NATIONAL DEVELOPMENT STRATEGY (2001-2010)

A POLICY FRAMEWORK

ERADICATING POVERTY AND UNIFYING GUYANA

A CIVIL SOCIETY DOCUMENT

ANNEX 19

HEALTH

Date of Publication: November 2000

Date finalised by Sectoral Committee: May 1999

Equivalent Chapter in Core Document: Used as Background Material for Chapter 19

The Annexes to the National Development Strategy: An Explanatory Note

In June 2000, the National Development Strategy (NDS) of Guyana was formally presented to the President of Guyana and the Leader of the Opposition in the form of a core document, a 348 page distillation of the main elements of the analysis of the Guyana situation and the resulting strategy for action drawn from material prepared by 24 sectoral committees of the National Development Strategy Committee (NDSC). While Chapter 1 of the core document provides an outline of the origins of the NDS and the methodology of its preparation, the purpose of the present note is to explain the Annexes to the core document.

The Annexes are edited versions of the original drafts that the sectoral committees prepared, using a format that facilitated systematic thinking, though at the cost of some repetition. They are therefore longer than the corresponding Chapters of the core document, and also differ from them in other ways:

1. While the Annexes were individually edited in terms of their content, in the core document, disagreements or dissonances between Chapters were removed; for example, if the Chapter on the Private Sector proposed a strategy for Education that was in contradiction with a strategy proposed in the Chapter on Education, the two were rationalised.

2. While the core document was updated with the most recent data where possible, the Annexes generally retain their original data; for recent economic and social statistics, the attention of readers is particularly drawn to the recently completed *1999 Guyana Survey of Living Conditions.* In addition, again because of differences in when they were prepared, what was a Bill at the time of the original draft may have become an Act by the time the core document was being edited. This type of difference may be footnoted in the Annexes.

3. The treatment of the Annexes as historical documents occasionally produced another kind of difference, the main example of which is the Annex on Energy which was written before the privatisation of the Guyana Electricity Corporation, and whose strategy was largely preempted by that privatisation; while the edited Annex deliberately relied on the original material, new material was developed for the core document. These differences may also be footnoted.

It is worth noting that the updates found in the core document usually demonstrate the soundness and continued applicability of assessments made on the basis of earlier data or other information.

There are fewer Annexes than there are Chapters in the core document. For various reasons, some sectoral committee drafts were finalised in the same format as the Chapters of the core document, and there would therefore be little difference between the Chapter and the corresponding Annex. (Examples of this are the Macro-Economic Strategies and the Management of the economy; Sugar; Urban Development; Land; Housing; and The Family). The core document also includes Chapters for which there were no corresponding sectoral committee drafts; the first three Chapters of the core document (Origins and Methodology, National Objectives and Governance) are examples.

For those sectors where there are both separate Annexes and core document Chapters, the titles and numbering of the two correspond except in two cases: one, the corresponding Annex for the Chapter on Manufacturing is titled Manufacturing and Technology and includes material on Science and Technology that the core document had placed elsewhere; and two, the corresponding Annex for Chapter 4, Macro-Economic Policy, is Annex 4, Financial Sector Policy, because the material prepared for the Financial Sector Policy Annex was incorporated into the Chapter on Macro-Economic Policy.

The National Development Strategy was published in summarised form (the core document) for the practical reason that few people would have the time to read the over 700 pages represented by the Annexes. Yet the Annexes have a clear value. They include background information and assessments that were too detailed for inclusion in the core document, but which trace the process that shaped the strategy. Above all, they preserve for us and for posterity the earlier thinking, and the full range of thinking, of the women and men whose work provided the foundation of the NDS. In doing so, they honour the labour which the sectoral committees put into distilling their own work and life experience and the views of the public they consulted in the process. It is this foundational material that is now being published, making the National Development Strategy of Guyana available in both summary and extended forms.

TABLE OF CONTENTS

LIST OF ACRONYMS

ACDS ...	Ambulatory Care Diagnostic Surgical
Bermine.	Berbice Mining Enterprise
CAREC.	Caribbean Epidemology Centre
Caricom.	Caribbean Common Market
CH&PA.	Central Housing and Planning Authority
CIDA ...	Canadian International Development Association
CT	Computerised Tomography
ECG	Electro-Cardiogramme
EPI	Expanded Programme of Immunisation
EU	European Union
GAHEF	Guyana Agency for Health Science Education, Environment and Food Policy
GDF	Guyana Defence Force
GDP	Gross Domestic Product
GUM	Genito-Urinary Medicine
GUYSUCO	Guyana Sugar Corporation
GUYWA	Guyana Water Authority
HIES	Household Income and Expenditure Survey
HIPC	Highly Indebted Poor Country
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
ICD	International Classification of Diseases
IDB	Inter-American Development Bank
IMF	International Monetary Fund
Linmine	Linden Mining Enterprise
MOH	Ministry of Health
NGO	Non-Governmental Organisation
NIS	National Insurance Scheme
PAHO	Pan-American Health Organisation
PHC	Primary Health Care

PHG	Public Hospital Georgetown
RDC	Regional Democratic Council
REO	Regional Executive Officer
RHA	Regional Health Authority
RHO	Regional Health Officer
SIMAP	Social Impact Amelioration Programme
STD	Sexually Transmitted Diseases
UG	University of Guyana
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organisation

LIST OF TABLES

ANNEX 19

HEALTH

I. Basic Features Of The Sector

A.Health Conditions of the Population[1]

During the 1970s and 1980s, Guyana's economic performance deteriorated and social conditions worsened, and the country's education and health indicators dropped from the highest to the lowest in the Caribbean as poverty pervaded the vast majority of the population. One of the most unfortunate consequences of the economic decline was that it led to deteriorated health conditions for a large part of the population. This was the result of several factors, including lower per capita income levels, a drop in educational levels, disrepair in economic and social infrastructures, and the reduced capacity of the health sector to service the needs of the population. Government recurrent allocations to the health sectors dropped sharply between 1988 and 1992, although subsequently that trend was reversed. While there has been success with immunisation programmes (see Table 19-1), the incidence of some diseases has increased precipitously in the past few years, for example, malaria and HIV/AIDS.

Guyana ranks poorly compared to other neighbouring countries in regard to basic health indicators. Life expectancy declined from 70 years in 1985 to 64 in 1992 (but it ceased to decline since). In 1998, life expectancy at birth was estimated at 64.6 for Guyana, 74.7 for Jamaica, 76.5 for Barbados, 71.6 for Suriname, 72.9 for Venezuela, and 73.8 for Trinidad & Tobago[2]. In Guyana, the infant mortality rate in 1998 was 22.9, and although this represented a decrease from 49 in 1987, it remains among the highest in the Caribbean. In Barbados, the rate was 14.9 in 1997, in Jamaica 24.5, in Suriname 25.1, in Trinidad and Tobago 16.2, and in Venezuela 22[3].

Maternal mortality in Guyana is also relatively high, with the Ministry of Health estimating a rate of 124.6 for 1998. Comparable figures for other Caribbean countries are 50 for Barbados, 75 for Trinidad & Tobago, and 100 for Jamaica[4].

---

[1]This section is based on material drawn from the Draft National Health Plan of Guyana, 1995-2000, produced by the Ministry of Health in collaboration with public and private service providers and managers, Georgetown 1996

[2] Source: PAHO (1998). *Health Situation in the Americas: Basic Indicators.* Health Situation Analysis Program, Division of Health and Human Development

[3] Source: ibid.

[4] Source: ibid.

Table 19-1

Selected Health Performance Indicators, Maternal and Child Health, Guyana

Indicator						1999 (target)	2000 (target)	2001 (target)
Infant Mortality Rate (per 1000 births)						20	20	15
Neonatal Death Rate						12	12	12
Age specific Death Rate in children 1-4 (per 1,000 live births)						1	1	1
Maternal Mortality Rate (per 100,000)						110	80	80
Immunisation status								
BCG (tuberculosis)						94%	95%	96%
OPV (Oral Polio Vaccine)						90%	90%	95%

-

DPT (Diphtheria, Whooping Cough, Tetanus)						90%	90%	95%
MMR (Measles, Mumps, Rubella)						95%	95%	96%
Low birth weight babies as % of live births						12%	12%	12%
Nutritional status of children under 5 as % of age group Severely malnourished Moderately malnourished Overweight						0.5 12 2.5	0.5 10 2	0.5 10 2
Anaemia in pregnant women						15%	15%	15%
% of women accessing ANC in 1st trimester						..	..	..
% of children breast fed exclusively for 4 months						40%	45%	..
# of Baby friendly Hospitals						8	10	..

Source: MOH and Bureau of Statistics

-

A health strategy has to be based on a determination of the leading health problems in the population, and the principal requirements for making the health care delivery system more effective.

Unfortunately, the inadequacy of statistics in Guyana constrains analysis of the health care needs of the population. Reliability, completeness and accuracy of data are poor. There are currently no statistics available on morbidity/mortality patterns by occupation, education, and income levels, which impedes identification and targeting, especially of the most vulnerable groups. Registries of births and deaths at the General Registrar Office are poorly kept, and do not report accurate and comprehensive information for an analysis of mortality patterns. The reliability of the statistics on morbidity is also low. It should be borne in mind that data on morbidity refer to reported cases (for all diseases and ailments), so it is highly likely that actual levels of incidence are more elevated, perhaps significantly for some diseases. Moreover, the completeness of data collected in some areas is limited, due to the absence of clinics, a failure to collect data, and poor reporting systems. The statistic presented in this section should therefore be assumed as indicative, i.e., as not always accurately reflecting the health needs of the population.

The leading causes of mortality for young children under 1 year are[5]:

Certain conditions originating in the prenatal period (46.9%)

Intestinal infectious diseases (15.6%)

Congenital anomalies (10.4%)

Other diseases of the respiratory system (6.7%)

Nutritional deficiencies (5.8%)

Other bacterial diseases (4.0%)

Diseases of blood and blood-forming organs (2.0%)

Endocrine and metabolic diseases immunity disorders (1.8%)

Other accidents including late effects (1.6%)

Diseases of the Nervous System (1.1%)

The ten major causes of death for infants accounted for 96.2% of the total number of deaths for 1996. Regional disparities exist.

[5] Data from 1996, Statistics Department, Ministry of Health and Labour. Total infant deaths – 1996: 443.

In the past, malnutrition has been one of the leading causes of mortality in the age group 1 to 4. In 1992, it was the second leading cause of mortality in this age group. These high rates resulted mainly from the high rates of poverty. According to the 1992/1993 Living Standards Measurement Survey, 2.2 percent of children suffered severe malnutrition and 16.1 percent mild or moderate malnutrition (see Table 19-2). The prevalence of severe and moderate malnutrition was highest in the lowest income groups, and in Regions 5, 6, 8 and 9 (see Table 19-3).

Table 19-2
Malnutrition among Children under 5 and by Consumption Quintile

	% severely malnourished	% mildly malnourished	Number
Total for regions 2, 3, 4, 5, 6, 7, 10	2.2%	16.1%	581
Consumption quintile			
I (poorest)	3.5%	28.2%	85
II	1.6%	17.6%	125
III	3.4%	16.0%	119
IV	2.5%	11.5%	122
V	0.8%	10.1%	129

Source: HIES data, 1993. N=581. Note that this percentage does not represent the 20% of the population

Table 19-3

Nutritional Status of Children under 5 and Low Weight Births by Regions (1991)

%											
Severely malnourished											

-

Moderately malnourished											
Low weight birth											

Source: Gahef, Health and Nutrition Survey (1992).

In 1996, the leading causes of mortality for all age groups in Guyana were[6]:

- .. Cerebrovascular diseases (11.6%)
- .. Ischemic Heart Disease (9.9%)

[6] Data from 1996, Statistics Department, Ministry of Health and Labour. Total deaths – 1996: 4813

-

- .. Immunity Disorders (7.1%)
- .. Other diseases of the Respiratory System (6.8%)
- .. Diseases of Pulmonary Circulation and other forms of Heart Disease (6.6%)
- .. Endocrine and Metabolic Diseases (5.5%)
- .. Diseases of other parts of the Digestive System (5.2%)
- .. Other violence (5.1%)
- .. Certain conditions originating in the prenatal period (4.3%)
- .. Hypertensive disease (3.9%)

The ten major causes of death accounted for 66.2 percent of the total number of deaths for 1996.

The leading causes of mortality in Guyana are similar to those of middle-income countries, with cerebrovascular diseases and heart diseases ranking first (21.5% of all cases in 1996, compared to 32.1 percent in 1992). An increase in the number of deaths from AIDS has occurred over recent years. In 1996, 288 out of 345 deaths in the category "immunity disorders" can be ascribed to AIDS or Aids-Related Complex. In the group "endocrine and metabolic diseases," 255 deaths out of 264 were from diabetes mellitus.

