract and monitor providers, and more elaborate control systems (financial management and quality) which take time to set-up and have additional costs.

4.1.2. Conditional and unrestricted cash transfers

Conditional and unrestricted cash transfers are typically a component of a social programme, which conditions regular cash payments to poor households on the use of certain health services and school attendance.[vi] Conditional cash transfers in development contexts significantly increase the number of preventative health services visits, and thus stimulate demand for health services.[vii] [viii] Measured effects differ by country and context depending on the conditions, social norms that determine attitudes to health care, possible sanctions for non-compliance, as well as accompanying measures in training and strengthening supply of services.

Introducing conditionalities have financial and administrative costs for monitoring compliance with the condition. Furthermore, several negative side effects have been identified, such as that their use may unfairly penalise families who cannot comply to the conditions for reasons beyond their control .[ixx] This needs to be better understood in humanitarian contexts.

4.1.3. Unconditional and unrestricted cash transfers, including MPG

For the food security sector there is evidence that unconditional and unrestricted cash transfers are more efficient, and thus likely to be more cost effective, compared to in-kind assistance.[xi] However, these findings can't simply be extrapolated to the health sector for the reasons explained in section 2. Available systematic reviews [vii, xii] indicate that there is little research evidence of the use of unconditional and unrestricted cash transfers for health in development programming, and a review of UCT for health in humanitarian contexts, that could only identify three studies, was inconclusive.[xiii]

The main risk with unrestricted cash transfers is that as there is no restriction on the choice of provider, patients may use substandard or ineffective (traditional) services, or buying poor quality medicines. If distributed as average amount to all households, this approach does not address the characteristic that health needs are generally not predictable and alike for all families, expenditures are not average and not equally distributed, , and it does not protect against catastrophic health expenditures. This will then disadvantage the poorest households that are expected to have the highest

needs, maintain the risk that health expenditures drive households into poverty, and may delay health seeking behaviour.

These shortcomings can be mitigated by targeting for example households with family members that have a chronic disease. Or an example of its use in humanitarian contexts has been for pregnant women to cover costs for a facility based delivery and some additional indirect costs.[xiv] The risk that in such case women may seek the delivery service in a substandard health facility can be mitigated through a 'pre-commitment' to go a health facility from a proposed list of clinics that meet minimum quality standards (a 'soft' restriction).

Multi-Purpose Cash Grants (MPG)

MPGs are defined as a transfer (either regular or one-off) corresponding to the amount of money a household needs to cover, fully or partially, a set of basic and/or recovery needs. They are by definition unrestricted cash transfers. The MPG can contribute to meeting a Minimum Expenditure Basket (MEB) or other calculation of the amount required to cover basic needs[3], but can also include other one-off or recovery needs.

Social cash transfers (as MPGs) that provide income support to meet basic needs can be expected to have positive effects on health outcomes.[xv] Poverty and ill health are intertwined. Poor countries tend to have worse health outcomes, and within countries, poor people have worse health outcomes[4].[xvi] [xvii] Health outcomes are only partially influenced by health system factors including access to care. Other determinants include for example income, education, water and sanitation and food security.[xviii] As such it is important that when developing the MEB[5], it includes items that contribute to disease prevention or improved health, e.g. water from improved water source, soap and other hygiene supplies, diversity in diet, etc.

When a household expenditure survey indicates that people have important health expenditures, and an average expenditure for health is thus included in the MEB, this amount cannot simply be used as average amount in the

[3] CaLP Glossary: The items that people need to survive. This can include safe access to essential goods and services such as food, water, shelter, clothing, health care, sanitation and education

[4] Health outcomes are usually defined in mortality, morbidity and malnutrition rates, or as cure and case fatality rates for specific diseases to measure the effective of treatment and epidemic control measures.

