HEALTH SYSTEMS AND SERVICES PROFILE OF

GUYANA

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ORGANIZATION AND MANAGEMENT OF HEALTH SYSTEMS AND SERVICES

DIVISION OF HEALTH SYSTEMS AND SERVICES DEVELOPMENT

PAN AMERICAN HEALTH ORGANIZATION

EXECUTIVE SUMMARY

Guyana, a former British territory, is the only English-speaking country in South America. Having gained independence in 1970, it is now a republic with a democratic form of government. The country is divided into ten regions, which are managed by Regional Democratic Councils. Each Regional Council is administratively responsible for the delivery of public services within its boundaries. The regional system of administration however has several constraints and new mechanisms are being considered for improving the delivery of health services.

Guyana, while rich in natural resources, is the second poorest country in South America and the Caribbean with per capita GDP of US $800 in 1999. The country has a high debt burden and is categorized as a Highly Indebted Poor Country. Debt relief strategies have ensured increased spending in the social sectors. Based on a survey conducted in 1999, about 36.3% of the population live below the poverty line and 19.1% below the critical poverty line. Poverty alleviation has therefore been the major social and economic goal.

The health care system includes both public and private sectors. The private sector, including non-governmental organizations, is increasing in size and scope of its functions. The main source of financing of the health sector is through Government taxation. Services are generally free at the point of use.

One of the main factors affecting the delivery of health care is the inadequate numbers of staff at all levels of the system. Staff vacancy rates are in the range of 25-50% in most categories. New cadres of workers have been introduced in the system but the attrition rate is high due to low public sector wages. The information systems are generally unable to deliver timely and relevant data. Thus, deficiencies in the planning and implementation of health services and programmes ensue.

The need for the health services to be managed and organized differently has been identified. The Government of Guyana has expressed its commitment to health system reform to increase equity, efficiency and quality of health services. The main proposals include: (i) decentralization of the management of health care delivery, through the creation of Regional Health Authorities; (ii) appointment of Hospital Management Boards and Committees for the regional and district hospitals, respectively; and (iii) upgrading managerial skills at all levels. Changes in the financing of the health care system are also envisaged.

The main activity so far has been the establishment of the Georgetown Public Hospital Corporation. The initiatives have just started and it is too early to evaluate their effect on the health of the population.

1. CONTEXT

1.1 Political Context: *Guyana*, a former British territory, gained independence on 26th May 1966 and became a Republic in February 1970. An Executive President is both the Head of State and Government. There are several levels of government ranging from Parliament and Regional Democratic Councils to Neighbourhood Democratic Councils and Peoples Cooperative Units**.** Members of Parliament comprise elected members, representatives from civil society and local government. The Ministerial system operates and the principle of collective responsibility prevails.

The Local Democratic Organs Act of 1980 divided the country into 10 administrative regions. The established local government system consists of a Regional Democratic Council in each region, seven mayoralties and sixty-five Neighbourhood Democratic Councils. There are also Amerindian Village Councils that operate under separate legislation. Regional and local governments play an important role in the supply of public services in Guyana. The Regional Democratic Councils (RDCs) are administratively responsible for delivery of services – health, education, etc- to their catchment populations. Their primary duties are *inter alia* " to ensure efficient management and development in their areas; to provide leadership by example; to organise popular cooperation in respect of political, economic, cultural and social development; to cooperate with the social organisation of the working people and to maintain and protect public property."[1]

The State Planning Secretariat, Ministry of Finance is responsible for national planning. Sector plans feed into the national plan. A National Development Strategy for Guyana was formulated in 2000 by civil society and has set the policy framework for the development of national programmes and plans.

The Ministry of Human Services and Social Security collaborates with other governmental and non-Governmental agencies in the management of social policy.

Health sector policy formulation is carried out at the level of the Ministry of Health with advice and participation from relevant governmental and non-governmental agencies. The Minister of Health is part of the Cabinet, which makes policy decisions. Cabinet and Parliament approve the sector plans. Some of the main political and social problems that negatively impact or influence the health situation or the performance of the health services are poverty, inequity, inefficient management of the sector, financing of the sector, and out-migration of health professionals.

1.2 Economic Context: Guyana is the second poorest country in South America and the Caribbean (after Haiti), with a per capita GDP of US$ 770.3 in 1999. Over the 1993-1997 period Guyana experienced a positive GDP growth rate, displaying an average of 7.3%. However, in 1998 there was negative growth (–1.8%). In 1999, the rate was 3.0% and –0.8% in 2000.

Selected Economic Indicators 1993-1999

Indicators	Year						
	1993	1994	1995	1996	1997	1998	1999
Per capita GDP in constant US$prices	531	612	680	766	808.3	777.5	770.3
Economically active population, in thousands	ND	ND	ND	ND	ND	ND	ND
Total public spending as a percentage of GDP (Consumption + Investment)	ND	ND	ND	40.5	45.5	43.9	45.2
Total public social spending as a percentage of GDP	7.0	7.6	8.2	8.4	8.2	9.0 est.	10.0 est.
Annual rate of inflation	7.7	16.1	8.1	4.5	4.1	4.8	7.4

Source: Bureau of Statistics; National Development Strategy, Ministry of Health; Guyana Human Development Report 1996, Budget Speeches.