The picture in regard to morbidity patterns differs. The ten leading causes of morbidity for all age groups as reported in 1996 were, in decreasing order: malaria, acute respiratory infections, symptoms, signs and ill-defined or unknown conditions, hypertension, accidents and injuries, acute diarrhoeal disease, diabetes mellitus, worms infestation, rheumatic arthritis, and mental and nervous disorders. The ten most prevalent diseases accounted for 86.3 percent of the total visits to clinics in all Regions. There are some gender differences in disease patterns, for example, men have a higher incidence than women of acute respiratory infections, accident and injuries, and worm infestation and asthma, while women have a higher incidence of hypertension, arthritis rheumatism, and diabetes mellitus (see Table 19-4).

-

Table 19-4
Ten Most Prevalent Diseases by Gender, 1996

	Male		Female		Total	
Malaria	N		N		3	
Acute Respiratory	1	2	1		2	
Symptom, signs & ill-defined or unknown conditions	7 , 0 9 4	1 3 . 9 %	9, 5 5 9		1 6, 6 5 3	
Acute Diarroheal Diseases	N A		N A		1 1, 9 7 6	
Accident & Injuries	6 , 5 1 2	1 2 . 8 %	3, 4 2 1		9, 9 3 3	
Hypertension	3 , 0 7 7	6 . 0 %	5, 9 6 4		9, 0 4 1	
Worm Infestation	3 , 3 7 1	6 . 6 %	3, 8 2 7		7, 1 9 8	
Rheumatic Arthritis	1 , 4 2 7	2 . 8 %	2, 7 1 6		4, 1 4 3	
Diabetes Mellitus	1 , 1 2 8	2 . 2 %	2, 5 0 9		3, 6 3 7	

-

Scabies	1,179	2.3%	1,467		2,646	
Mental & Nervous Disorders			1,396		1,942	
Infection	1,095	2.1%	1,237		2,332	
Asthma	863	1.7%				
Total 10 leading cause, by gender group	38,945	76.5%	47,491			

Source: Statistics Unit, MOH. Total number of first visits (males): 50,915. Total number of first visits (females): 66,824

Statistics based on visits to clinics are likely to underestimate the real incidence of diseases, and therefore are not an accurate representation of the health needs of the population. However, assuming that real health needs do not substantially differ from the picture emerging from data on visits to clinics, important policy implications can be drawn. The morbidity profile reveals that it can be improved substantially through enhanced preventive health care, better education on health issues, more widespread access to potable water and sanitation services, and increased access to basic health care of good quality.

Reported cases of malaria increased twelve-fold between 1984 and 1991. In the 1940s, Guyana's anti-malaria programme was one of the most successful in South America, and by the 1950s the disease was virtually eliminated. This experience demonstrates what is possible. The resurgence of malaria began when anti-malaria measures were suspended between 1963 and 1974 owing to fiscal limitations. Poor environmental health is in part responsible for the seriousness of vector-borne diseases, including malaria, filaria and dengue fever. Malaria is endemic and represents the major cause of morbidity in Regions 1, 7, 8, which are also among the poorest areas of Guyana. Cases of gastro-enteritis and typhoid fever increased sharply as well. Filaria is endemic along the coastal trips, and dengue fever is prevalent especially in the coastal area. In

-

general, diseases spread by vectors and those associated with environmental problems showed the most rapid rates of increase.

The high incidence of dental caries can be addressed through preventive and conservative care, including oral education. According to the 1993 Oral Health Survey report, 70.7 percent of all children were affected by caries, and the total number with caries in all Regions amounted to 49,726. At present, the incidence of dental caries among the Guyanese population has not decreased. This high incidence is influenced by the lack of qualified dentists (the dentist/population ratio is estimated at 1/38,421, the dentex/population ratio at 1/42,942).[7] Moreover, up to present public interventions have been limited to emergency care, especially extractions of teeth, with limited or no curative and conservative treatments.

Cancer is becoming an increasingly serious health issue for the Guyanese population. However, a system of diagnosis is currently lacking, which impedes a sensible appreciation of the magnitude and seriousness of the problem. Cervical cancer appears to be increasing among the female population, although its impact could be reduced by preventive actions such as early detection. Smear tests are taken in Georgetown and since 1997, also in Linden and New Amsterdam. The Guyana Cancer Society estimates a total of 1,019 tests carried out since 1996. Awareness campaigns carried out on TV seem to be correlated to the number of smear tests carried out. Most of the women whose tests were positive could have reduced the severity of their condition through earlier detection and cure. At present there is no oncologist in Guyana, and the assessment of the urgency of each cancer case is not accurate. A Cancer Board, which is in the process of drafting a national cancer programme, was established in September 1998.

Table 19-5 shows the incidence of health problems by age group. For the under 5 population, acute respiratory infections, acute diarrhoeal diseases, and worm infestation are the most common afflictions. In the 20-64 age groups, malaria, symptoms, signs and ill-defined or unknown conditions, acute respiratory infections, and hypertension are the most frequent diseases**.**

There are significant differences in the incidence and patterns of morbidity by Region. This is due in part to the geographical isolation of some communities and the attendant difficulties of delivering equipment and services to them, and in part to the fact that the deterioration of the health infrastructure mainly affected the most remote communities. In 1996 the total number of cases of diseases per 1,000 population as reported by clinic attendance was 1,247 for Region 1 and 1,748 for Region 8, compared to 24 for Region 4 and 123 for Region 6. The Regions with the lowest overall morbidity rates (according to statistics on reported cases) are Regions 3, 4, 6 and 10. However, the reliability and completeness of data are not uniform across Regions, and are especially poor in areas where there are no health clinics, or where clinics are poorly staffed, and statistics poorly reported. Hinterland areas are often the least accessible both by river and

[7] Source: Ministry of Health-Dental Health Services (1998). MOH-Oral Health Access Program. March 1998, p. 5.

by air, and suffer from a lack of basic infrastructure and facilities, such as electricity and potable water. This makes the delivery of certain services a difficult task.

-

Table 19-5

Morbidity Patterns by Age Group in Guyana, 1996

Causes of Morbidity	Age Group					
	TOTAL First Visits	0-4	5-14	15-19	20-64	64+
Malaria	34,075	NA	NA	NA	NA	NA
Acute Respiratory Infections	28,602	13,107	4,909	1,896	7,846	1,024
Symptoms, signs and ill-defined or unknown conditions	16,653	3,051	2,040	1,579	8,761	1,222
Acute Diarroheal Diseases	11,976	8,347				
Accident and injuries	9,933		1,691	1,199	5,738	

-

Hypertension	9,041				6,043	2,946
Worm Infestation	7,198	3,824	2,261	370		
Arthritis rheumatism	4,143				2,745	1,312
Diabetes Mellitus	3,637					982
Mental & Nervous Disorders	1,942					

Source: Ministry of Health, Statistical Unit.
Note:Subtotals do not add to totals because the latter include cases in which the age was not stated.

Malaria is mainly responsible for the high rates of morbidity in the hinterland, accounting for 291 cases per 1,000 population in Region 1, 206 in Region 7, 549 in Region 9, and 1,119 in Region 8. One of the causes of the pervasive spread of malaria in the hinterland is the influx of small-scale agriculture and timber workers. Moreover, indiscriminate use of malaria drugs in these areas has caused an increase in the drug-resistant strains of malaria.

Food accessibility and availability vary across regions. During 1998, the "El Nino" effect caused drought in many hinterland regions, mainly in areas closer to the border with Brazil, resulting in food being unavailable locally. Insufficient dietary intakes, lack of nutritional education and lack of access to clean water are among the factors causing poor nutritional status. A micronutrient survey carried out in 1997[8] proves increasing iron deficiencies among school children, while deficiencies in pregnant women did not seem to be improving in the past few years. Major nutritional problems in Guyana also include under-nutrition in young children (10 percent of children appear severely malnourished), obesity in adults (48 percent of women, and 29 percent of men) and iodine deficiencies. Most of the nutritional problems in Guyana at present seem to

[8] Ministry of Health, Caribbean Food and Nutrition Organisation, Pan-American Health Organisation (1997). Micronutrient Study Report, Guyana. Sponsored by UNICEF. Kingston, Jamaica: CFNI.

derive from an absence of healthy lifestyles and diet. However, there also seems to be a direct correlation between nutritional deficiencies and poverty.

The nature of the most pressing health concerns varies by population group. The analysis of disease patterns and other socio-economic variables reveals groups and areas of vulnerability, namely: women; children; people affected by STDs/AIDS; people affected by mental health problems and drug abuse; disabled people; elderly people; and Amerindians.

Regarding women's health, the principal concerns centre on reproductive health, including childbearing, maternal mortality, anaemia during pregnancy[9], teenage pregnancies[10], the prevalence of abortion[11], and complications arising during attempted abortions. Abortion is among the leading causes of maternal mortality.

However, women's health issues are not limited to their reproductive role, but include other issues deriving from sexuality and gender relations, such as child bearing and survival; vulnerability to health risks in the work place; intra-household violence; the spread of STDs and AIDS; and breast and cervical cancer. Cancer is one of the leading causes of morbidity and mortality for women**.**

Regional imbalances in the nutritional status of children and mothers exist. In Guyana, the highest percentage of low birth weight babies (which indicates an inadequate nutritional status of both the mother and the baby) is found in the hinterland Regions (7, 8, and 9). Low weight babies accounted for 15.4 percent of live births in 1997 (Table 2). The incidence of wasting in 1994 in a sample of 2,572 primary school entrants from fifty-five schools across the country was found to be 8.1 percent, with 1.1 percent exhibiting severe wasting.[12] The overall proportion of stunted children was 13.7 percent. Again, there were ethnic and regional imbalances, with the Amerindian population scoring worst in terms of height for age, and the Indian population worst in terms of weight for height. Stunting was particularly high in Regions 1 and 9, the interior regions bordering Venezuela and Brazil respectively. However, the significance of these last findings is limited by the existence of natural anthropometric differences across ethnic groups.

Malnutrition among women (indicated by the high prevalence of anaemia) and children is highest in the most destitute households, mainly in the rural interior.

---

[9] According to the Micronutrient Report (op. cit.), 52% of all pregnant women tested with haemoglobin levels below 11gm.

[10] In 1990, women below the age of 20 accounted for 30% of all births.

[11] According to Dr. T.B. Jagdeo, "Guyana Contraceptive Prevalence Survey, 1991-1992", 25.7% of all women 15-44 who use a form of contraception used abortion as a contraceptive method.

[12] Gahef (1995). Report on the Nutritional Status of Primary School Entrants, 1994-1005. Funded by UNICEF & PAHO Georgetown, Guyana: Gahef.

According to the HIES[13], the highest percentage of children with nutritional deficiencies are the offspring of women with more than four children, an educational attainment below primary level, and residence in houses with public standpipes. The Micronutrient Report confirms that iron deficiencies are twice more likely to be found among women than men in the age groups of 15 and above. The health and nutritional status of children and mothers could be significantly improved by preventive care.

The MOH has been investing into an Expanded Programme on Immunisation which was started in 1992. Coverage rates differ by Region, and are particularly low in Regions 8, 9 and 1, although remarkable results have been achieved in terms of BCG coverage (See Table 19-6).

Table 19-6

Vaccination Coverage in the Regions, 1996

Region	MEASLES	BCG	DPT	OPV	TOTAL
1	84.0	100	68.2	70.4	80.7
2	100.0	91.1	88.9	86.1	91.5
3	89.0	88	87	87	87.8
4	89.6	94.1	81.8	83.0	87.1
5	74.8	81	86.3	85.3	81.9
6	87.2	77	80	77	80.3
7	60.4	95.7	97.1	94.9	87.0
8	93.2	66	36.4	30.8	56.6
9	77.6	100	79.4	79.3	84.1
10	80.0	83.9	79.3	79.7	80.7
TOTAL	91.1	88.4	83.0	83.0	86.4

Source: Maternal and Child Health Department, MOH

[13] Bureau of Statistics (1993). Report on Income and Expenditures Survey, 1992-1993. Georgetown, Guyana: Bureau of Statistics.

HIV/AIDS and other sexually transmitted diseases are becoming a serious concern. In 1993, 6.8 percent of blood donors tested positive for syphilis and 4 percent tested positive for Hepatitis B at the Genito-Urinary Clinic (GUM); 37.1 percent of adolescents tested positive for syphilis.

The number of cases of AIDS increased from 10 in 1987 to 35 in 1988, to 1,055 at the end of 1997. Females accounted for only 16.2 percent of the cases in 1988, but this percentage increased up to 36.9 percent at the end of 1997. Children under 5 years accounted for 2.7 percent of the overall cases, adolescents for 2.9 percent. However, it is the 19-35 age group that has the highest incidence (75 percent of overall cases). It is estimated that 80 percent of transmissions occur heterosexually. HIV prevalence rates are the highest of all CAREC members, estimated at 3.2 percent among blood donors, 7.1 percent among pregnant women (up from 3.7 percent in 1993), 21 percent among male STD patients, and 45 percent among commercial sex workers (up from 25 percent in 1989).