[5] CaLP glossary: Defined as what a household needs – on a regular or seasonal basis – and its average cost over time. The MEB can be a critical component in the design of interventions including Multipurpose Cash Grants/Assistance (MPG/MCA), with transfer amounts calculated to contribute to meeting the MEB.

design of a subsequent MPG to meet health needs. The optimal response option is first to explore provider payment mechanisms that will reduce the application of user fees, and then to consider alternative cash transfer modalities with better characteristics and targeted to patients when they need to use a service.

If financial barriers should then still remain, caused by charges for essential services or linked with indirect costs, and only after having explored these preferred options, then including an average amount of money for health could be considered in a MPG, but this should not exceed more than 15% of the total health expenditures (see section1). This can also be a temporary option applied during the period required to implement the appropriate provider payment mechanisms or other more appropriate cash transfer modalities.

For incentivising the use of services, positive effects are described from labelling MPG in other sectors, such as education. There is no evidence yet if this also applies to health services.

4.1.4 Conditional and restricted cash transfers

These potentially combine the desirable characteristics of conditions and restrictions, but as a consequence they also require the additional systems for management and compliance monitoring of both. Examples of this would include vouchers for supplementary feeding or Long Lasting Insecticide Treated bed nets provided to caretakers when they bring their children to growth monitoring or immunisation programs.

4.1.5 Health Equity Fund

Health Equity Funds (HEF) are categorised as demand side financing, but not as CTP because the cash transfers are not directly provided to beneficiaries. A third party pays for user fees and, in some cases, transportation and food expenses, for the target group (Grundy et al 2009). HEF have some of the characteristics of service vouchers but the advantage is that they can operate at larger scale and pool funds from several donors. They have been successfully used in several countries, most notably Cambodia [xix]. The reimbursing (by NGO) of health services as for example in Kenya during the post-election violence, by paying the bills for patients referred for surgery to a private hospital, or reimbursing the hospitalisation costs for patients referred from NGO supported primary care facilities, can be seen as variations of a HEF.

4.2 Supply side financing

From the various options for purchasing services from existing providers, we will discuss the ones that are being implemented in humanitarian contexts. All

these approaches are usually linked to an agreed essential package of health services and a form of quality assurance of the provider. There is not much experience with pooling of funds for the health sector in humanitarian contexts. An example could be the Health Transition Fund that was created in Zimbabwe to abolish healthcare user fees for children and women, and fund medicines.[xx]

4.2.1 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). Pilots are starting in Darfur to seek integrated solutions for refugees, returnees, IDPs and vulnerable households in the host population, by subsidising their coverage under the National Health Insurance Fund.

4.2.2 Contracting providers to deliver prioritised health services

Contracting with non-state providers as well as within a public provider system was introduced in post conflict contexts such as Cambodia, Afghanistan, Timor Leste and South Sudan. In most cases non-state providers were already delivering a significant proportion of the health services. This approach can build on the current practice through which NGOs are contracted by humanitarian donors on a project basis to support existing health providers, and reduce fees through their inputs of supplies and resources. Paying incentives to health workers as compensation for the loss of revenue when user fees for prioritised services are suspended is also a form of contracting.

Different types of contracting of private and national NGO health services providers are taking place in Syria. 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 hospitalisation of patients referred), or sometimes with additional incentives based on reaching **performance targets** or milestones.

5. RESPONSE OPTIONS ANALYSIS AND PLANNING

In the acute phase of an emergency, the priority is to restore access to priority services and to address immediate health risks, such as epidemics. In later phases, health system strengthening and early recovery approaches can be integrated in the humanitarian response, including building capacities of national authorities and services providers.

New guidance is being developed for Response Options Analysis and Planning (ROAP)[xxi] that considers all possible response options; in-kind, support to service delivery and CTP. It is likely that such process will complement the analyses based on the Multisectoral Initial Rapid Assessment and Humanitarian Needs Overview that are currently the basis for humanitarian response planning. More detailed guidance on how to do a response options analysis in the health sector to decide on the most appropriate response strategy falls outside the scope of this paper.