In 1997 the IMF and World Bank approved Guyana's eligibility for Debt Relief under the Highly Indebted Poor Country Initiative (HIPC). The money from debt relief is allocated to the social sectors (health and education) and to poverty alleviation programmes. Government expenditures on health are estimated at 2.31% of GDP in 1998, 2.55% in 1999 and 1.39 in 2000. Priority has been given to budgetary allocations for primary health care programmes. Expenditures on drugs and maintenance have increased. Agriculture, forestry and fishing account for 34.6% of GDP in 1998 and 35.1% in 1999, with sugar being by far the main contributor. In 1999, the mining sector accounted for 16% of GDP while services, manufacturing and construction accounted for 36.4%, 10.1% and 13.6% respectively.

1.3 Demographic and Epidemiological Context

In 1998, the life expectancy at birth of the population was 64.8, with that of males being 61.5 and females 68.2. The life expectancy rate has fluctuated over the period 1990-1998, between 63.0 in 1990, 65.0 in 1991 and 64.0 in the years 1993-1996. The Life Expectancy Ratio is 0.66. The estimated rate of population growth for the period 1998-2015 is 0.7%. During the period 1975-1998 it was 0.6%. The dependency ratio was 54.1 in 1998 and is expected to be 41.3 in 2015.

The expected trend in the distribution of the population is towards ageing. External migration still plays an important role in the demographics of the country. During the period 1996-1999 external migration amounted to over 56, 000 persons.

	YEAR						
	1993	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**
Crude birth rate	26.5	29.2	29.8	24.0	26.1	24.1	23.2
Total fertility rate	2.9	2.3	2.3	2.1	2.0	2.0	2.0
Crude death rate	6.7	7.1	7.1	6.5	6.8	6.5	6.6

Maternal mortality rate	190	190	190	159.9	105.9	124.6	ND
Infant mortality rate	34.9	28.8	27.8	25.5	25.5	22.9	ND

Source: Bureau of Statistics, Ministry of Health.

It has been estimated that about 80-90% of births and 85-90% of deaths are registered. The percentage of deaths from ill-defined causes has shown a decline from 1.6 in 1997 to 1.4 in 1999. The trend in mortality is characterized by a predominance of chronic non-communicable diseases, the continuing importance of the communicable diseases, the increasing burden of injury, and the Acquired Immune Deficiency Syndrome.

When the deaths for the period 1997-1999 are classified according to the six broad groups, Diseases of the Circulatory System account for 34.2%, Communicable Diseases 18.0%, External Causes 13.3% and Neoplasms (7.9%). Diseases of the Circulatory system affected mainly the adult population while the effects of communicable diseases and external causes could be seen throughout the life cycle. The five leading causes of mortality for all age groups combined during the period 1997-1999 were cerebrovascular diseases (12.2%), ischemic heart disease (10.2%), Acquired Immune Deficiency Syndrome (7.0 %), undetermined injury (6.6%) and diabetes mellitus (6.2%).

The most important chronic communicable diseases are tuberculosis and Hansen's disease. The incidence of tuberculosis has been increasing steadily since 1992. In 1995, the rate was 38.27 and by 1999, it stood at 52.58 with 407 reported cases. The rise in incidence has been attributed to HIV/AIDS, poverty and urban overcrowding as well as increased transmission due to lack of treatment completion by patients. The largest number of new cases occurs in young adults aged 20-40. Males are affected more than females. The incidence of Hansen's disease has increased from 0.6/10,000 in 1997 to 0.9% in 2000 while the prevalence has increased from 0.3 in 1997 to 0.4 in 2000.

Heart disease is the main cause of mortality. In the period 1997-1999, cerebrovascular diseases were responsible for 11.7% of all deaths, ischaemic health disease 9.8% and hypertensive disease 4.6%. Ischaemic heart disease affected more males than females while the reverse was true for hypertensive disease. The main sites for malignancies in males were the prostate and stomach, while in females they were the uterine cervix and breast. Diabetes mellitus is a leading cause of morbidity, disability and mortality and is a major public health problem.

Protein-energy malnutrition, iron deficiency anaemia and obesity remain the major nutrition-related problems in the population. The 1997 micronutrient survey showed that iron deficiency anemia affected 40%-55% of children, adolescents and adults. About 52% of pregnant women were found to have low haemoglobin levels (<11g/dl). Obesity is also a major public health problem in adults. The Physical Activity Survey has shown that about half (51.0%) of adults over 20 years had a BMI 25 and higher. Of

these, 22.4% were classified as obese. There has been an upward trend in the prevalence of exclusive breastfeeding and a declining trend in malnutrition among children attending public health clinics.

Accidents and violence are overall the third leading cause of death. More males are affected than females. Suicide accounted for 164 deaths in 1999, compared with 65 in 1996, 41 in 1997 and 38 in 1998. More women than men attempted suicide but more men were successful in their attempts. The age groups most affected were 15-24 in females and 15-34 in males.

The five leading causes of infant mortality are hypoxia, intestinal infections, other perinatal conditions, acute respiratory infections and congenital anomalies. There is a downward trend in the Infant Mortality rate. The percentage of deaths in the under 5 population from acute diarrhoeal diseases and acute respiratory infections was 16.0 and 10.9 respectively in 1999.