Problems of reporting reduce the reliability of current data. Officially reported cases represent less than 1/3 of estimated numbers. It is assumed that less than 20 percent of the infected persons are aware of their infection. The estimated incidence for the general adult population is 3 to 5 percent. Use of contraception (condoms) is still relatively low, and abortion is still a common method of family planning.

The impact of HIV/AIDS could be dismal. The AIDS Secretariat estimates that if the present trend is not reversed, life expectancy in Guyana could be reduced to 52 years by the year 2010, and 50 percent of all cases would be concentrated in the age group 10-24. Substantial effects on production, productivity, and social services could result. According to the Social Science Faculty at the St. Augustine Campus of the University of the West Indies, "If present trends continue, this disease (AIDS) will have major dehabilitating effects on production and productivity, and social services, by the end of the century, if not sooner."[14]

Statistical information on drug abuse is extremely limited; however, simple observation suggests an increase. Drug abuse is partially responsible for the surge of STDs, including HIV/AIDS. Moreover, conditions related to drug abuse are increasingly a major cause of admissions at the Psychiatric Hospital, and of admissions of psychiatric patients at the National Referral Hospital. The New National Co-ordination Council for Drug Education and Rehabilitation was established in 1994, under the responsibility of the Ministry of Health. There are at present no statistics on the number of persons with mental health problems, although schizophrenia is likely to be the leading cause of admission for psychiatric patients. To date, not much priority has been given to dealing with mental health issues.

[14] Source: Staff of the Social Science Faculty, St. Augustine Camp, University of the West Indies, Trinidad and Tobago, "Report on Reform of the Health Sector and Monitoring of the Sectoral Reform Processes in Guyana", prepared for the IDB and PAHO, 1995.

Little information is available about disabled people; however, no more than one-third of the people affected by disabilities have access to rehabilitation services, three-quarters of which are concentrated in the Georgetown area. Facilities to help disabled children are very limited.

Ageing patterns of the population increase the need for more institutionalised care of the elderly. At present, the services available to the elderly are poor and concentrated in urban areas. Institutional facilities fall under the responsibility of the Ministry of Health and Labour and the Ministry of Human Services.

Amerindians represent one of the most vulnerable groups to health issues. Their conditions are harsh compared to any other group in terms of malaria[15], acute respiratory diseases[16,] water- borne diseases[17], nutritional deficiencies[18], women's health[19], and access to health care.[20]

B. Environmental Risks to Health

The geographical breadth of Guyana and the dispersed nature of part of the population have limited the extent of epidemics and the transmission of some diseases. Nonetheless, a number of risks to health arise from the environment. Environmental risks arise in the physical, work and home environments, as summarised in the Draft National Health Plan of Guyana (pp. 51-54).

Within the physical environment, concerns have been identified in terms of air pollution, the supply and quality of water, basic sanitation, housing quality and quantity, and natural disasters.

---

[15] Around 50% of total annual cases occur among indigenous people.

[16] In 1995, Amerindians accounted for 23.8% of all tuberculosis cases. Children in Region 7 and 8 are the most affected by respiratory tract infections (30% and 50% respectively). Source: Gahef (1992). Health and Nutrition Survey. Co-operative Republic of Guyana. Georgetown, Guyana: Gahef.

[17] These are mainly due to the dependence on creeks for water supply and to the effects of mining on remote villages. The highest percentage of children with diarrhoea was found in Region 9. Source: Gahef (1992), op. cit.

[18] In terms of severe malnutrition Region 8 ranked second after Region 5. Region 8 also recorded the highest percentage of moderately malnourished. The highest percentage of low birth weights was found among Amerindians (29.9%). Source: Gahef (1992), op. cit.

[19]Teenage Pregnancy is among the highest in Guyana. Additionally, a survey on health centres discovered that 70.5% of Amerindian women checked had low haemoglobin levels. Source: Forte (1996). Thinking about Amerindians. Published by Janette Forte, Georgetown, Guyana.

[20] Drugs and staff shortages in village areas limit access to quality health care. In the interior, some capital improvements have been NGO-aided, often resulting in an unbalanced delivery, with the Rupununi (Region 9) and coastal villages being favoured compared to other areas such as the Parakaimas (Region 8), the North West (Region 1) or the Upper Mazaruni District (Region 7). Source: Forte (1996), op cit.

Air pollution is mainly derived from the blowing of bauxite dust and the spraying of pesticides in the canefields; however their effects have not been investigated thoroughly. Bacteriological contamination of the water continues to occur in the distribution system and surface water is often used without treatment or disinfecting facilities. Moreover, the high concentration of soluble organic matter encourages the rapid growth of bacteria. .....

Basic sanitation is still poor. Sanitary conditions are dismal in squatter areas, many of which have no hygienic means of waste disposal. New housing schemes, factories, commercial institutions and industries have been developed without compliance with existing land development plans. In fact, individual septic tanks and pit latrines utilised as the only means of sewage disposal are often not constructed at the recommended distance from the water supply. The current housing stock is inadequate, therefore overcrowding in buildings is common. This encourages the transmission of obstructive pulmonary and other communicable diseases. Furthermore, the shortage of housing has encouraged the expansion of squatting areas. It is evidently important to strengthen the development of new housing programmes, which are still inadequate despite the recent development of Government housing programmes.

Excessive rainfalls leading to flooding in most of the Regions occurred during 1996 and this natural disaster was further compounded by the El Nino drought in 1997. Natural calamities necessitate adequate disaster and crisis management, which has been recently identified as priorities.

In the work environment a number of health risks are displayed. In the past six years, 53 deaths were reported as results of occupational injuries, and there has been no decrease in the number of annual cases. The total number of accidents registered in the period 1993-1998 was as high as 30,563; however, this has been steadily declining in recent years from 8,883 in 1993 to 2,880 in 1998. Most injuries occur in agricultural occupations (2,616 in 1998), followed by the manufacturing (98 in 1998) and mining sectors (32 in 1998). Two main factors account for recent improvements: one, the increase in the number of training, education and awareness programmes; and two, the establishment of Safety and Health Committees. Nonetheless, further interventions are required in order to minimise the risks of accidents, especially fatal accidents.

In the agricultural sector, the main risks to health are derived from the use of pesticides, which are a major cause of poisoning. In 1989, traces of organochlorine pesticides were found in water samples taken from artesian wells, fresh water canals and drainage canals in the agricultural fields of Mibicuri and Black Bush Polder in Region 6. In the rice and sugar industries, workers have been recorded as suffering from silicosis and bagassosis. Silicosis, dermatitis, hearing loss, heat stress and diseases related to the lack of proper ventilation affect workers in the mining industry. Proper regulations and legislation for reducing health risks in the workplace, including safety standards and protective measures, must be introduced.

In the home, domestic violence represents a major health problem in Guyana, causing physical harm and damaging mental health. However, it is difficult to get reliable

-

statistical information on the extent of domestic abuse, since it is often concealed. Although a clear legislative framework is important for the protection of individual rights in the case of domestic violence, domestic violence and abuse are social problems whose root causes need to be tackled through the joint effort of all key actors in the social sector.

Lastly, contamination of food constitutes an important health risk. Despite Government regulations and food inspection programmes, chemical contamination of food continues to occur and enforcement mechanisms are weak.

Environmental risks to health can be reduced only through concerted action involving a number of agencies and organisations besides the MOH. Such agencies include, for example, water authorities, the Ministry of Public Works, the Ministry of Housing, the GDF, and the Police Force.

.....C.The Health Care System

The health care system comprises a variety of institutions, both public and private. These include Government Ministries (primarily the Ministries of Health and Labour, Public Works and Communication, Local Government); local government bodies and Regional authorities such as the RDCs; parastatals such as GUYSUCO[21] and BERMINE; other governmental agencies such as the Guyana Agency for Health Sciences Education, Environment and Food Policy (the Liliendaal Annex, former GAHEF), the Social Impact Amelioration Programme (SIMAP), the Central Housing and Planning Authority (CH&PA), GUYWA, the Sewerage and Water Commissioners, and the National Nutrition Council; the National Insurance Scheme; non-governmental organisations; the private sector and international donor agencies.

Delivery of health services is provided at five different levels in the public sector:

Level I:Local Health Posts (166 in total) that provide preventive care and simple curative care for common diseases and attempt to promote proper health practices. Community health workers staff them.

Level II:Health Centres (109 in total) that provide preventive and rehabilitative care and promotion activities. Ideally, these are staffed by a medical extension worker or public health nurse, along with a nursing assistant, a dental nurse and a midwife.

Level III:Nineteen District Hospitals (with 473 beds) that provide basic in-patient and outpatient care (although more the latter than the former) and selected diagnostic services. They should also be equipped also for simple radiological and laboratory services and be capable of providing preventive and curative dental care. They are designed to serve geographical areas with populations of 10,000 or more.

[21] See Appendix B

-

Level IV: Four Regional Hospitals (with 620 beds) that provide emergency services, routine surgery and obstetrical and gynaecological care, dental services, diagnostic services and specialist services in general medicine and paediatrics. They were designed to include the necessary support for this level of medical service in terms of laboratory and X-ray facilities, pharmacies and dietetic expertise. These hospitals are located in Regions 2, 3, 6 and 10.

Level V: National Referral Hospital (937 beds) in Georgetown that provides a wider range of diagnostic and specialist services, on both an in-patient and out-patient basis, the Psychiatric Hospital in Canje, and the Geriatric Hospital in Georgetown. There is also one children's rehabilitation centre.

This system is structured so that its proper functioning depends intimately on a process of referrals. Except for serious emergencies, patients are to be seen first at the lower levels, and those with problems that cannot be treated at those levels are referred to higher levels in the system. However, in practice, many patients by-pass the lower levels.

The health sector is currently unable to offer certain highly sophisticated tertiary services and specialised medical services, the technology for which is unaffordable in Guyana, or for which there are no medical specialists. Even with substantial improvements in the health sector, the need for overseas provision of medical services which Guyana cannot afford to provide, will remain. The Ministry of Health will continue to provide financial assistance to patients requiring such treatment, priority being given to children whose condition can be rehabilitated, with significant improvements in their quality of life. Civil society, including charities, NGOs, and other benefactors, could greatly contribute to alleviating the conditions of patients requiring overseas treatment by collecting a pool of resources to be utilised for travel and care.

In addition to the facilities mentioned above, there are 10 hospitals belonging to the private sector and to public corporations, plus diagnostic facilities, clinics and dispensaries in those sectors. Between them, these 10 hospitals account for 548 beds. While funding for the public health sector declined in the 1980s, the private provision of health services has expanded rapidly. The 18 clinics and dispensaries of GUYSUCO are especially noted for the high quality of their care. [22]

The Ministry of Health and Labour is responsible for the funding of the National Referral Hospital in Georgetown, which has recently been made a public corporation managed by an independent Board. The RDC of Region 6 is responsible for the management of the National Psychiatric Hospital. The Geriatric Hospital previously administered by the Ministry of Labour has become the responsibility of the Ministry of Human Resources and Social Security since December 1997.

The facilities at the other levels receive their funding from the Ministry of Local Government. In each of the Regions there is a Regional Health Officer reporting to

[22] See Appendix B

higher levels of the Ministry of Health on professional and technical matters. Under the regionalised system established with the decentralisation of 1986, the Regions assumed responsibility for health care within their boundaries, and now administrative control over health resources rests with the Regional Executive Officer, who is chief officer of the Regional Democratic Council. The possibilities of confusion and conflict between mandates are obvious, and have materialised. Despite recent improvements in the co-ordination between the Central Ministry and the Regional Governments (the Ministry must approve all capital investments in health infrastructure), the regionalised system of health administration has proved ineffective and problematic.

The divided mandate makes it difficult for the Ministry of Health to collect the necessary information on regional health issues and hence to plan adequately for meeting the overall system's needs. Similarly, the fact that the Ministry of Health authorises purchases of equipment while the Regions are responsible for operating and maintaining that equipment, has resulted in instances of pieces of equipment being unused after installation for lack of personnel trained in operating them, or because no sufficiently accurate diagnosis of needs was made before the equipment was purchased.

Under this system, the Ministry of Health is also responsible for establishing and implementing health policy and standards, accrediting facilities, and identifying the human resource needs of the sector. It has responsibility for the procurement and distribution of pharmaceuticals and medical supplies in all regions. It funds and manages the vertical health programmes, including vector control, rehabilitation services, dental care, mental health programmes, and management of Hansen's disease, AIDS, and alcohol and drug abuse.

The regulatory bodies for the health system include the Central Board of Health, the General Nursing Council, and the Pharmacy and Poisons Board. A Cabinet Subcommittee reviews developments in the health sector.

Recent proposals for reforming the Regional system by creating Regional Health Authorities have been advanced and approved by Cabinet; however, implementation modalities have not been discussed thoroughly. Under the new system, the Ministry of Health and Labour will not be responsible for day-to-day management and service delivery; rather, it will have responsibility for policy-making, regulation, planning, setting standards, monitoring and evaluation.