Annex 4 provides a simplified diagram that can be used to systematically consider the various response options, including opportunities for CTP.[xxii] It proposes the following questions to determining the optimal response to identified health needs:[6]

1. Are essential health services to address the main causes of morbidity and mortality available with sufficient capacity?
2. Are there any major financial barriers to access essential services?
3. Are there other barriers to access services?
4. Are utilisation/coverage targets met?

A toolkit for Public Health Information Services[xxiii] has been developed with endorsed assessment methods and monitoring tools that informs the response options analysis for health. It includes tools to measure the health status and threats for affected populations, the availability of health resources and services, and health system performance.

In addition, there are several assessment and monitoring tools that should be considered to complement these when indicated and feasible[7]:

1. Health risk assessment: Strategic tool for assessing risks (STAR) and the Vulnerability and Risk Assessment and Mapping (VRAM), to identify health risks for health emergency preparedness, contingency planning and risk reduction interventions.
2. Rapid Health Sector Assessment (HSA); HAS is the health equivalent of a market assessment. It look at the capacities, quality, performance and constraints related to the six health system building blocks (Governance, Health Information, Human Resources, Health financing, Pharmaceuticals, and Service Delivery).
3. Health facility based tools for measuring and monitoring performance and quality of health services, such as a balanced score card.
4. Additional household and community survey tools to look at health needs, knowledge/attitude/practice, health seeking behaviour, barriers to access, and health expenditures.

[6] Please note that these questions are not designed to look at responses needed to address health risks or epidemics.
[7] These documents will be made available on the GHC website.

6. CTP AND COORDINATION OF THE HEALTH SECTOR

Based on its commitment to the Grand Bargain, all health cluster/sector coordination should consider CTP systematically in the health response options analysis. This will require the development of further guidance and tools, and training of cluster coordinators and partners. Health sector specific CTP should be coordinated within the Health Cluster/sector coordination and thus be part of the health sector strategy in the HRP. When health is considered as part of a MPG, this needs to be coordinated with and under the Inter- Cluster Coordination Group, and included under the multisectoral section in an HRP.

It is important that health cluster/sector coordination establishes explicit links with a Cash Working Group (CWG). The multisectoral household surveys to support a ROA include questions on health needs and barriers to access services, and household health expenditures need to be reflected in the MEB. Reports from Post Cash transfer Distribution Monitoring provide important information on health expenditures and barriers to access.

Health experts need to ensure that the assessment questions for health are appropriate and to ask for additional analysis that are relevant for the health programs (such as the proportion of households with catastrophic expenditures in addition to the average expenditure).[8]

Furthermore, CWGs can assist the health partners in the analysis when discussing CTP as possible solutions to identified problems and underlying causes. If any or a mix of cash transfer modalities is proposed alongside other responses, the CWG can connect the health CTP with an existing transfer platform to find the most efficient solution. Health partners can also use existing cash transfer platforms for provider payment solutions or payments of incentives to health workers.

7. PROMOTING EVIDENCE AND DOCUMENTING EXPERIENCE

There is limited evidence on the link between CTP and access to health services or health outcomes in humanitarian contexts. Existing evidence on the effectiveness of CTP for the health sector from development contexts may not be transferable to humanitarian contexts.[9] We know little about the dynamics and changes that take place at household level of how people

[8] Examples of such appropriate questions will be made available on the GHC website, including proposed indicators for analysis.
[9] A list of relevant references from literature and guidance on CTP will be made available on the GHC website.

access and use health services or prioritize expenditure in complex emergencies where cash transfers are being provided. More work is needed on comparative effectiveness and efficiencies between CTP and provider side financing options, or direct support to existing services.

Humanitarians require better evidence of what type of health needs can or cannot be effectively addressed by CTP, and how to develop an optimal mix between different supply and demand side financing options based on comparative advantages and efficiencies.

As a first step, a recent survey identified an agenda for research on CTP for health in humanitarian contexts.[xxiv] There is a need to advocate for funding and operational support for research on this topic. Research methodologies need to be standardised so studies can be compared, and to measure robustly its impact on health service uptake and health outcomes. This should include standards for the analysis of the added value of CTP within the existing health financing policies, and the capacities of the existing health system to deliver quality health services.