An effective immunization programme has ensured that there are no reported cases of measles. There have also been no reported cases of cholera. In keeping with the WHO Initiative to eliminate lymphatic filariasis as a public health problem, a national plan has been developed and is being implemented. Malaria is endemic in the hinterland regions of Guyana where it is the leading health problem. The incidence of malaria has been declining in recent years due to heightened surveillance and the emphasis placed on prompt diagnosis, treatment and follow up. The Government of Guyana is committed to the global initiative, Roll Back Malaria. There is laboratory evidence that Dengue Types 1 and 2 were circulating in Guyana during the period 1997-2000. There have been no reported cases of Haemorrhagic Fever or Dengue Shock Syndrome. There were 248 reported cases of AIDS in 2000 compared with 234 in 1999. The major risk factor was unprotected heterosexual sex. The male/female ratio which was 1.7:1 in 1997, stood at 1.5:1in 1999. The use and abuse of drugs have become cause for concern in Guyana. Guyana, like many countries in the Caribbean, is used a transshipment point. Alcohol abuse is also considered to be a critical problem in Guyana.

1.4 Social Context: The last population census was held in 1991. The estimated mid-year population for 2000 is given as 743,004, which is a decrease in the estimate for 1997 (775,137). Approximately 29.8% of the population is under 15 and 9% less than 5 years old. The percentage of the total population over 60 is 6.7%. The Guyana Survey of Living Conditions (GSLC)[2] 1999 states that approximately 29.7% of the population live in urban areas and of the 70.3% which live in rural areas, 61.3% live in the rural coastal parts of the country. The rural interior is very sparsely populated. Over the period 1992-1999, the trend has been towards reduced urbanization, in contrast to the worldwide trend of urbanization. That survey also indicates that in 1999 East Indians represented 48.2% of the population, the group classified as Negro/Black 27.7% and the Amerindian population 6.3%.

Adult literacy is given as 98.3%- 97.8% for females and 98.8 % for males in 1999. The gross enrollment

rate for males at the secondary level was 67.2% and for females 68.9%. Enrolment at the primary ages was 92.8% and secondary 74.9%.

According to the 1999 GSLC, 36.3% of the population lives in absolute poverty (US$ 510 per year or US$1.40 per day) and 19.1% in critical poverty (US$ 364 per year or US$1 per day). This is a reduction in the levels found in the Living Standard Measurement Survey (LSMS) carried out in 1992/1993 when the figures for absolute and critical poverty were 43.2% and 27.7% respectively. Of those living in absolute poverty, 78.4% were from the rural interior and 39.8% from the rural coastal areas. The figures show a reduction in the levels of absolute poverty in Urban Georgetown and other urban areas. Critical poverty was predominant in the rural interior (70.8%) and to a lesser extent in the rural coastal areas (18.1%). The levels of critical poverty also show a reduction in the urban areas. The Amerindians recorded the highest level of poverty.

The economically inactive population is given as 7% in 1999. "Furthermore, although the rate of unemployment for those who indicate that those who are actively seeking jobs had decreased in 1999 to 9 percent, almost 50 percent of the country's workforce was not gainfully employed."[3] The labour force participation (labour force over population over 15) is 57%, down from 60% in 1992/93. In 1999, the population outside the labour force increased by 5% when compared with 1992/1993.

The lowest quintile accounted for 9.2% and the richest, 39.2% of total consumption. There has been some improvement since the GSLC carried out in 1992/1993 when the poorest were responsible for only 4.0% and the richest 55.1% of total consumption.

In 2000, Guyana ranked 96th on the Human Development Index and 80th on the Gender-related Development Index (GDI). The GDP Index is 0.59.[4] The Gini coefficient for Guyana is given as 0.421 based on income and 0.413 based on consumption.

2. THE HEALTH SYSTEM

2.1 General Organization

For the System as a Whole: The responsibility for the health care of the population rests with the Minister of Health. However, in 1986, the responsibility for the delivery of health services was devolved to the Regional Democratic Councils who receive funding through the Ministry of Local Government. The Ministry of Health retained responsibility for the vertical health programmes in the entire country, including vector control, rehabilitation services, dental care, mental health programmes, Hansen's disease, AIDS, and alcohol and drug abuse. The Ministry also formulates policy, sets standards and monitors and evaluates the health sector. The emerging model is that of decentralization to semi-autonomous bodies, with the Ministry of Health relinquishing its role in service delivery.

Public Institutions. The main public institutions that participate in the health sector are the Ministries of Health and Local Government. These Ministries are part of the public service. They are headed by a Minister who is the political head of the Ministry and is a member of the Cabinet. The Permanent Secretary is the Accounting Officer and is the administrative head of the Ministry. The Ministries receive funding from the Central Government. The donor community and other sources also contribute to the Ministry of Health. The human and technological resources of the health departments of the Regional Democratic Councils, Ministry of Local Government are for the most part provided by the Ministry of Health. There are five levels of care ranging from the health posts to health centres, district hospitals, regional hospitals and the national referral hospital. Within a region, at least 4 levels are found. Although the levels of care are well-defined, in practice they do not function in that manner as patients often bypass the health centre and district hospital levels to attend the regional hospitals and the national referral hospital. The technical head of the services at regional level is the Regional Health Officer whose role is to ensure the linkages among the various levels. There is no formal relationship with the private subsector. The National Insurance Scheme operates a social insurance programme for employees of the public and private sectors. Participation in the Scheme is mandatory for employed person between the age of 16 and 60, including the self-employed. The Scheme provides benefits for sickness (not employment related), maternity, medical care and job-related injury. Medical coverage is provided for consultations, hospitalisation, overseas treatment, spectacles, dental care, surgery and the purchase of drugs. Some employers provide insurance for their employees. These may be contributory or non-contributory.