The personnel in the system include about 336 doctors (190 within the public sector), 1597 registered nurses, 127 Medex personnel (medical extension workers who are qualified as nurses and have 18 months of clinical training), 133 community health workers, 80 pharmacists (3 public, 77 private), 24 environmental health officers and 27 dentists. There is heavy reliance on overseas personnel in some disciplines. For example, more than 90 percent of the specialist medical staff in the public sector are expatriates. Many medical personnel in the public sector also work in the private sector, and some observers have noted a neglect of their duties in the former, in favour of the latter.

In the public health sector the staff vacancy rates range between 25 and 50 percent in most categories. Moreover, imbalances exist in terms of staff distribution. Almost 70 percent of the doctors are located in Georgetown, where one-quarter of the population lives. In rural areas and in some specialisations like pharmacy, laboratory technology, radiography and environmental health, the vacancy rates are even higher. However, with the improvement of the technology of delivery of health care over the years, some of these vacant posts may have become redundant since they were first created.

Per capita Government spending was US$26 in 1997, which is well above the US$12 per capita assumed as minimal threshold by international organisations for a basic primary health care package. However, biases occur in the allocation of resources, reducing the efficacy of spending towards the stated priority of Primary Health Care. There is a clear bias towards hospital services. In 1998, as much as 35 percent of total recurrent Government expenditures on health was allocated to the Public Hospital Georgetown[23], while the Regional budget for health was 25 percent. Patterns of capital expenditure show a similar bias towards hospital care. Investment to restore the physical infrastructure at primary and secondary levels of care decreased in real terms from 1985 to 1993. Although SIMAP, Future Funds, the EC-funded Sector Programme, and other agencies targeted this sector, physical infrastructure is still run-down. Only in 1998 did investment in Primary Health Care facilities achieve the same level as in 1985 in real terms.

The University of Guyana and the Liliendaal Annex of the MOH, (the former GAHEF), carry out almost all health-related training. UG offers curricula in medicine, pharmacy, medical technology, radiography, environmental health, health sciences tutoring, and health service management. In collaboration with the Institute of Adult Learning and Continuing Education, evening classes for health professionals are offered in mental health, developmental psychology, care of the elderly, and childcare.

The Liliendaal Annex manages a variety of clinical and technical health education programmes, including professional education to work as Medex personnel, nurses, X-ray technicians, dental auxiliaries, laboratory aides, community health workers, physiotherapy assistants, pharmacy assistants and nursing aides. The Liliendaal Annex also offers a public health nursing programme. The Health Education programme of the Ministry of Health also includes two nursing schools attached to the public hospitals of Georgetown and New Amsterdam. The Linden Hospital Complex also operates a nursing school (Charles Rose Nursing School) and internal training is provided at the St. Joseph's Mercy Hospital (private).

The Liliendaal Annex also has responsibility for developing and implementing policies on environmental health, food quality and nutrition, and for carrying out inspections of wastewater, sewerage removal activities and disposal of hazardous waste.

[23] It is true however, that an unknown portion of outpatient services at the PHG is essentially Primary Health Care. There are no studies at present investigating how much is spent on primary, secondary and tertiary health care. Although spending for tertiary care might be less than a third of the National Budget, it still accounts for a far too high share for a country where Primary Health Care is the stated priority.

The Mackenzie Hospital of LINMINE, established as a hospital providing service to employees of the mining corporation, has recently been separated from the parent company and is now part of the Linden Hospital Complex. The Complex has an autonomous Board and partially finances its activities through a company insurance programme; however, a subvention from Ministry of Health covers most operating cots.

GUYSUCO provides diagnostic and outpatient services for some 20,000 employees and their dependants, and some of them also have NIS coverage. GUYSUCO also carries out preventative activities through annual screening of all employees, family planning, and immunisation through collaborative actions with the Ministry of Health. For example, GUYSUCO and the Ministry of Health joined efforts for the implementation of the Yellow Fever and MMR Immunisation Campaign launched by the Ministry at the beginning of 1999. As noted, the quality of GUYSUCO's health services is generally high.[24]

SIMAP (Social Impact Amelioration Programme) is an autonomous agency financed by the Government of Guyana and an IDB loan, which was established by the Government in 1990 with the aim of alleviating the social costs of the Economic Recovery Programme. SIMAP is responsible for the implementation of programmes aimed at protecting the poor and strengthening safety nets (e.g., nutritional programmes, educational programmes, primary health care, water supply and basic sanitation).

The private sector provides curative services, while the public sector provides most of the preventive, secondary and tertiary services. According to a survey carried out in 1992[25], 43 percent of those injured or seeking care rely on private sector facilities, while 48 percent use public sector facilities and 9 percent use traditional medicine or other forms of care. In the public health sector in 1997, expenditures accounted for about two-thirds of total health sector outlays, including parastatals which accounted for about 5 percent, while the private sector accounted for the remainder.

The private health sector consists of six institutions in Georgetown providing inpatient care and almost 24 hours of physician cover. A significant aspect of private care can be attributed to solo-medical practitioners who operate out of dispensaries and provide basic diagnostic services in terms of laboratory, X-ray and other less familiar forms, such as ECG and Sona-graphs. Within recent years, due to the absence of legislation for the accreditation of institutions, small nursing homes have developed in Region 6, and there has been a proliferation of pharmacies and laboratories, many of which are co-providers of health care.

Community involvement in health services has been weak. However, the community health workers (CHW), who are indigenous to the regions in which they work, represent a vital link between the public health system and the populations in remote areas. The CHWs' training programme has provided one of the few opportunities for Amerindians

[24] See Appendix B
[25] Bureau of Statistics (1993). Household Income and Expenditures Survey.

to improve their professional status, and it is generally considered a success from all perspectives.

NGOs have been active in providing equipment and supplies. Many of them are actively encouraging health-promotion activities, as well as providing health care and health care-related services in hinterland areas. In recent years the co-ordination between Government and NGOs has been strengthened; however, information on NGO activities is not gathered systematically and therefore not channelled into a process of national planning.

Besides Government allocations and various funding from donor agencies (IDB, EU, PAHO, UNDP, UNICEF), a limited proportion of health financing is provided by social and private insurance. The National Insurance Scheme (NIS) provides insurance for a portion of the cost of some private medical expenses of insured persons, but dependants are not covered under the scheme. At present the Ministry of Health does not recover any cost from patients insured by the NIS, although they use the public system. The NIS was not intended to serve primarily as a health insurance scheme, and its claim-processing procedures leave much to be desired. As it is presently constituted, there are serious concerns about the institution's long-run financial viability and ability to serve as a social health insurance scheme, having lost three-quarters of the real value of its assets between 1989 and 1992.

Private health insurance is an option utilised by some families. It is estimated that no more than 20 percent of the population is covered under some kind of insurance scheme. Coverage by private health insurance, the profile and needs of insured people, factors affecting demand, and services included in the cover are not known at present.

II.Policies of the Sector

A..... Description of Past Policies

The past policies of the health sector have been characterised chiefly by a commitment to provide free health care to all citizens, the structuring of the system in the above-mentioned five distinct levels, and the establishment of a referral process which should have handled patients within the 5-level system.

Since the 1960s the role of the private sector in providing health care was severely restricted. However, fiscal allocations to health, the only source of funding of the public health sector, have not been adequate to providing quality health care for all. Economic decline throughout the 80s, widespread poverty and the reduction in allocations to the health sector have been some determinants of the deterioration in many health indicators of the population. Health services, nominally free of charges, were in reality not free of cost because of high hidden and household costs (transportation, waiting time, poor service

quality). Moreover, most patients had to purchase essential drugs and medical supplies for hospital stays and other curative services. Two main consequences of the high hidden costs and low quality of care occurred:

1.The referral system on which the 5-level structure was based did not function properly. Although existing in theory, the referral system is in practice by-passed by patients seeking better care at the highest levels. The breakdown of the referral system resulted in allocative inefficiencies, the congestion of health facilities at higher levels, a confusion of responsibilities for care, and increased costs to the patients, e.g., they were either forced to travel to Georgetown or they failed to seek needed care.

2.Increasingly, more patients have turned to the private sector, which has been expanding the coverage and scope of its activities. Funding requirements in the health sector exceed the availability of funds by a considerable margin, so the restrictions on private provision of health services have been relaxed. According to the 1992 Household Income and Expenditures Survey, almost half the patients seek treatment in the private sector (and a small number use traditional healers).

Despite the increasing share of services, especially curative care, provided by the private sector, the respective roles of the private and public sectors in the provision of health services have not been defined. Although many specialised procedures are still available only in the principal public hospital, possibilities for collaboration in health between the private and public sectors have not been explored.

The administration of the health system of the public sector was divided between three Ministries (Health; Labour; and Public Works, Communication and Regional Development), two public corporations, and the Regional Development Councils. Only "vertical programmes," such as vector control, maternal and child health, dental care and the AIDS programme, fall entirely under the aegis of the Ministry of Health for all regions. As already noticed, this institutional structure created a number of co-ordination problems, duplications and inefficiencies, which will have to be tackled through a process of institutional reforms.

Finally, health policies have placed considerable emphasis on primary health care activities, especially immunisation programmes, which yielded a high degree of success. Vector control and programmes for environmentally-related maladies have not received the same degree of priority, nor has education on maternal health and sexually transmitted diseases.

B. .....Description of Current Policies

The trend toward declining real budgetary allocation to the health sector has been arrested since 1992. Investments in facilities and equipment have been greatly increased, especially with donor assistance. A clear priority has been given to the rehabilitation of

the Georgetown Hospital. The Ambulatory Care Diagnostic and Surgical Centre at the Referral Hospital was terminated in 1996.

The Draft National Health Plan 1995-2000 prepared by the Ministry of Health has analysed many of the problems besetting the health care system, identified priority areas of health care, and raised significant questions about possible reforms in the institutional aspects of health care. In effect, it has raised issues that must be faced and resolved to satisfaction in the course of establishing national health policy. It also provides details and insights about prevailing health standards and the health care system.

In terms of causes of morbidity and mortality, the most pressing priorities have been identified in malaria, sexually transmitted diseases, acute respiratory infections, immunisable diseases, and prenatal problems. These areas constitute priority also because they are cost-effective, i.e., they yield the maximum benefit for each dollar invested.

The next set of priority problems includes malnutrition, diarrhoeal disease, abortions, maternal mortality, accidents and injuries, diabetes and hypertension, dental caries, mental ill health and drug abuse, and skin conditions (primarily scabies among children). Because of the importance of improving nutrition in general and maternal health in particular, programmes of nutritional fortification of wheat have been implemented.

For the health delivery system as a whole, the plan has defined objectives and targets for expanding primary health care, improving secondary and tertiary health care, and strengthening the management of the health sector, but policies to achieve those objectives were not defined. Possibilities for restructuring the management of regional hospitals are mooted but no definitive stance was adopted in the document. Similarly, issues on financing health by instituting user fees for selected services were raised but no policy decision was indicated.

The National Health Plan shows a willingness to come to grips with the main issues in health care, and many lines of action are set out. This Annex and the relevant chapter in the core National Development Strategy set out some of the national health policies that will facilitate the achievement of the plan's main objectives.

C. ..... Description of New Policy Directions and Sector Reforms

In the past few years there has been growing consensus that factors constraining quality and access to health care "for all" need to be addressed through adequate institutional and structural reforms of the public health sector. Health care in the public sector yields hidden costs especially to the poorest, despite being "free of charge for all". The need to improve effectiveness and equity is paramount. However, due to resource constraints, the public health sector needs to cater more efficiently to the health needs of the population. The Ministry of Health has recently engaged in a process of health sector reform designed to meet the challenging objectives of improving efficiency, guaranteeing

effectiveness of health care provision, correcting institutional mismanagement, and ensuring equity.

....

The process of reform has been partially driven by the Highly Indebted Poor Country Initiative (HIPC)[26], initiative for which Guyana qualified during 1997. Under this initiative, debt burden relief will translate into increased budgetary resources for investment in poverty alleviation and the social sectors. In order to qualify for debt reduction, the health sector has to continue efforts towards the implementation of a reform agenda, while rigid requirements for the prioritisation of expenditures to primary health care programmes, drugs and maintenance of health facilities have been introduced.

The Guyana's public health sector reform process consists of three main strategies:

1.Corporatisation of Hospitals, through the creation of autonomous Boards for the National Referral Hospital and the Linden Complex (Regional Hospital);

2.Divestment of responsibilities for health service provision to autonomous public agencies, the Regional Health Authorities;

3.Development of new financing and resource allocation mechanisms.