Alongside the research agenda, there is a need to systematize the way we capture experiences with CTP for health services from the field. Experience capitalization for continuous learning can be a good model on which we can begin to define those good practices that are considered successful, and which can be tested, validated and repeated. A template has been developed for this purpose.[10]

[10] These documents will be made available on the GHC website.

ANNEX 1: A proposed hierarchy in selecting preferred financing options including cash transfer modalities for health

The proposed hierarchy is meant to help decision makers consider the most appropriate financing option to address financial barriers to access prioritised health services. It proposes a ranking of the different options in relation to their characteristics for equitable health financing and protection against catastrophic expenditures. The underlying condition is that essential health services are available of adequate quality.

Besides being informed by the different comparative advantages, the choice for the optimal (mix of) option is also determined by what mechanisms are already present in a given context, or the feasibility to implement an option when not able to build on something that already exists.

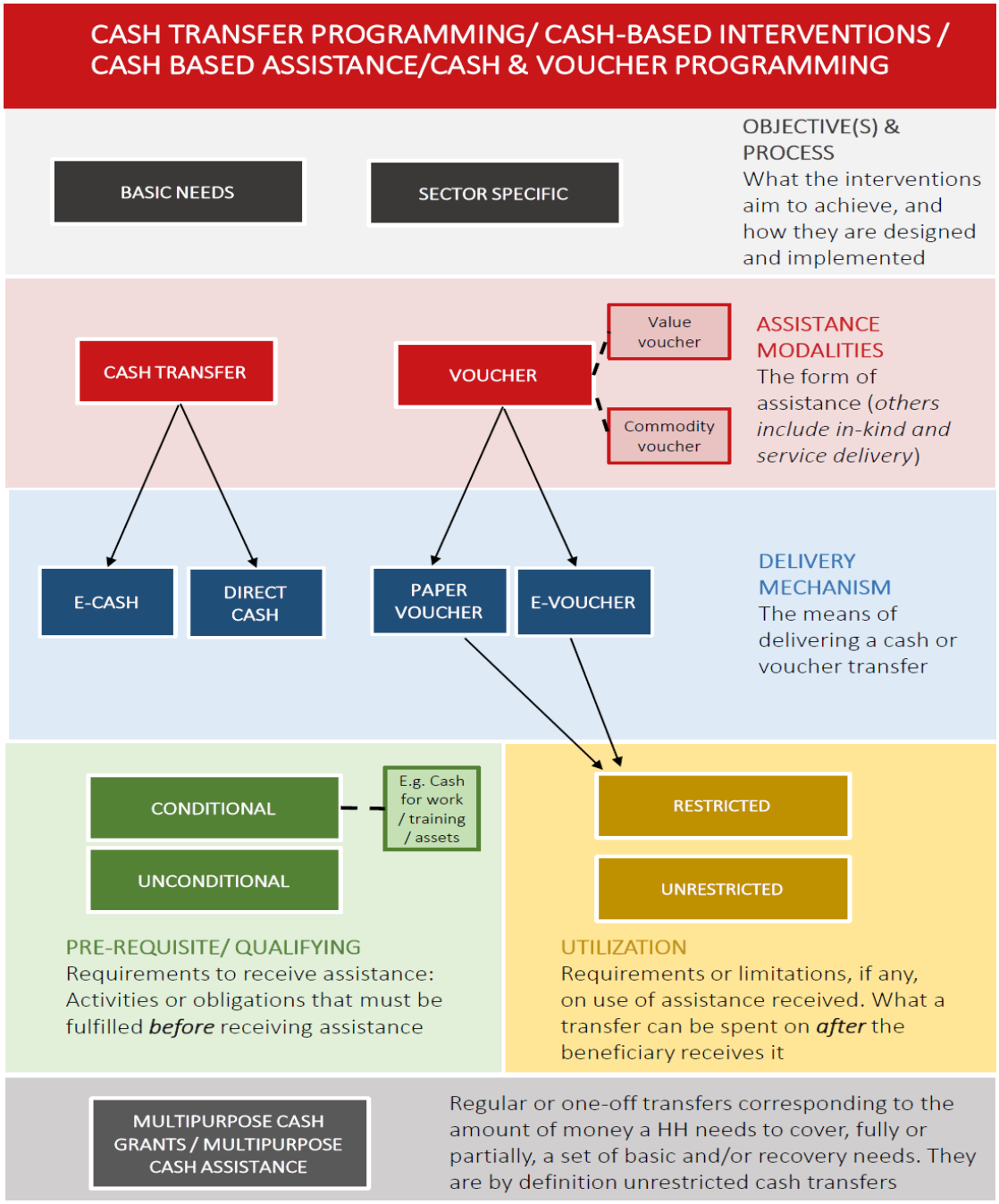
1. Have people of concern included in national health insurance schemes, with subsidised premiums as needed
2. Purchasing or reimbursing priority health services, if possible from a pooled health emergency fund, based on a type of contracting with selected providers that meet minimum quality standards.