Private Institutions. The private sector and private companies own 10 hospitals as well as diagnostic facilities, clinics and dispensaries. The private health services have been expanding rapidly and provide about half of all curative services. Most of these services are provided in the capital city and other urban centres. Several non-governmental organizations including religious organizations provide services on a not for profit basis. The principal sources of financing in the private sector are through fees from individual patients. There is no formal relationship among the various actors in the private sector. The Ministry of Health has legislation, the Private Hospitals Act, which makes provision for the licensing of Private Hospitals.

2.2 System Resources

Human Resources. Over the years, there have been shortages of many categories of staff. "There is heavy reliance on overseas personnel in some disciplines. For example, more than 90% of the specialist medical staff in the public sector are expatriates. In the public health sector, staff vacancy rates are in the range of 25-50% in most categories. In rural areas and in some specialisations such as pharmacy,

laboratory technology, radiography and environmental health, the vacancy rates are at higher levels. Moreover, imbalances exist in terms of staff distribution: almost 70% of the doctors are located in Georgetown, where one quarter of the population lives." [5]

New cadres of health workers have been introduced into the system including the dentex, rural midwives, rehabilitation assistants, community dental therapists and environmental health assistants. However there is a high attrition rate as salaries in the public health sector are low. The ratio of physicians to population has shown some improvement in the years 1993-1996, but has fluctuated for the period 1997-1999. The ratio in the more remote Regions is low. The ratio of dentists has remained constant. The ratio of pharmacists per 10,000 population has shown a decline in the period 1998-1999. There are 3 pharmacists in the public sector. Seventy function in the private sector. In the immediate future, it is expected that the ratios will show very little improvement in the absence of a health human resources development policy and unattractive remuneration.

HUMAN RESOURCES IN THE HEALTH SECTOR

	Year						
Type of Resource	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**
Ratio of physicians per 10,000 population	2.1	3.1	3.0	3.8	2.8	4.3	2.6
Ratio of nurses per 10,000 population	5.9	5.03	6.3	8.0	9.4	15.3	8.6
Ratio of dentists per 10,000 population	0.4	0.4	0.4	0.4	0.4	0.4	0.4
Ratio of mid-level laboratory technicians per 10,000 population	ND	ND	ND	ND	ND	ND	ND
Ratio of pharmacists per 10, 000 pop	ND	1.5	2.1	2.0	2.2	1.8	1.7
Ratio of radiologists per 10,000 pop.	ND	ND	ND	ND	ND	ND	ND
No of public health graduates.	4	4	6	10	10	10	10

Source: Planning Unit, Ministry of Health

HUMAN RESOURCES IN PUBLIC INSTITUTIONS, YEAR: 2001

Institution	**Type of Resource**					
	Physicians	Nurses	Nursing auxiliaries	Other health workers	Administrative personnel	General services
New Amsterdam Regional Hospital	12	195	296	37	21	195

Source: Region 6 Administration.

The ratio of specialists to general practitioners at the national referral hospital is 2.1:1. During the period 1994-1999, general practitioners received higher salaries than the medical specialists in the public health sector. Since the Georgetown Public Hospital became a corporation, there has been a reversal of that trend. Since 2000, specialists have been receiving higher salaries than the general medical practitioners.

Remuneration of general practitioners vs. that of specialists and compared with other professionals. There is no periodic measurement of the productivity of health personnel in the main public institutions.

Drugs and Other Health Products: There is no policy on drug prices. There is also no national drug policy. During the period 1993-1999, approximately 30% of the Government's health expenditures was used on drugs and medical supplies. Information on the five largest selling products on the national market and their unit price is not available. An essential drug list has been recently developed and 172 active ingredients (209 dosage forms and 9 combination drugs) are included. In addition a hospital drug list has been developed with approximately 350 active ingredients. The utilization of the drug list is not mandatory. On average 70% of essential drugs are stocked in the health centres and hospitals. However the supply is not constant. To improve access to vaccines, private practitioners are sold the biologicals at cost price. However, generally there are no schemes to facilitate access to drugs based on population groups or insurance systems. Although standardized treatment protocols exist for diabetes and hypertension, they are not generally applied. Government regulations stipulate which staff can dispense drugs. The presence of a pharmacist is required in private pharmacies and hospitals if prescription drugs are being dispensed.

INDICATOR	1993	1994	1995	1996	1997	1998	1999
Total number of pharmaceutical products	ND	ND	ND	ND	ND	ND	ND
Percentage of brand-name drugs	ND	ND	ND	ND	ND	ND	ND
Percentage of generic drugs	ND	ND	ND	ND	ND	ND	ND
Total spending on drugs (selling price to the public)	ND	ND	ND	ND	ND	ND	ND
Percentage of public spending on health allocated to drugs*	ND	ND	ND	ND	ND	ND	ND
Percentage of the expenditure executed by the Ministry of Health for drugs	30.0**	29.8	28.6	26.2	26.2	29.9	30.5

Sources: Ministry of Finance, World Bank and IDB. *Includes materials and medical supplies. ** Projected under HIPC Initiative.

The total number of blood donations for the years 1998, 1999, and 2000 were 2807, 2332 and 3343 respectively. There is no available data on the percentage of donations that are remunerated. A draft National Blood policy has been developed. There are standardized procedures for the control of blood. The donations in the public sector are controlled according to those standards.

Equipment and Technologies: In 1998, the total number of acute hospital beds is given as 3,274, of which 2,919 (89%) are in the public sector. The ratio of beds available per 1000 population is 4.4.