The creation of autonomous Boards will maintain management responsibility within the hospitals and improve their accountability for the services delivered. The Public Hospital Georgetown and the Linden Hospital Complex have autonomous Boards. While the Ministry of Health will continue to bear final responsibility for public hospitals, the corporatisation of hospitals aims at removing the day-to-day management of services from the jurisdiction of the Ministry of Health and/or the Regions. The devolution of managerial responsibility to hospital boards is intended to create direct links between responsibility, authority, and control over resources, which should result in improved service management, increased human resource motivation, improved accountability and results-oriented management. The hospitals will enjoy a larger degree of autonomy over financing and provision modalities, including the implementation of selective cost recovery, sale of services to the private sector and contracting out, within the guidelines set by the Ministry of Health. The hospitals will continue to receive contributions or subventions though Government allocations. The Ministry of Health will monitor that equity and quality of services is guaranteed through adequate exemption mechanisms and guarantees of minimal standards of care.

The establishment of Regional Health Authorities is the main institutional reform on which the Ministry of Health and Labour has engaged. The creation of a decentralised system of service provision based on Regional Health Authorities (RHAs) is coupled with the restructuring of functions and roles of the Ministry of Health.

---

[26] The HIPC Initiative entitles highly indebted poor countries with good economic performance to exceptional debt relief. Debt burden relief will translate into increased budgetary resources available for allocation to poverty alleviation programmes and the social sectors.

-

The Ministry of Health is being restructured to reflect the "steering" roles of policy-making, regulation, monitoring, standards-setting, planning and evaluation, in accordance with a "new public management" model. Organisational restructuring will involve changing lines of responsibility and a redefinition of roles, skills and positions. Day-to-day service management functions are expected to be de-linked from the MOH. Areas and functions of possible de-linking include, among others, Vector Control, Health Education, the Pharmacy Bond, the Food and Drug Administration, and Dental Services. The restructuring of the MOH is proceeding simultaneously with the establishment of Regional Health Authorities.

The Regional Health Authorities are meant to replace the current service-delivery system based on the RDCs, and correct its inherent deficiencies. The problems of co-ordination, duplication of functions and associated inefficiencies have already been mentioned. Moreover, at present the Ministry of Health has little information on the delivery of health services by the RDCs, no control over and little knowledge of resource needs and health expenditures at local level. National planning for the health sector is a difficult task. The rationale behind the creation of the Regional Health Authorities (RHAs) is therefore two-faceted.

First, there is a need to separate the direct providers of the services from the Ministry of Health which finances and regulate these agencies. The separation of purchaser and provider functions aims at creating greater transparency and accountability in the delivery of health services, because the tasks of providing the services and monitoring their quality and effectiveness are no longer the responsibility of the same agency. Secondly, by de-linking responsibility for the delivery of services from the Ministry of Health, needs assessments and the planning and management of these services are brought closer to the people. This should increase accountability to final users, the responsiveness to community needs and promote a focus on outcomes and health status rather than services. In order to achieve these objectives, the RHA's responsibilities will be matched with managerial autonomy and authority over resources.

According to a decentralised RHA model, the Health Authorities are responsible for developing health programmes, and they submit their budgets for approval and funding to the Central Government. Allocations from the National Budget should maintain adequate and equitable funds for a package of essential primary health care services, public health programmes, and other priorities agreed with the MOH. The RHAs should have the autonomy to identify priorities within their territories, and invest in those areas. The RHAs can be also given authority over alternative ways of funding health programmes, including cost recovery, community financing, and access to the local tax base. In a decentralised RHA system, the MOH should maintain its steering and monitoring role. The Ministry should also perform an equity function, in order to guarantee fair allocations across different Authorities (according to need), equity of the financing mix, and appropriateness of exemption policies. These arrangements will give the Health Authorities flexibility in addressing their financial needs and make them accountable for public monies used and services provided, while guaranteeing equity.

-

New policies for financing health and improving resource allocation mechanisms are being developed. In Guyana, resources are not sufficient in relation to needs; moreover, they are inefficiently allocated. For example, the National Referral Hospital absorbs one-third of the health budget despite the fact that Primary Health Care includes the most cost-effective services and is considered the priority for health management in the National Health Plan. The reform process seeks to improve resource generation, financing and resource allocation mechanisms by: a) prioritising spending to maximise cost effectiveness, and b) investigating and developing new options for financing health care.

Resource allocation mechanisms are being reformed. First, financial management reforms in the Government sector have started by changing the budgeting structure from line to programme budgeting, according to which resources are allocated on the basis of detailed work plans prepared by activity managers. Second, the approach to the budget preparation is changing from an incremental approach (where existing services and activities dictate future resource needs) to a zero-budgeting approach (where all resource needs are planned and justified afresh each year). Third, in order to maximise cost-effectiveness, resource allocations from the Centre to the RHAs system will be based on priority primary and preventative care and other special needs of the RHAs' population, possibly on the basis of estimates of the per capita cost of a basic package of services.

Health financing mechanisms other than budgetary allocations are being considered within the Ministry of Health. New approaches to health care financing include: a) the implementation of selective user fees at Government facilities, at higher levels; b) the sale of services to the private sector; c) a more extensive use of insurance. Recommendations on health financing will be dealt with in Section V.

In order to ensure the success of sectoral reforms, a process of institutional strengthening of the entire health sector is underway, facilitated by technical assistance from the IDB and the UNDP. The IDB will provide Technical Assistance to the sector through a two year "Health Sector Policy and Institutional Development Programme", while the UNDP will assist the Health Sector during the same period through the "Integrated Health Sector Development" Project.

III.Issues and Constraints

This section takes back up a number of weaknesses in the health system, to which reference has already been made.

.....A.Issues

-

.....**1.All-Encompassing Issues**

The fundamental issues that the health sector must confront on a continuing basis are the need to guarantee access to health care for all (particularly those most in need), improve the quality of the health services offered, and improve efficiency.

In 1992, it was found that 12.5 percent of the population did not have access to health care. The situation is proportionately more severe for the lower-income groups. The 1992 Households Income and Expenditures Survey[27] reports that in the lowest-income quintile, 24 percent of the ill or injured did not seek medical care "due to expense or distance factors". In the next-lowest quintile, the corresponding figure was 19 percent and in the highest quintile it was only 3 percent. Of the patients in the poorest quintile, 37 percent received medical attention from a doctor, whereas a doctor saw 67 percent of those in the highest-income quintile. Inequality in access to health care is also shown by the lowest percentage of people seeking preventive care among the poorest quintiles (35 percent in the bottom quintile, compared to 49 percent and 45 percent of the top two quintiles). The bottom quintile spends only 1.2 percent of household budget on health care, compared to 2.0 percent for the top quintile. These are clear indications of the road to be travelled to make access to health care for all a reality.

It is important to recognise that making health care free of charge at the point of delivery does not guarantee universal access to health care, because the overall costs incurred by the households in receiving health care might be perceived as high. The most important factors affecting the demand side of health care utilisation are the distance and travel time to a health facility, the perceived quality of the care, the educational level of the patient, the type and severity of the illness, and the out-of-pocket expenditures for health. The price of the service plays an important role, but is not the only determinant of health services demand.

There is a vital interaction between quality and access. When the quality of the care is perceived to be weak, patients are more likely to defer treatment until the illness acquires greater severity. At that stage the illness becomes more debilitating or life-threatening, and the cost of treatment is higher than it could have been otherwise. The patient suffers, and at the same time the financing problem for health care is aggravated, both on the supply side (provision of more costly care) and on the demand side (higher costs incurred by the households).

The question of the quality of health care is pervasive and partially accounts for the dismal statistics presented in the first section of this Annex. During the long period of economic and social decline, many of the most qualified medical practitioners left the country, health facilities deteriorated, many pieces of equipment lay inoperative, and pharmaceuticals and other medical supplies became scarce. Prominent among other continuing consequences is the breakdown on the referral system.

[27] Bureau of Statistics (1993).

Overall, both structural quality and process quality are poor. In spite of recent increases in financing and improvements in management, the health sector still operates with vacancies in several key posts and malfunctioning equipment. Storage facilities for and quality control over drugs are inadequate. Patients routinely purchase their own pharmaceuticals and medical supplies and have to spend excessively long hours in repeated visits to medical facilities. Despite some staffing increases and improvements achieved in immunisations, the overall quality of health operations has not improved and in some respects continues to decline. In large part this is due to problems in the institutional structure of the sector, in its management practices, and in the availability of adequate financing. These partially account for the low responsiveness of the system. Health services are not responsive to users, particularly those most in need, thus resulting in increased inequity. Moreover, poor accountability to users undermines the responsiveness of the system.

A further challenge to the health sector is the need to remove inefficiencies. Both allocative and technical inefficiencies plague the sector, particularly the public health sector. Allocative inefficiencies derive from the fact that resources are not allocated to the services that are most cost-effective. Technical inefficiencies result from an inefficient use of resources for health facilities. Unit costs of facilities at all levels are known to be high, although there is a dearth of cost-accounting studies. In terms of input-specific inefficiencies, staff productivity is low. Inefficiencies also occur in the distribution and supply of drugs.

The sector today faces the twin challenges of widening access to medical care and improving the quality of service delivery. Furthermore, the reduction of inefficiencies and inequities, and the increase in the responsiveness of the system are essential. In the past few years the deterioration of the system has been arrested. Considerable progress has been made in setting new priorities and directions for health care programmes, and the modernisation of the structure of the public health care sector has started under a programme of institutional reforms. Nevertheless, the need for further improvement is still large.

While all levels of health care (primary, secondary, and tertiary care plus vertical programmes) require strengthening, special priority has to be placed on improving the primary level of care, where the greatest health gains for the population can be expected. Primary health care therefore remains the stated main priority for the heath sector in Guyana.

.....2.Basic Concept of Health and Its Determinants

The health status of the Guyanese people cannot be improved or sustained by medical services alone. Factors beyond the health care system itself affect the health status of the population, including healthy lifestyles and individual behaviours, education and awareness of health issues, family and community supports, quality of the environment, economic stability and prosperity.

-

Prevention and health promotion have been recognised to be the most cost-effective approaches to achieve improvements in the health status of the population. A health promotion strategy requires interventions beyond the purely medical sphere, and therefore considers all other factors constituting determinants of health, as opposed to a purely curative strategy focusing on the health care system. Health promotion involves factors such as biological endowment (i.e., hereditary disorders), the physical environment (i.e., air and water pollution, sanitation and housing conditions), the social environment and structures (i.e., family relationships and social support systems, employment status and income levels, educational systems), individual behaviours (lifestyle factors such as diet, exercise and smoking), and the health care system itself (i.e., health care services).

From the considerations and concepts elaborated above stems the Government's definition of health: "*health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity*." However, so far there has been a generalised tendency to focus only on diagnosing and eliminating diseases, rather than actively preventing illness and promoting health. A shift in both strategies and actions is needed in order to emphasise the concepts of health promotion and education.

.....3.Institutional Co-ordination in the Management of the Health Care System

As noted in the foregoing, institutional responsibility for the public sector system of health care is dispersed among various Ministries and agencies. Under the present system, the operational responsibility for the implementation of the Ministry's policy lies with the Regional Health Officer (RHO). The RHO reports to the Regional Executive Officer, who also has the financial authority and responsibility for programmes in all sectors. The REO, however, is not accountable to the policy-making Ministries. The Ministry of Health, therefore, has virtually no downstream control on the implementation of its policies. There is no mechanism to hold the REO accountable for the delivery of the sectoral programmes (Nuria Homedes, *Health Strategy Paper***,** 1994, p. 5). The lack of training and preparation in planning and management of the RHOs constitutes a major constraint to the management of health services at the regional level (*Ibid.*).

The decentralisation of health management and service delivery functions has the potential of ensuring greater responsiveness to patients and increased efficiency in the delivery of health services, as well as reducing the overlaps and conflicts between institutional responsibilities. However, this potential has not been realised completely under the present regionalised system of administration.

The restructuring of institutional responsibilities is therefore a key component of the institutional reforms of the public health care system. Regional Health Authorities are expected to take over responsibilities for the delivery of health services at Regional and local level, presently within the responsibility of the RDCs. The new RHAs system is intended to tackle most of the institutional weaknesses of the present regional system. The

-

process of transition between the present and the new RHAs system and the implementation phase are critical to the success of the institutional reforms, and may require long and accurate planning. A too quick implementation led by the will to change and not accompanied by adequate planning might in fact hamper the benefits derived from a decentralised RHA system.

Collaboration in the health planning process is also non-existent or ad hoc at best, both within public health system institutions, and between the public health system and other stakeholders. More effective collaboration among health-related agencies is essential in order to increase the efficacy of collective action aimed at minimising the causes of ill health. Mechanisms for increasing collaboration among various agencies should be established, including, for example, the Ministry of Education, the Ministry of Public Works, the Guyana Sugar Corporation, the Ministry of Agriculture, non-governmental organisations, including associations such as the Guyana Association of Professional Social Workers, and other stakeholders.

4.Financial Aspects of Health Care

Although Guyana's public expenditures on health have increased significantly since 1992, resources remain below the levels necessary to restore the system to the desired state. If national health priorities are to be properly addressed, adequate funding for these priorities is vital, within the country's economic capacity. Moreover, as mentioned earlier, large inefficiencies and poor financial management of the system reduce the efficacy of spending, and there is a compelling need to improve financial management so that the available funds are used more efficiently.

