USAID, UHC and the Private Sector

[Caveat: this is a veteran field-based practitioner's view, not an official statement of USAID's policies]

50+y old organization, established by JFK

USAID's vision statement: We partner to end extreme poverty and promote resilient, democratic societies, while advancing our security and prosperity

US foreign assistance (FY 2014) - $32 B in total, 26% dedicated to health (~$8.4B)
- ~$2.7B went directly to USAID Global Health
    - Main goals: AFG, EPCMD, Protecting communities from infectious disease

We work through Global and Mission programs
- Most missions are bilateral, only a few regional
- Global awards, bought into by missions
- Mission awards
    - developed through a decentralized, Mission-led process,
    - very sensitive to local context – means there's no universal USAID approach
- Each typically on a five-year time cycle
- Funding provided in carefully delineated categories – linked to disease or subsector

Perspective on health systems, and health finance
- USAID active across all six building blocks (world too diverse/country contexts too different to limit)
- We believe evidence extremely important
    - DHS, NHAs, private sector assessments / censuses
- Health finance
    - Promote domestic resource generation
    - Promote access to services by the poor
    - Promote efficiency in service delivery
- UHC involves three dimensions: population coverage (who's covered), depth of coverage (the package), and financial coverage
    - USAID plays a role in all dimensions – there are many different pathways toward the long term objective of UHC

Perspective on private sector
- Seek to partner to leverage resources / capabilities
- Recognize health systems are mixed in terms of public & private service delivery
- Private providers play a role in many UHC systems, including Thailand
- Private sector extremely varied, and includes commercial sector, NGOs, FBOs, informal providers, health information providers, medically-related manufacturers, pharmacies, drug shops, community based associations
- Partnerships between MOH and private sector entities are important, and not always optimal

    - Suspicion of motives
    - Lack of awareness of universe of providers (census/assessment sometimes needed)
    - Private sector atomistic – professional associations can help facilitate interactions
- Private sector sometimes reaches extensively into communities – community health workers, ASHAs in India,
- Large focus on innovation
    - mobile money
    - application of new technologies (Chlorhexidine, Udon device, etc.)

Examples of activities

- Social franchise networks
- Vouchers schemes
- NGO involvement
    - HEF administration in Cambodia, TB treatment in Philippines
- Global PPPs – GAVI, etc.
- Market shaping activities (primarily at the global level)
- Social and behavioral change communication

Capacity building

- Health care finance capacity building workshop (Nigeria)
- WBI's Flagship course in Asia
- Business process efficiency improvements – in public insurance agencies (Ghana, Egypt)

Other

- PPP units in MOHs
- Contracting arrangements – contracting for specific services
- Provider access to finance – Development credit authority
- Vouchers for services
- Exploring domestic revenue generation possibilities
- Shaping benefits packages (w/JLN)
- CBHI – Ethiopia, Benin
- Ghana – financial sustainability (pilot capitated payment, NHIA's claims data collection/analysis, internal performance improvements)