AVAILABILITY OF EQUIPMENT IN THE HEALTH SECTOR, YEAR: 1999

	Type of Resource

Subsector	Beds available per 1,000 population	Clinical Laboratories per 100,000 population	Blood banks per 100,000 population	Basic diagnostic imaging equipment per 1,000 population
Public	3.77	ND	0.13	ND
Private:	0.46	ND	0	ND
- For profit	ND	ND	ND	ND
- Not for profit	ND	ND	ND	ND
TOTAL	**4.23**	**ND**	**0.13**	**ND**

Source: Bureau of Statistics; National Blood Transfusion Service,

There are no dialysis units in the country. One CT Scan and one MRI machine are available in Guyana. Both are located in the private sector. There is an intensive care unit and neonatal unit at the main referral hospital.

AVAILABILITY OF EQUIPMENT IN THE HEALTH SECTOR, YEAR: 1999

	Type of Resource					
	Delivery Rooms		Clinical Laboratories		Radiodiagnostic equipment	
Public	1st Level	2nd Level	1st Level	2nd Level	1st Level	2nd Level
	31	5	ND	ND	ND	ND
Private (for Profit and non-profit)	ND	ND	ND	ND	ND	ND
TOTAL	ND	ND	ND	ND	ND	ND

Source: Ministry of Health.

Information is not available on the percentage of equipment that is defective or out of service. Data show that the percentage of the operating budget allocated to preservation and maintenance has grown from 2.8 in 1993 to a proposed 11% for the period 1999-2000.

2.3 Functions of the Health System

Steering Role. The Ministry of Health led by the Minister of Health is responsible for sectoral management and for regulating the sector. The essential public health functions have not been explicitly defined but many of the functions identified are carried out by State agencies. For example several agencies are responsible for guaranteeing the protection of the population against the principal environmental risk factors.

The Ministry of Finance releases funds to the sector based on an approved annual budget exercise. That Ministry has control over the public financing of the sector. The Permanent Secretary in the Ministry of Health is the administrative Head of the Ministry and is also the Accounting Officer. He has responsibility

for the use of the funds in his Ministry. Since funds are also disbursed to the Ministry of Local Government for the delivery of health services, the administrative Head of that Ministry will also be accountable for disbursements to the regional health services. There are no public mechanisms to regulate the different modalities of private health insurance.

The Ministry of Health is responsible for the supervision, evaluation and control of health services delivery by the various public and private subsectors. The private hospitals are monitored through the Private Hospitals Act, which provides for the establishment of inspection teams to monitor the private hospitals. No mechanisms exist for the rest of the sector and plans are being developed to establish a mechanism for monitoring both the public and private hospitals. The Ministry also carries out its roles in supervision, monitoring and control through training of staff in both public and private sectors and through the development of guidelines and protocols. The various professional Councils have roles to play in monitoring the functioning of health professionals.

Intersectoral activities and programmes are promoted. The private and public institutions that deliver health services are often part of the planning and implementation of the inter-sectoral programmes and activities. The health authorities have, on a limited basis, systems that provide reliable or timely information on the status of health, financing, insurance and delivery of services. The available data are used for decision-making. For example they are used in human resource allocation and training.

There is no specific entity in the Ministry of Health that has overall responsibility for human resource planning and development. At present both the Planning Division and the Health Sciences Education Division shares this role. The approach is uncoordinated and decisions about training are sometimes made in an ad-hoc manner, primarily due to the absence of a human resources development plan.

No accreditation procedures are mandated for the institutions that train health professionals. As a result, standards of performance of the institutions are not clearly defined. There are no accreditation procedures for health facilities. There are no public or private agencies devoted to health technology assessment. No policies exist for the preparation, introduction, and use of guidelines for clinical practice.

Financing and Expenditure: The data on health expenditure are not reliable or up to date. The Draft Health Plan 1995-2000 indicated that "the lack of annual reporting of health expenditures by all health care services to a centralised authority makes it impossible to accurately establish the level of health sector expenditure in Guyana."[6] One facet of the Public Sector Reform has been the move from line item budgeting to programme budgeting in the Ministry of Health from the fiscal years 1997/1998. This has facilitated the costing of health programmes and has given managers more control over the resources for their programmes.

In Guyana, the main source of health sector financing is Government taxation. Funds are directed to the

health sector through the Ministry of Health, Regions, other Ministries and agencies. The public health sector generates only insignificant revenues. Revenue generation from user fees and sale of services for 1999 was budgeted at only 0.16% of the government health budget. Reliable information is not available on the distribution of private health expenditure. Secondary sources of this type of information are not readily available. Studies are infrequently carried out. There is no form of public financing of private health insurance. No tax breaks are given to individuals when they purchase health insurance policies. Not much information is known about expenditure in the private sector.

The country receives significant technical cooperation for the health sector. In 1999, donors accounted for 5.22% of government health spending compared with 12.60% in 1997 and 7.34 in 1999.[7] All the funds are from grants. The principal sources of external financing in 1999 and 2000 were other UN agencies, Inter American Development Bank, United Nations Development Fund, USAID and German Technical Cooperation. The Ministry of Finance prepares data on health expenditure. The national per capita expenditure on health was US$24.8 in 1997 and US$25.3 in 1998. In 1999, health expenditure amounted to 6.51% of total government expenditure. If debt payments are excluded, the percentage was 8.51%.