There are many sources of inefficiencies in the financial management and accounting of the sector. Several initiatives to correct such shortfalls have commenced; however, there is still considerable scope for improvements.

The structure of the annual budget estimate was based until 1997 on a line format, consisting of three heads (Ministry of Health; National Hospital; Other Programmes) and detailed by line items (drugs, maintenance, salaries, etc.). This system resulted in inappropriate allocations of resources and expenditure patterns. In fact, under the head budget system it was impossible to direct resources to areas of priority. Further, resources did not reflect the real financial needs of the various programmes/services provided by the MOH, because of a historical budgeting approach, according to which the previous year's budget would dictate the overall allocation of resources. Finally, financial accountability of programme managers was poor, performance appraisal was not based on actual departmental budget allocations, there was minimal or non-existent financial autonomy at the departmental levels, and responsibilities and accountability were not matched by authority over resources.

Since late 1997, the MOH has been benefiting from the introduction of a system of programme budgeting. Although it is too early to evaluate the impact on financial

management, programme budgeting has helped improve allocation mechanisms and direct resources to priority areas. Resource allocations to the Ministry of Health are now based on projected programme outputs and objectives. In addition, it is now possible to assess the impact of implementing a programme on the MOH's budget. However, programme budgets are still not based on actual cost estimates, and the absence of cost indicators for services at all levels impedes economic costing and cost-effectiveness analysis. The shift of managerial focus from input to output has not been completed, and changes in the attitudes and culture of programme managers are still to be fully realised.

Establishing the overall resources needed in the public health sector presents some difficulty. As already mentioned, budgets are not based on actual cost estimates or productivity criteria. The Ministry of Health does not have control over the health budgets of the Regional administrations and there is a lack of co-ordination of donor funding. At present, the Ministry of Health is not involved in setting the Regional health budgets: rather, authority for health spending is demanded of the Regional Democratic Councils. Often a perceived crisis in another sector means that budgeted funds at Regional level are reallocated away from the health sector. This situation can be corrected in part with the introduction of institutional reforms within the public health sector. For example, in the RHAs system, the service provision function will be the responsibility of the RHAs, who will be allocated financial resources from the Centre on the basis of Regional Health Plans. Donor funding to RHAs, including both loans and grants, will have to be co-ordinated and channelled through the Ministry of Health.

There is a scarcity of qualified and experienced professionals in health care accounting and financial management. Planning, training and retention of skilled personnel are key to improvements in financial management. However, the lack of qualified human resources is a constraining factor for the successful implementation of institutional reforms. This factor should not be neglected when designing and implementing reforms, in order to avoid capacity problems and the creation of a system not suited to our specific conditions.

Human resource deficiency does not affect finance and managerial positions only. The lack of funding and inefficiencies of spending have been the major contributing factor to the flight of talented medical personnel. The reduction in expenditures for personnel has been dramatic. From 1986 to 1991, a period when the total budget of the Ministry of Health was declining in real terms, expenditure on salaries dropped from 38 percent to 11 percent. A similar phenomenon occurred in the Regional administrations over the same period, with the share of total spending devoted to salaries of health care personnel falling from 50 percent to 26 percent. These figures indicate that the costs of declining health spending had a higher incidence on the human resource factor. In real terms, salary schedules for medical personnel suffered the same erosion experienced by all salaries in the public service. These reductions in funding led to both increased vacancies and reductions in real earnings. Salaries for fully qualified physicians declined by almost half between 1985 and 1991.

In recognition of these problems, substantial increases in emoluments for medical

personnel were decreed in 1992. However, salaries in the public health care sector are still well below what is offered in the private sector and abroad. Some of the benefits are not linked to levels of qualifications or to performance. Absenteeism of medical personnel is still a major concern in the public sector's health institutions. Civil sector reforms required under the Highly Indebted Poor Countries Initiative promise to upgrade salaries by up to 80 percent of private sector levels, yet reforms are still underway and wage increases have not yet materialised. In addition, more flexible and efficient personnel policies are required. The system of Regional Health Authorities which is currently being designed should therefore allow for more responsive personnel policies, which might require a partial detachment of the health system from public service rules.

While financing is still a limiting factor, social sector funding from the Central Government budget has increased in recent years, rising from 13.5 percent of total current expenditure in 1987 to 16.4 percent in 1997. Health care expenditure of the Ministry of Health and the Regions increased to 3.5 percent of GDP in the 1999 budget (2.7 percent in 1998), twice its share at the beginning of the decade (1.8 percent in 1991). Moreover, under the HIPC Initiative expenditures for the social sectors are expected to rise from 6.7 percent of GDP in 1992 to 12.7 percent of GDP by the year 2002. Financing options other than Government allocations, such as cost recovery, the sale of services to the private sector, and health insurance, are currently under exploration. Selected user fees have been implemented on a pilot basis. Revenue generation from user fees accounts for an insignificant amount and is likely not to account for a substantial share of revenues in the future.

International donor agencies play an important role in financing the sector. Most of the capital funding for infrastructure projects has been provided by two donors, the IDB (e.g., the Ambulatory Care Diagnostic and Surgical Centre at the PHG) and the European Union (e.g., the National Dental Centre). The Caribbean Development Bank has provided other funding to the health sector infrastructure (e.g., Bartica District Hospital). SIMAP, jointly financed by an IDB loan and by the Government of Guyana, has financed the rehabilitation of various health centres and the provision of medical equipment. CIDA provided counterpart funding to the health sector, in support of the structural adjustment programme of the GOG. USAID and churches have assisted with other facilities. UNICEF support is significant in Maternal and Child-related Programmes.

Recently, donor assistance has focused on institutional strengthening. Under a two year "Health Policy and Institutional Development Programme" the IDB will assist the Government of Guyana in the implementation of policies to "address the institutional financial managerial and service delivery problems of the health sector". Additional support to institutional strengthening will be given by the UNDP "Integrated Health Sector Development". UNDP has also supported the health sector through the provision of doctors as UN Volunteers.

Financing to the health sector in Guyana is fragmented among a variety of sources, including, in decreasing order of magnitude, the Central Government budget, out-of-pocket expenditures, donor agencies, parastatals such as GUYSUCO, and health

insurance schemes such as the National Insurance Scheme and the LIMNINE Health Plan. It is significant that approximately 20 percent of total funding comes from out-of-pocket expenditures on the part of patients. Coverage by government services is low. Policies for increasing the sector's funding must take this diversity of sources and low coverage into account.

.....5.The Geographical Referral System

In principle, the referral system is well-suited to Guyana because of its geographic barriers to communications and transport. However, as we have seen, in practice it is not functioning well. Technical inefficiencies, the lack of structural and process quality, and low provisions at lower levels of adequately trained medical staff, supplies and equipment, induce patients to bypass the referral system and seek care in the National Public Hospital, or in private hospitals concentrated in the Georgetown area.

In a cruel irony, it is the poor who visit the local facilities and endure the consequences of lower-quality care in disproportionate numbers. The 1992 Living Standards Measurement Survey showed that 16 percent of the poorest patients used public health posts, while only 3 percent of those in the highest quintile used health posts. Similarly, 21 percent of the poor used the public health centres while only 9 percent of the median-income and rich families visited them. Significant hidden costs such as distance, transportation and long waiting time limit access to health care, especially for the poorest sections of the society. It is estimated that while 11 percent of the ill are not seeking care due to such hidden costs, that percentage is as high as 24 percent for the bottom quintile. The collapse of the referral system therefore has profound implications in terms of equity.

The principal reasons why the referral system is not working as planned appear to be the following:

The lack of sufficient administrative co-ordination between the Ministry of Health and the Regional authorities inhibits the planning and implementation of measures to upgrade the lower-level facilities and to make the referral system function better.

Shortages of funding and technical and allocative inefficiencies also limit the possibilities for improving the quality of care at the lower levels.

The ability of the Ministry of Health to provide leadership to the Regions is limited by its own shortages of skilled staff.

The Ministry of Health does not have authority to implement policies or to set the budgets of the Regional Administrations, which makes efficient and equitable planning of health sector resource use on a national basis a difficult task.

-

Regional Health Officers usually are not trained in public health or in administration, and thus they are not properly equipped to be leaders of the health team in the Region.

Files and other information on patients are either non-existent or are not systematically passed from one level to another, so valuable knowledge about the patient is lost and there is a costly duplication of examinations.

Needs assessments are conducted only rarely, if at all, in the Regions.

In some parts of some Regions, it is easier to travel to Georgetown than to the appropriate health facility in the Region.

The system appears to be over-designed in the sense that there are too many levels to be functional and too many hospitals in relation to the budgetary possibilities of equipping them all well.

Mobile health units have not been sufficiently emphasised.

These considerations suggest that the referral system requires serious rethinking and a new design if it is to play an effective role in Guyana's health care in the century ahead.

A specific aspect of the referral system that merits comment is the spatial distribution of health centres. Health centres are vital elements of the system, as they provide a wide range of preventive services and some curative care, including maternal and child care, treatment of chronic diseases, health education, dental care, and environmental health services. However, the health centres in Regions 3, 4 and 6 cater to at least twice as many people as the centres in the other Regions. A distribution of health centres based on the population to be catered for would be highly inequitable. Inefficiencies in the spatial distribution of health centres are somehow inevitable, given the geographical features of the country and the difficulties of travelling. A trade-off between equity and efficiency seems therefore to exist, in that what is an equitable spatial distribution of health centres does not necessarily constitute the most efficient solution. While communication and transportation are issues outside the scope of this Annex, it is undeniable that the health sector has a moral obligation to provide adequate arrangements to ensure that people receive preventative services and access facilities in case of emergencies.

6. <u>The Procurement and Distribution of Pharmaceuticals and Medical Supplies</u>

It is widely recognised that the supply and distribution of pharmaceuticals and medical supplies is a major bottleneck in the health care system. There are periodic shortages vis-à-vis needs, delivery is often not timely, and wastage occurs because of poor management. Issues affecting the procurement and distribution of drugs and medical supplies include the

following:

The Pharmacy Bond is responsible for all procurement, storage and distribution of all drugs and medical supplies, but shortages sometimes occur.

Regional health facilities do not furnish the Government Pharmacy with annual drug needs, sometimes leading to either overstocking or shortages of essential drugs. This may also lead to costly losses of drugs due to time expiration.

The annual budget for drugs is released in 'tranches', rather than at once, which further inhibits the possibility of purchasing through international tendering.

Hospitals do not have adequate management controls to prevent leakage of drugs and supplies to the private market, and low staff salaries encourage that kind of behaviour.

There is an absence of standard treatment protocols for drug use in the treatment of common diseases. This is a serious gap.

There is a gross insufficiency of qualified pharmacists within the public system.

Storage facilities are inadequate and in many cases not suitable to the storage of drugs both at central and regional levels. In addition, part of the available space is taken up by expired drugs or drugs in poor condition both of which should be destroyed, and by unused medical equipment.

There is no comprehensive management information system for pharmaceuticals and other supplies in use at the Pharmacy Bond.

The distribution system from the Pharmacy Bond to the Regions is inadequate, and there are logistical difficulties in the distribution of drugs and supplies in the interior.

There is inadequate consumer awareness about proper use of medications.

It is evident that the national drug policy needs to be the basis for facilitating, developing and implementing a system for the supply and distribution of pharmaceuticals that corresponds more closely to the needs of the population.

The Ministry of Health has recently established an autonomous Materials Management Board, with the task of managing all procurement and distribution of materials (including drugs) in the public health sector. The reformed material management programme is expected to deal with procurement of drugs and medical supplies on a business oriented basis. The Board will be responsible for all the activities of procurement, port clearing, inspection, accounting, distribution and quality control of drugs and supplies. The Board will be held accountable for all the activities with which it is tasked.

-

.....7.The Health Information System

A nation's health information system is the backbone of the delivery system: it is essential for monitoring health status, and for making informed decisions about programme planning, management and resource allocations at all levels of the delivery system.

Improvements in the Health Information Systems within the public health sector have been made in recent years. For example, reporting forms and procedures have been standardised. Statistical information on the health conditions of the population is compiled and periodically sent to the Statistical Bureau, and to senior managers as needed. Technical assistance from PAHO has facilitated the introduction of the ICD 10 classification, effective since the beginning of 1999. One senior statistician has returned from overseas training.

However, limitations still impede the effective functioning of the health information system, including:

The incompleteness of data supplied and collected from the health units in the Regions; this is partially explained by the inadequate training of the personnel collecting this information and the lack of feedback to the health workers who are primarily responsible for collecting the data.

The lack of adequate numbers of skilled and trained staff to manage and analyse the information.

The delays in information flows sent from interior and remote locations to Georgetown.

The lack of systems to collect information on the private sector and parastatal organisations, and the absence of co-ordination with the information systems established in these sectors.

The strengthening of the information system is a precondition of successful decentralisation policies. In fact, in a decentralised system the need for information to support planning and monitoring is greater. Information includes not only reports generated through Health Information Systems (HIS) as traditionally conceived, but also the output reports of Management Information Systems (MIS), which support managerial decision-making processes, both at central and local levels.