If these options are not (yet) possible, or when they are implemented but there are still financial barriers (direct or indirect), then consider complementary cash transfer modalities:

3. Service and/or commodity vouchers with the transfer targeted to patients when they are in need of predefined priority service or medicines, the transfer amount sufficient to cover the related direct and indirect costs, and a contract with selected providers that allows adherence to quality standards and agreed pricing
4. If this is not (yet) possible, provide value vouchers for certain services or medicines to selected vulnerable groups that have predictable health needs (e.g. people with chronic illness).
5. If that is not (yet) possible, provide an unconditional cash transfer, linked with a health need (such as a delivery) and a pre-commitment to seek services from an agreed provider, or targeted to households with predictable health needs
6. If there are still direct or indirect costs not fully covered by the options above, include an average amount of cash for health in the Multi-Purpose Cash Grant, but with the condition to work on one of the more preferable options above.

7. In addition, consider conditional cash transfers to incentivise access to publicly funded essential public health services and preventive services as immunisation, Ante Natal Care, TB control, etc.

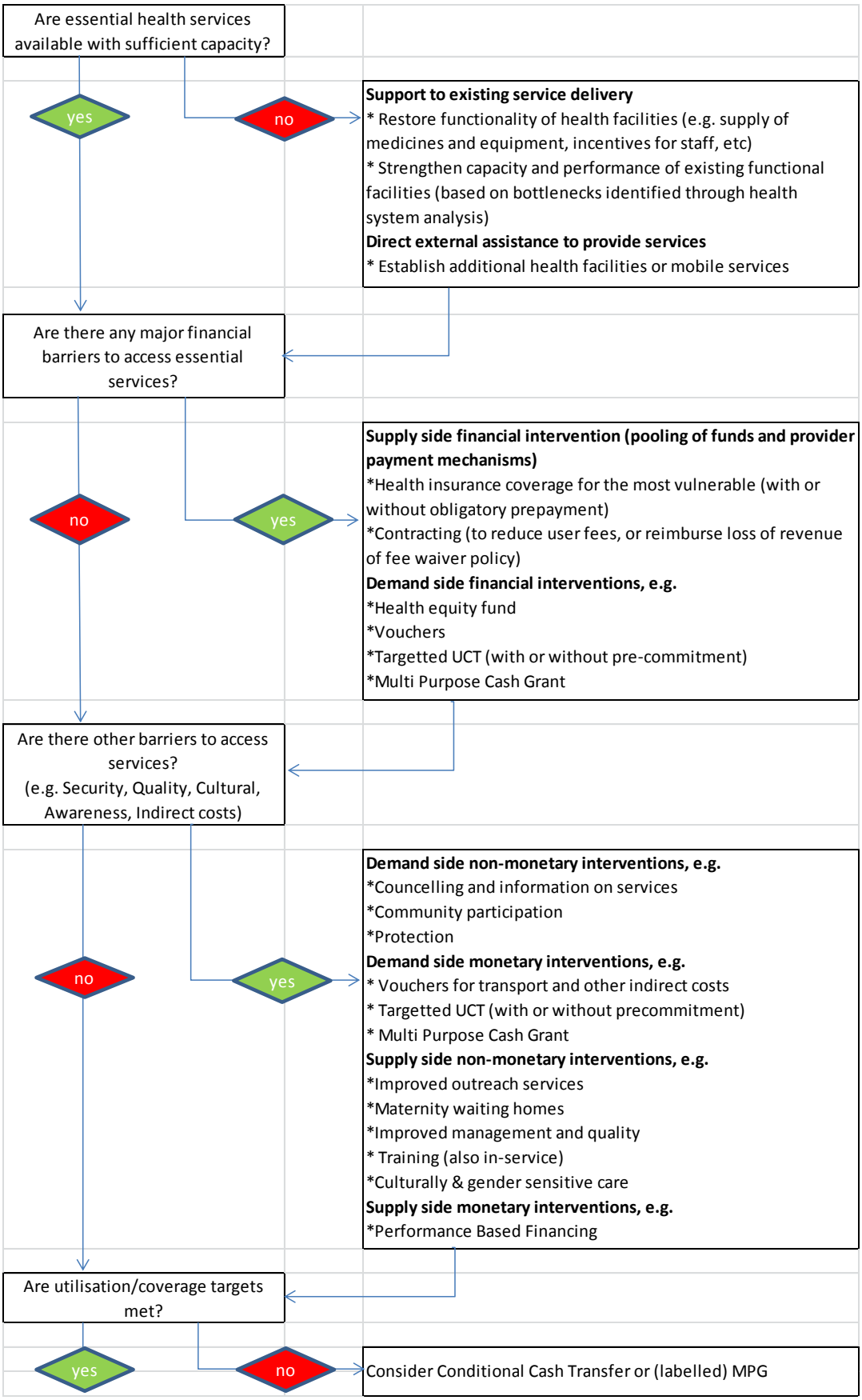
ANNEX 2: CaLP classification of cash transfer modalities



ANNEX 3: Comparing characteristics of different financing modalities (indicative only):