Health Sector Financing, 1993-1999 in US$ and % of GDP

	1993	1994	1995	1996	1997	1998	1999
1.PUBLIC SUBSECTOR							
1.1 Ministry of Health and other public institutions at the central, regional and local levels							
1.1.1 Internal financing							
Funds from the Treasury	15,989,459 (4.10%)	19,449,011 (4.26%)	24,758,011 (4.79%)	19,091,238 (3.24%)	19,244,873 (3.07%)	19,561,983 (3.18%)	19,954,911 (3.46%)
Ministry's own funds							
1.1.2 External Financing	0	0	0	0	0	0	0
1.2 Social Security							
Member contributions	ND	ND	ND	ND	ND	ND	ND
Sales of goods and services	ND	ND	ND	ND	ND	ND	ND
Capital income	ND	ND	ND	ND	ND	ND	ND
	ND	ND	ND	ND	ND	ND	ND
2. PRIVATE SUBSECTOR							
2.1 Private Insurance	ND	ND	ND	ND	178,364	192,415	ND
	ND	ND	ND	ND	(0.03%	(0.03%)	ND
2.2 Nonprofit NGOs	ND	ND	ND	ND	ND	ND	ND
2.3 Household financing for private services	ND	ND	ND	ND	7,072,872 (1.13%)	7,744,242 (1.29%)	ND
TOTAL	ND	ND	ND	ND	ND	ND	ND

Source: Ministry of Health

	1993	1994	1995	1996	1997	1998	1999

Per capita expenditure on health in US$	29.1	34	39	43.4	45.4	45.4	ND
Public expenditure on health /total public expenditure	6.9	6.7	8.8	6.0	5.0	5.8	6.5
Total expenditure on health as a % of GDP	5.2	5.2	5.2	5.1	5.1	5.4	ND
External health debt/total external debt	ND	ND	ND	ND	ND	ND	ND

Source: World Bank, Ministry of Health.

Expenditure patterns as percentage of total expenditure in health sector: 1993-1999

Expenditure	**1993**	**1994**	**1995**	**1996**	**1997** est.**	1998 proj*.	1999 proj.*
Current expenditure	57.9	58.3	46.0	74.6	85.9	88.3	89.1
Drugs, materials and supplies	30.0	29.8	28.6	26.2	26.3	27.3	28.9
Maintenance	2.8	2.9	3.9	4.4	3.6	10.6	11.0
Capital expenditure	41.8	41.5	49.9	29.5	14.3	11.7	10.9

Source: Guyana Authorities; World Bank; IDB. * projected ** estimated.

Information is not available on health sector expenditure by subsectors and functions.

Health Sector Expenditures by Item, 1993-1999 in US$

	1993	1994	1995	1996	1997	1998	1999
1.PUBLIC SECTOR							
Services to individuals	ND	ND	ND	ND	ND	ND	ND
Population -based services	ND	ND	ND	ND	ND	ND	ND
Medicines and pharmaceuticals	2,582,660	3,100,309	3,150,911	3,016,534	4,025,95	4,186,948	3,491,982
Materials and supplies	190,865	248,804	394,952	501,012	617,856	799,254	925,900
Medical and health equipment	ND	28,937	152,815	55,934	143,696	176,914	145,604
Other equipment and repairs	10,741	18,556	49,097	98,048	414,793	440,137	383,165
Construction projects	317,432	608,102	928,711	999,373	1,203,035	573,043	588,505
TOTAL	**ND**	**ND**	**ND**	**ND**	**ND**	**ND**	**ND**

Source: Estimates of the Public Sector: Current and Capital Revenue and Expenditure (various years).

No data are available of the private sector's health expenditure by item.

Insurance: In Guyana, health care is offered free to the population and there is no social security system. However, all employed and self-employed persons are required to make contributions to the National Insurance Scheme, a portion of which is used to cover some health benefits. Some companies provide health insurance for their employees and families. Private health insurance is an option utilized by some families. Coverage is provided through insurance companies. Reimbursements are provided based on claims from the insured person. The health authorities do not have reliable and timely information on the

levels of coverage and modalities of the various health insurance schemes. No data are available on the percentage of the population covered by the different insurance models nor on coverage by age and sex.

2.4 Delivery of Services

Population-based health services: The Ministry of Health, Regional Authorities and non-governmental organizations carry out Health promotion and protection programmes. However, the lead agency for health promotion is the Division of Health Sciences Education, which is involved in training health staff and non-governmental organizations about the concepts and principles of health promotion. Health protection programmes are the responsibility of the programme managers of the Ministry of Health. The programmes extend throughout the country although areas where need is greatest are targeted as priorities. Some of the programmes identified as priorities include HIV/AIDS, Maternal and Child Health including the Expanded Programme on Immunization, the Prevention and Control of Diabetes and Food and Nutrition. Others include the prevention and control of tuberculosis and malaria and the elimination of filariasis. The programme managers with the support or relevant national and international agencies carry out these programmes. For example, non-governmental organizations are involved with the National AIDS Programme, which also receives financial support from international agencies. It is difficult to determine the coverage of the various programmes. The programmes have resulted in increased awareness among the population on health issues. The several difficulties encountered include inadequate supplies, personnel and equipment. The Ministry of Health in collaboration with the Cancer Board is initiating a comprehensive cervical cancer prevention programme. The coverage is limited at this time.

The Expanded Programme on Immunization has been one of the successful programmes in Guyana. Coverage with three doses of oral poliomyelitis and DPT vaccine was approximately 88% in 1997. This increased to 90% in 1998. In 1999 and 2000, coverage for polio was 83% and 78% respectively. Coverage for DPT for those years was 83% and 88%. Coverage with BCG vaccine has remained consistently over 90% during the period 1997-2000. Over the last five years, coverage for prenatal care and the percentage of deliveries conducted by trained personnel has been over 90%.