Decision-making is still often reliant on precedent rather than on analysis, though recent developments in the health information systems have improved the use of data for decision-making by senior managers. Management information systems need to be enhanced as well as data analysis for planning, evaluation and policy-making. Reform of Information Systems, including HIS and MIS, is therefore urged.

-

8.Community Participation

In the past, attempts have been made to involve communities in the planning and delivery of health services, primarily at the regional level and in certain health areas. However, these initiatives, even when initially or partially successful, have suffered from a lack of nurturing and so have not been sustained or pervasive.

One of the more successful initiatives in community participation is the Bamako Initiative. The Bamako Initiative is a UNICEF-promoted project to increase community empowerment and bottom-up approaches to health care management. It has been implemented in Guyana since 1996 in four health centres. Each health centre is managed by a Community Health Committee, comprising health workers, teachers, members of the Neighbourhood Democratic Councils, NGOs and other community leaders. Health Committees are set up to manage, plan, implement and facilitate health-related activities in the community, with the aim of facilitating the development of the bottom-up approach at primary levels of care. Activities carried out at the four health centres or planned for the future include: household surveys, seminars on health care delivery and community participation, community involvement through self-help labour, training on drug management, workshops on budgeting and supply management, and collection of financial contributions for investment in health improvement activities.

Besides the Bamako Initiative, there is presently a vacuum of initiatives encouraging community involvement in the planning, implementation, and evaluation of the health services. There are few incentives for sustaining the community participation process in the health sector or for establishing these mechanisms anew. In order to secure downward accountability, the RHA system will need to establish mechanisms for community involvement in the monitoring and planning of health services.

9.Gender Sensitivity

Issues of gender sensitivity have manifested themselves in all sectors of the Guyana economy, and the health sector is faced with addressing many such issues. Annex 25 identifies some of them.

10.....Vulnerable groups

Poverty alleviation and the protection of the vulnerable constitute socio-economic objectives for Guyana and are pre-conditions for meeting the health sector's goal of "health for all". Poverty undermines socio-economic wellbeing and the long-term sustainability of the developmental process. In the public health sector, inequitable access to health care and inequalities in health come at a huge cost, especially for the poorest categories.

An analysis of Guyana's poverty profile shows a significant overlap between the

bottom consumption quintile and groups with low human development. In particular, groups who are vulnerable owing to special health needs constitute a target for the heath sector. In fact, should their needs not be addressed, these groups are likely to fall below the poverty line. Vulnerable groups, whose health needs have been already described in section I, are identified among:

- .. **Amerindians,** estimated at 49,000 persons in 1993, living mainly in the hinterland in Regions 9, 8, 1, 2 and 7. Amerindians are the poorest and most neglected ethnic group in Guyana, with a head-count ratio of 87.5 percent, the highest fertility rate, no political voice, geographical isolation, and outstanding settled claims.

- .. **Elderly people** (6 percent of the population in 1992). Patterns of population ageing have relevant socio-economic implications. Old people whose health and social needs remain unmet are likely to fall in the poorest groups. The lowest income quintile in Guyana presents the highest incidence of ageing people. In Guyana, low pensions, high migration, and high inflation rates have in the past substantially worsened the socio-economic conditions of the majority of the above 60s.

- .. **Infants and children; reproductive health**. The related areas of child and reproductive health are crucial to wellbeing. In Guyana, the lowest income quintile presents the highest incidence of people below 20. If the health needs of these groups are not addressed, they are likely to experience increased impoverishment.

- .. **Groups affected by AIDS and STDs**. The HIV/AIDS epidemic is becoming one of the major health issues in Guyana. People contracting the HIV virus often spiral into a status of poverty, physical deprivation and social exclusion.

- .. **Disabled people.** The prevalence of people with disabilities is estimated at 9 percent, with higher rates among the socio-economic impoverished areas.

- .. **People with mental health problems.** People with mental problems and drug users are both likely to fall in the category of the poor and socially excluded. Although there is currently a lack of data on drug abuse, it has been estimated that the 15-35 age group is the most affected, including mainly males from the area of Georgetown.

.....**11.<u>Issues Related to the Stages of Health Care</u>**

. a.Primary Health Care

....

A comprehensive programme of primary health care would emphasise health promotion, disease prevention, healthy lifestyles, and community participation. Greater awareness and activity in these areas will have the most significant impact on health status in the

-

long term. The Ministry of Health has recently adopted a programmatic structure, and primary health care responsibilities are now shared between the PHC Programme and the Disease Control Programme. This structure should ensure that there is a clearer focus on primary health care, and that primary health care activities are integrated into other programmes and adequately funded. However, community participation, a foundation for primary health care activities, is limited.

In the past, activities in the area of nutrition have been the prime responsibilities of GAHEF but they are currently integrated into the Ministry of Health. Recent developments have increased inter-sectoral collaboration in this area. However, emphasis on nutrition in training programmes is still limited, trained nutritionists are not included within regional level positions, and technical and material resources for public education programmes are inadequate.

Despite an increased recognition over the past ten years of the importance of a healthy physical environment, environmental health services are still weak. Veterinary care, an integral component of primary health care, is also in a weakened state.

The maternal and child health programme is the largest vertical programme of the Ministry of Health and its services include ante- and post-natal check-ups, immunisation through the Expanded Programme on Immunisation (EPI), nutritional advice and supplementation, and family planning. It is one of the most important priorities of the health care system. Important results have been achieved, especially in the EPI.

. b.Secondary and Tertiary Care

The quality of secondary and tertiary care has suffered from the deficiencies of management and financing of the system noted elsewhere in this Annex. While improvements in management are expected at the PHG as a result of the creation of an autonomous Board, there are still no strategic plans for most hospitals. Poor hospital management, shortage of staff, and poor physical infrastructure are also prevalent. Moreover, diagnostic facilities are inadequate and supplies of drugs and medical equipment not always reliable.

.....B.Constraints

1.<u>Inadequacy and Paucity of Leadership and Direction at the Central and Regional Levels</u>

. . . .

This Annex has already identified the general insufficiency of trained, experienced and qualified management as a serious constraint within the health sector. Delegation of managerial authority is insufficient, and attitudes and motivations to work are weak. Lack of responsibility derives from a combination of poor incentives and the absence of accountability over results, decisions and implementation measures. Leadership is weak and

-

as a result, there is a lack of direction in the system at all levels; this is often due to insufficient training of managers in health administration and financial management. Leading by example is not an ingrained practice and the morale of staff is low. The absence of institutionalised and adequate reward systems partially accounts for these flaws. Constraints can also be found in the weaknesses of top-down feedback mechanisms, limited capability transfers, and the lack of adequate opportunities for human resource development.

In addition, as discussed elsewhere in one Annex, planning is inadequate. In the Regions, planning for health services may be the responsibility of managers with no expertise in the health sector. Strategic plans for health services development are not produced regularly and the planning of outreach activities is minimal. Decision-making is rarely based on supporting evidence. On the contrary, decisions are often made on an adhoc basis or as a response to crisis rather than via a rational planning process. Insufficient information to support decision-making processes is generated within the system. There are no mechanisms through which data on the health status of the population and the incidence of particular diseases and syndromes can be channelled into the decision-making process.

Human resource management is poor and manpower planning is weak. A staff database for the MOH has been recently developed; however, the information contained is often inaccurate. Management of procurement and inventories is constrained by the lack of a sufficiently professional basis as well as the absence of adequate information system to support monitoring of “ins”, “outs” and stocks. Needs assessments, impact assessments and feedback systems are neither regular nor rigorous.

. 2.Human Resources and Their Planning and Management

Human resource management also represents one of the major weaknesses of the public health system. A lack of sufficient numbers of optimally distributed and adequately trained human resources poses perhaps one of the greatest challenges to the health sector. Major problems occur especially in certain key areas such as pharmacy, laboratory technology, radiography and environmental health. Moreover, the shortage of nurses, who form by far the largest contingent of the work force and are the backbone of the health sector, severely hampers the ability to deliver quality care. There is also a shortage of medical specialist staff and other technical health professionals. As a result, the ratio of physicians and nurses to population is still unacceptably low in some Regions, especially in Regions 1, 5, 8, 9 and 10.

The management of the system is poor and most personnel in key positions lack managerial training and planning expertise. Difficulties are experienced in recruitment, retention, training, deployment and utilisation of staff. The development and management of human resources is still not approached in a systematic and organised fashion due to several constraints and bottlenecks that plague the system; however, some of these are outside the control of the Ministry. The major factors contributing to the public health sector’s inability to attract, recruit and retain staff within the public health system are as follows: low incentives (salaries and employment benefits); unappealing working conditions; the lack of career development systems; limited opportunities for in-service

-

training; a general shortage of adequately trained teaching staff and teaching-related materials; and the absence of a comprehensive human resources development and management plan.

The shortage of personnel can be analysed at two levels. Considering the health system as a whole, insufficient numbers could result from insufficient numbers being trained and the phenomenon of brain drain. Training-related issues will be analysed below. As to the brain drain, Guyana undergoes substantial flows of talented personnel out of the country. The inability to retain staff derives mainly from low salaries compared to the more profitable opportunities available abroad, especially for highly skilled and trained staff. Although brain drain is partially unavoidable, interventions can be made to make domestic posts more appealing, including increases in salaries and related employment benefits, improvements in the working conditions, and better training and opportunities for upward mobility. All of these improvements require institutional changes to make the public health sector more flexible and thus create adequate manpower management practices.

Insufficient numbers in the public health sector also result from brain drain between the public and the private sector. The working conditions and reward systems within the private health sector are no doubt superior to those available within the public health sector. Often, the public health sector loses skilled personnel as they move into better-remunerated and more satisfying jobs within the private sector. The problem is two-faceted. On the one hand, only improvements in the work conditions of the public health sector (monetary and non-monetary benefits) will help minimise the gaps between public and private sectors and hence reduce the flow of human resources from the former to the latter. On the other hand, doctors remaining within the public sector often enter private practice with a view to complementing public service salaries. While the private practice of doctors is not *in* and *per se* detrimental, a strong regulatory framework is nonetheless required in order to avoid doctors neglecting their duties at the public institutions due to their private sector involvement. Terms and conditions of private practice by public doctors need to be regulated.

Imbalances in the distribution of health care personnel also exist within the public sector itself, particularly between Georgetown and rural/hinterland areas. The lack of adequately-designed reward systems for health care workers serving the interior is the main reason for the inability to attract personnel to these areas. Hinterland conditions are poor, infrastructures and education facilities for families are inadequate, and the cost of living (e.g., the cost of a food basket or of certain non-food items) might be higher than in Georgetown. At present, the MOH compels health personnel to serve the hinterland areas for a certain period after their training is completed. Better incentives will need to be designed, and this requires institutional changes to make civil sector rules and manpower management arrangements more flexible.

Finally, health education and training is key to the development of human resources. The Ministry of Health administers a variety of clinical and technical health-training programmes, for example, training of professional nurses, midwives, community health workers, multipurpose technicians, and environmental health assistants. The absolute

shortage of personnel in certain positions could be addressed through enhanced training activities. However, a number of constraints impede effective planning and development of human resources and training needs.

First, there is an absence of mechanisms to provide accurate information on training and re-training needs, and a shortage of staff within the Health Education Unit to carry out field visits and assess needs. A lack of co-ordination with the Ministry of Local Government further constrains the planning and development of human resources by contributing to the vacuum in information on the numbers of persons and skills needed by the system.

Another constraining factor is the inadequate complement of trainers resulting in part from the absence of "training of trainers" programmes and in part from rigid public service rules, according to which individuals are considered qualified to teach even if they are not educated in training and teaching techniques.
....
In terms of educational methods, distance learning, which could amplify the coverage of programmes and of in-service training, has not been developed thoroughly. In the past, this method was used for continuous on-the-job training of medexes serving the interior, through weekly radio communications, but the programme was discontinued due to the disrepair and poor maintenance of the radio equipment.

There are other disincentives to having trained personnel for work in the interior. Programmes of recruitment and training of health care personnel have not given sufficient emphasis to persons coming from remote areas of the country. The educational background of local people in most remote areas is often poor, and most of them do not meet the rigid entry criteria applied to training courses, particularly nursing training. A programme for training Community Health Workers (where trainees are selected from communities and trained for 4 months) was developed to offset the problem, but is currently inadequate compared to needs.

In sum, better incentive systems must be developed in order to retain both qualified trainers and trained personnel. Only improvements in the general work conditions within the public sector, including training and retraining opportunities, can adequately attract personnel where needed.

. 3.Buildings and Equipment

Many donor agencies are currently involved in funding the rehabilitation of hospitals and health centres. In addition, the IDB Health Care II Project financed the Ambulatory Care Diagnostic and Surgical Centre at the National Referral Hospital, the National Dental Centre received funding from the European Union Health Sector Programme, the maternity wing at the PHG was completed with funding from CIDA, and other health infrastructure has been supported through donor assistance.