			equity (payment linked to the need to use a health service)	reduce reliance on user fees	protection against catastrophic exepnditure	ability to pay for indirect costs	quality assurance of services and medicines	quick to set up (also depends on what exists)	costs to manage + = only costs for the transfer ++/+++ = additional costs, e.g. for contracts with providers, monitoring compliance, etc	potential for contributing to health system srngthening
Provider side financing		Coverage under an existing insurance scheme	+++	+++	+++	0	+++	++	++/+++	+++
		Contracting (input, output or performance based)	+++	+++	+++	0	+++	++	++/+++	+++
Demand side financing	Health sector specific	Restricted CT								
		Commodity/service voucher	+++ (if targeted, e.g. to people with a health need)	0	+++ (e.g. if linked with referral, or patients with reccurent health needs)	+++	+++	++	++/+++	++
		Value voucher	0 (if average amount to everybody) ++ (if targeted, e.g. to people with predictable health needs)	0	0	+++	+++	++	+	+
		Conditional CT	+	0	0	+	+	++	+++	+
		Unconditional CT	0 (if to everybody) ++ (if targetted to a patient with a health need)	0	0 (if to everybody) ++ (if linked to a health need)	++	0 + (if combined with precommitment to seek a service from a qualified provider)	+++	+	0/+
		Health Equity Fund	+++	0	+++	++	+++	+	++/+++	++
	Multisector	MPGs	0 (if equal amount to everybody) + (if a higher amount is given to vulnerable households with chronic health needs)	0	0	++	0	+++	+	0/+

ANNEX 4: Health Response Option Analysis



ANNEX 5: References

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[xxii] The column with response options is informed by http://www.who.int/alliance-hpsr/resources/alliancehpsr_jacobs_ir_barriershealth2011.pdf , specifically Table 3.

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