Individual Health Care Services: Data for the management of establishments and services are not usually timely and reliable. Monthly reports on utilization of health services at the regional and district levels are regularly submitted. The data are used in administrative decision-making to improve delivery of care. The ability of urban users to choose among various providers of a single type of service has increased as more providers and services have been concentrated in the urban areas. This does not apply to the rural areas.

Primary Care Level: "Twelve and one-half percent of Guyana's population does not have access to any

health care."[8] Access is restrained by geographical as well as financial factors. There are no computerised information systems in primary care facilities for administrative and personnel management. The leading causes of morbidity at the health centres (and the 5 most frequent reasons for consultation) are: acute respiratory infections; malaria; accidents and injuries, skin disorders and hypertension. Public health nurses make home visits, mainly for maternal and child health services. In 2000, there were approximately 100,845 procedures carried out in the dental services. Extractions were predominant. In 1999, there were 185,185 visits to outpatient clinics throughout the country.

***Secondary Care Level*:** No data are available on the coverage of the various networks of public and private providers for secondary level care. Since the secondary level facilities are all in the urban areas, access from rural areas can pose serious problems. Only the national referral hospital has a computerised information system that is used for administrative but not clinical management.

Production of Secondary Health Services, Public Hospital Georgetown, 1999

Indicator	
Total number of discharges	12,531
Occupancy index	58.2
Average stay in days	7.4

Source: Ministry of Health.

The five most frequent reasons for hospital discharges at the Georgetown Hospital in 1999 were motor vehicle accidents, falls, assaults, hypertension and threatened abortion. There is a problem with lists or delays in some areas such as for cataract surgery. Efforts are being made to reduce the backlog.

***On Technical Quality*:** No establishments have a fully operational Quality programme. However it is an area that is receiving attention and training programmes have been held to sensitise health personnel on quality issues. A Quality network has been established to support the Quality initiative. In the public facilities there are no functioning ethics and/or professional oversight committees.

At the main public hospital , the trend has been to increase deliveries by cesarean section- 12.8% in 1999 compared with 8.8% in 1997. No data are available on the rate of hospital infections. The major public hospital has established an infection control committee. The percentage of autopsies to total hospital deaths is not known but it is probably very low. Generally, audits of deaths in children are not carried out. Maternal deaths that occur in public facilities are investigated.

On Perceived Quality: There are no facilities which have established a fully operational programme for improving user relations. None in the public sector has specific user orientation procedures. User satisfaction surveys are rarely conducted. There are no arbitration committee or entities for handling complaints.

3. MONITORING AND EVALUATION OF HEALTH SESCTOR REFORMS

3.1 Monitoring the Process

Monitoring the Dynamics: The genesis of the present reform process is the result of a sector analysis completed for the formulation of both the National Health Plan and the Draft National Development Strategy. The Plan pointed out the need for improvement in management at all levels of the health system. The Draft National Development Strategy also recognised the need for the health services to be organized and managed differently. Other studies carried out by the international agencies have also provided support for reform of the health sector. The principal actors have been the Ministry of Health and the International Financing Agencies.

Public opinion and/or demands were considered when the reform was being proposed. This was not done in a formal manner. A sectoral reform agenda was developed. The objectives of the reform agenda are to parallel the reform programme of the civil service in which the health sector currently functions; to restructure and re-organize the Ministry of Health from having service delivery functions to a sectoral steering/leadership role; to further decentralize the health services through the establishment of legal boards; to establish legal/autonomous boards to manage the Georgetown Hospital, other major regional hospitals at certain departmental units; and to broaden financing/cost sharing options through the introduction of selective user fees charges. Sectoral reform is part of the State's development plans and programmes.

The Ministry of Health has led the design of the reform. Different groups such as the trade unions, the regional authorities and the professional associations have participated in the consultation process. They participated soon after the proposed changes were enunciated. A preliminary plan of action was developed. The Inter American Development Bank, through the project "Health Sector Policy and Institutional Development Programme" is funding the studies, field-testing and implementation of the sectoral reform activities. The reform is underway but the process has been slower than anticipated. One of the factors has been the need to identify new consultants to conduct the studies. A review of the staffing of the Ministry of Health was completed and recommendations made that would allow the Ministry to carry out its steering role. The main public institution, the Georgetown Public Hospital is now a semi-autonomous agency. With the assistance of PAHO, a communication plan was developed. Some public education activities have been carried out, especially in the regions where it is expected that the pilot implementation will be done. Steps have also been taken to inform and involve the health professionals. Evaluation criteria have not been defined. It is too soon to carry out an evaluation of the impact of sectoral reform. No evaluation has been done of the development and/or impact of the reform process.

Monitoring the Contents

Legal Framework: The Georgetown Hospital was made a semi-autonomous agency by means of the existing Public Corporations Act. The policy paper for the establishment of Regional Health Authorities has been completed as well as the draft legislation. Consultation for possible revision or implementation is in progress. Draft legislation has also been completed for the establishment of the materials management Agency, the Health Facilities Accreditation Act and the Allied Health Practitioner Act. Legislation to amend the Medical Practitioners Act has been approved by Parliament. One of the measures is to include lay persons on the Board of the Medical Council. It is also proposed to revise and up-date the existing public health legislation and regulations, which are outdated. No constitutional amendments are needed at this time for the implementation of the reforms. Equity has not been defined in the legal norms governing health. The legal changes will not specifically favour an intersectoral approach.

Right to Health Care and Insurance: The right to health care is guaranteed under the current Constitution. The reform proposals include the development of a Patients Charter. Specific programmes have been designed to increase coverage. The target groups are those most at risk. These include programmes for AIDS, cancer, chronic non-communicable diseases and the Integrated Management of Childhood Illness. Emphasis is also placed on training of health workers such as the Medex and Community Health Workers who will function mainly in the rural areas of the country. A guaranteed plan or basic package of benefits has not been introduced but the reform proposals support the development of a basic health care package.

Steering Role and the Separation of Functions: Steps are being taken to enable the Ministry of Health to carry out its steering role in the health sector. Proposals have been made for a change in the organizational structure of the Ministry. To date an assessment of the staffing required has been conducted and preliminary studies to determine how the present staff can be utilised in the proposed new structure have been done. No new public institutions have been created to be responsible for financing or insurance. A policy committee has been established to advise on policy issues. Work has begun on the development of information systems that will guide the establishment of priorities and support the decision-making and resource allocation processes. The United Nations Development Programme has provided assistance in this area. The IDB consultancy will also support the strengthening of the information system.

Modalities of Decentralization: It is proposed that as part of the reform process, the administrative levels of the health system will be reviewed. They do not bear a relationship to more general proposals for decentralization of the civil service and /or other social sectors. Responsibilities, authority and resources have been transferred to the newly established semi-autonomous agency, the Georgetown Public Hospital

Corporation. When the Regional Health Authorities are established, the same will apply.

Social Participation and Control: Social participation is an objective of the proposed sectoral reform. Very few mechanisms have been developed as yet to facilitate social participation. The proposed changes to the professional councils will result in public participation at the level of the Boards.

Financing and Expenditure: Some preparatory work has been carried out on the information systems on financing and expenditure. Programme budgeting, which focuses on the expenditure side, has been introduced into the sector. The IDB project will also support this aspect of the reform. Some of the financing reform objectives are: (1) financial sustainability for the public health system through the development of adequate financing mechanisms; (2) established social assessment systems for exemptions, and or subsidizing the medically indigent; and (3) increased emphasis of resource allocation on primary health care, health promotion and illness prevention. There are proposals to modify the composition of the financial regulations and financing. More funds will be injected into the sector through the HIPC Initiative. More money will be allocated to personnel costs to upgrade the salaries of workers in the public sector so that they can approach the salary levels in the private sector. Through the Poverty Reduction Strategy,[9], programmes and actions have been developed to identify and target vulnerable groups.

Service Delivery: The models of care are being refined at present. There is an expressed goal to make Primary Health Care the focus of the reforms but there has been no realignment of the resources and services to reflect that goal. The management of some health programmes will be delegated to semi-autonomous agencies. This has started with the establishment of the Cancer Board. An important strategy in the provision of secondary and tertiary care is the building of relationships with personnel and agencies externally. There are links with other agencies and non-governmental organizations to address some issues such as Family Life Education, Adolescent Health and Substance Abuse. The need for the strengthening of the referral system has been recognised and is one of the activities of the reform process.

Management Model: Changes are being introduced in the management model for public health facilities. The proposals are to have the Regional Health Authorities be responsible for service delivery. There is the intent to work closely with the private sector in the provision of health care. It is envisaged that the State may need to procure some services from the private sector and vice versa. No management contracts have been introduced between the different levels of the public health care system. It is proposed that the Ministry of Health will enter into Health Services Agreements with the Regional Health Administrations for the supply of services. These Agreements will also contain specific targets for improvements in the health status of the catchment population of the Region. There is no stated intention to hand over public health facilities to private management.

On Human Resources: Some modification has been made in human resources education to include areas such as health promotion. No changes have been made in labour law or the professional regulations governing health workers. No modifications have been proposed or introduced in the multidisciplinary orientation of professional practice. Mechanisms are being formulated for the certification of health workers mainly through initiatives at the Caribbean sub-Regional level. The trade unions have been involved in the early general discussions on health sector reform but their participation with respect to human resources has been limited. Through the HIPC Initiative, more money will be allocated to personnel costs to upgrade the salaries of workers in the public sector so that they can approach the salary levels in the private sector. Data is not available on the volume of resources that have been consumed in the past years in each major public health service facility for training health workers.

Quality and Health Technology Assessment:: The procedures for regulating facilities in the private sector have been created through the Private Hospitals Act. Sectoral reform does include initiatives in the area of technical quality or perceived quality for the different levels of care. These initiatives include the development of a Value Improvement Programme, the establishment of a Health Complaints Authority and the Health Sector Quality Council. No proposals have been made for evaluating health technology.

3.2 Evaluation of Results

It is too early to evaluate the progress of the sectoral reform as implementation has been delayed.

* The profile was prepared by a group of five professionals and national policy decision makers from the Ministry of Health of Guyana and the PAHO/WHO Representation in Guyana. Technical coordination of the national group was the responsibility of the Planning Unit of the Ministry of Health of Guyana and the PAHO/WHO Representation in Guyana. The external review was completed by the Social Development Specialist of the Inter-American Development Bank country office in Guyana. Final review, edition, and translation are the responsibility of the Program on Organization and Management of Health Systems and Services of the Division of Health Systems and Services Development of PAHO/WHO.

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