-

At present there is only limited co-operation among the public, parastatal and private providers for more efficient use of facilities. A survey on the status of buildings has been carried out recently by the Ministry of Health; however, there is still a need for on-going assessment of what buildings and equipment are required at all levels.

.4.Transportation Equipment

Transportation and communication in Guyana are problematic, often due to the geographical and physical features of the country. While the provision of adequate transportation and communication facilities is outside the scope of this Annex, the public health sector has an obligation to ensure that everyone has access to preventative services and health facilities in case of emergencies.

The ability to provide adequate transportation and communication has been constrained by an inadequate supply of cars, bicycles, boats, and horses required for servicing the interior regions. Budgetary allocations for the purchase of transportation equipment have been limited and the supply of radio equipment to serve hard-to-reach areas insufficient. Available boats and vehicles are often in poor working condition. Difficulties are also experienced in recruiting drivers due to the low and unattractive salaries and benefits offered.

In the past, maintenance has been poor, but expenditures in this area have recently been increased following the requirements of the HIPC initiative, according to which they have to reach 12 percent of current health spending by the year 2002.

No economic evaluation of alternatives to the purchase of transportation equipment has been carried out so far; these might include, for example, renting of transportation equipment and contracting out of services requiring transportation.

.5.Norms and Standards for the Delivery of Health Services

Currently, only a few documented standards exist and applications of the few that exist are seldom effectively enforced or monitored. Although the Standards and Technical Services Unit of the Ministry of Health has been consolidated through a better definition of the role and functions, and the head of the Unit has undergone overseas training, major constraints still affect the development and application of standards. In particular, the main limitations relate to the inadequacy of trained staff in the Unit; insufficient staff to develop, carry out, monitor and enforce technical standards; poor co-ordination among all stakeholders in standards development and enforcement; lack of quality assurance schemes and total quality management at hospital facilities throughout the country; and lack of leadership of the Ministry of Health in monitoring and regulating standards in both the private and public sectors. The Bureau of Standards sets general standards and guidelines for laboratory services.

As the Ministry of Health is undergoing restructuring to assume and perform a steering role, a clear identification of its regulatory function and standards-setting role is of central

-

importance. Furthermore, difficulties arising from a the current Regional Health system (the lack of co-ordination between the Standards Unit and Regional field officers and health institutions) should be addressed in the process of institutional restructuring of the public health sector, within which Regional Health Authorities are being established.

....

. 6.Health Information System

Major constraints still hamper the effective functioning of the health information system. First, data collected are incomplete and long delays occur between data collection, compiling and transmittal. Secondly, there is not enough adequately trained staff to support data analysis and generate statistical reports. Lastly, the scope and level of disaggregation of the data collected are limited.

The management of data collection and the generation of information have improved, but need to be strengthened further. The current lack of co-ordination between Regions and the Ministry of Health in this area is a major hindrance to the functioning of the current system and needs to be adequately addressed. Management Information Systems are only embryonic, and need restructuring if the sector is to be institutionally reorganised and strengthened.

. 7.Primary Health Care

....Specific constraints within several primary health care areas are:

.a.Health education

....

Health education is delivered in Guyana by the Health Education Unit and by a variety of other agencies and organisations. Some of the problems have been identified in the earlier discussion of problems of manpower planning. Other constraints include the following:

- .. programme managers do not fully utilise health education programmes;
- .. health personnel are not adequately oriented or trained to be health educators;
- .. there are limited education-support materials at health facilities; and
- .. there is inadequate emphasis on health education in schools.

....b.Nutrition

.....Despite recent improvements in creating a surveillance system to monitor food and nutrition status on a continuous basis, there is still insufficient emphasis on nutrition within health institutions.

....c.Environmental health services

-

....
.... Major constraints identified in this area include: lack of co-ordination among environmental health agencies and between these and other stakeholders; an acute shortage of environmental health officers, and outdated environmental health legislation.

d.Maternal and child health

....The constraints facing this programme include: shortage of staff; limited availability of pharmaceuticals and instruments; difficulty in reaching some remote regions; lack of data analysis, no explicit family planning programme or policy and limited family life and reproductive health education in schools.

....8.Secondary and Tertiary Care

Some principal constraints already mentioned in this area include: lack of sufficient autonomy in decision making in the hospitals; poor managerial practices at the Hospitals; lack of sufficiently trained personnel; insufficient equipment; deteriorated facilities; lack of proper maintenance; inadequate information for informed decision-making; inadequate community involvement in hospital management; poor staff attitudes; lack of standards and personnel regulation.

. 9.Vertical Programmes

Vertical programmes include vector control, sexually transmitted diseases and HIV/AIDS, Hansen's disease, tuberculosis, dental services and veterinary public health. Institutional factors related to the existing Regional system constraints the implementation of vertical programs by making integration between vertical programs and the Regional system a difficult task. Moreover, the following constraints face all the vertical programs: over-stretched staff at the central level; insufficient support and field staff; inadequate inter-institutional co-ordination in programmes such as malaria control, and inadequate support services such as supplies of reagents, drugs and equipment.

IV.Sectoral Objectives

In the broadest sense, the policy objectives of the sector are to increase the span of healthy life for all people in Guyana and to reduce health disparities between social groups, thereby ensuring that increasingly, most Guyanese enjoy a better quality of life, and minimising the incidence of illnesses and disabilities that cause premature death.

The overall operational objectives for achieving this goal are to improve the population’s access to health care and the quality of the care offered, while promoting cost-effectiveness and value for money.

The access objective refers to ensuring universal access to a defined mix of basic services,

-

emphasising the essential strategy of primary health care. The question of access is double-sided. From the supply-side perspective, improving access requires increasing the availability of health services and ensuring that services are responsive to the needs and preferences of the clientele at all levels of the delivery system. From the demand-side perspective, improved access requires a reduction in the household costs of accessing care (i.e. all direct and hidden costs). Recent improvements in access to health care have occurred mainly because of the improved availability of certain services (i.e., vaccination, dental care, antenatal services). However, shortfalls continue to be pervasive, both in terms of the limited outreach activities and inadequate availability in remote areas (supply side), and in terms of high hidden costs (transportation, waiting costs), depressing demand below needs.

Improving access to health care will mark a major step toward satisfying the equity or distribution objective of the National Development Strategy. The achievement of equity objectives within the health sector also requires improvements in resource allocation mechanisms to ensure fair distribution of resources, and the prioritising of the health needs of the most vulnerable sections of the population. Despite recent increases in allocations to the health sector, and notwithstanding the fact that primary health care is the stated priority for health investment, resource allocation mechanisms are still based on historical spending patterns and dictated by existing rather than needed services. Reforms of allocation mechanisms and criteria for the determination of resource needs constitute a pre-requisite for improving equity and a challenge to the health sector.

The quality objective refers to the pervasive need to restructure several key aspects of the system, seeking fundamental improvements in all areas, so that a patient's visit to any unit of the system yields greater and more immediate health benefits. As noted in Section II, there is an important interaction between quality and access, so that improvements in the former will also lead to improvements in the latter. Quality improvements are targeted both in the structure of facilities and in the processes and quality of operations.

Another leading objective of the health sector is the need to improve cost-effectiveness and remove the inefficiencies characterising the public health sector. Institutional changes are required to address structural factors which endanger the effective management of the health care system and weaken institutional co-ordination between the Ministry of Health and the Regions, as described in Section III. Institutional changes are also aimed at improving technical efficiency by strengthening management practices. The responsibility and accountability of health service providers for the resources used and the results achieved also need to be improved, both upward and towards final users.

....

Supporting objectives, which require inter-sectoral collaboration, are to create a healthier environment and inculcate a healthier lifestyle in the Guyanese population. Achieving these supporting objectives will depress the population’s need and demand for curative health care services and reduce human suffering. It will also improve the cost-effectiveness of public health sector activities. Co-operation towards the fulfilment of these objectives will be required from the education sector, the environmental sector, the urban development and housing sector, and the poverty alleviation programmes, among others.

-

....
In working towards the achievement of these objectives, special emphasis should be placed on ensuring the survival and healthy development of children and adolescents, and on improving the health and well-being of target-priority population groups of all ages, in particular women and Amerindian communities. As noted earlier, other vulnerable target groups include the elderly, the disabled, the mentally ill, the urban poor and people affected by HIV/AIDS and other sexually-transmitted diseases.
....
The pursuit of the overall objectives will require policy actions in the following five fundamental areas:

The institutional structure of the health system

The management of the system

The financial basis of the system

Primary healthcare, including prevention and health promotion

Secondary and tertiary healthcare

Improvements in the health care system will require leadership and effective management, adequate financing and appropriate use of funds. Specific goals for each of the above areas are presented with a description of the sector's basic policies in the next section.

V.The Strategy

.....A.Structures and Functions in a Re-organised Sector

Many of the institutional problems that afflict the sector can be resolved by unifying the "steering" authority for the health sector. In keeping with this analysis, the Ministry of Health will be responsible for planning, policy-making, monitoring and regulating in the health sector, while Regional Health Authorities will be decentralised public bodies responsible for service delivery. Within this plan, already approved by Cabinet, the following specific steps will be taken:

1.The Regional Health Authorities will assume responsibilities for operating and maintaining health facilities that are now under the aegis of Regional Administrations. Since this might reduce the benefits of inter-sectoral collaboration existing in the present system, mechanisms to retain the present synergies across sectors will be worked out. As

-

the system is reformed, the process will be monitored to ensure that the coordinating and structural problems currently existing are not replicated in the new system.

2.Funding will be re-channelled from the Regional Administrations to RHAs on the basis of service agreements negotiated with the Ministry of Health. Mechanisms to ensure financial accountability for the public health sector will be accurately planned. The Ministry of Health will develop the capacity to prepare service agreements, monitor their implementation and assess the performance of devolved authorities.

3.Hospitals operated by parastatals which receive budgetary allocations will operate under similar service arrangements agreements. As the quality of the national health system improves, and the parastatals focus increasingly on their own economic needs, a transfer of their hospitals to the national public system will be introduced.

4.The Regional Health Authorities will account for their performance to an appropriate functionary at the central Ministry of Health.

5.In order for the system to work, the Ministry will carry out a needs assessment exercise in all health facilities and develop systems for in-service training and human resources upgrading. All regional senior officers will be trained in health administration.

6.A division of primary health care will be established in the Ministry of Health, to work in close co-operation with the regional units, where most of the primary care is provided.

The changes in the organisational structure and functions of the public health sector will not result in the centralisation of authority within the Ministry of Health. Rather, institutional reforms will be designed to improve co-ordination within the public health sector. The following strategies will guide the "new" Ministry of Health's role:

The Ministry will be restructured to reflect services integration and decentralisation of service delivery functions. As mentioned earlier, it will function in a regulatory capacity over the entire health sector, rather than in its traditional role as the centralised manager of the public health system, while service delivery and management responsibilities will be devolved to the health authorities and other devolved agencies that will report to the Ministry. In the re-structured Ministry, the following functions will be retained and strengthened centrally:

Developing National Health Policies and Strategies – The Ministry of Health will develop national health policies on the basis of health needs assessments. Strategies for achieving policy goals will guide the setting of objectives, resource allocation and manpower training and planning.

Allocation of Resources - Allocation of resources to health authorities will be made on the basis of prior agreements between the Ministry and these entities. The Ministry will monitor expenditure and ensure that funds are deployed in the manner intended.

-

Objective Setting and Performance Review - The Ministry will establish specific objectives for the achievement of national health priorities, but specific outcome targets will have to be agreed with each devolved body to ensure managerial autonomy. Annual performance reviews will verify whether objectives and targets have been achieved, and identify problems and possibilities for improvement. The Ministry will develop capacity for carrying out organisational and clinical audits to allow standards and targets to be set and monitored.

Research and Development and Sponsorship - The Ministry will provide support to key individuals, NGOs, Health Boards and authorities in activities aimed at achieving national health priorities. This will include health service research and development as well as the promotion of the use of information technology.

Regulation Setting - The Ministry will provide certain regulatory functions aimed at quality and standards. This will include regulating the private health sector, and establishing regulatory frameworks for pharmaceuticals, food, and the assessment of new technologies.

2.The Ministry will develop a "leaner", more focused and more skilful technical staff. The present technical staff of the Ministry does not have the capacity to carry out the new Ministry role. The staff will be trained to reflect a different technical skills mix. The following capacities will be developed:

Epidemiology - A strong Epidemiology department to undertake ongoing health needs assessment, direct and assist health authorities and other devolved agencies to identify the health needs of their populations, and assess their effectiveness in satisfying these needs.

Policy-making - The use of health needs assessments to determine priorities and hence shape policies and strategies to meet needs.

Planning - The development of policies and strategies into detailed, time-bound and costed plans indicating how the Ministry's objectives will be achieved. The Ministry's planning function will also: i) monitor whether objectives and targets are being achieved; ii) develop strategic plans for the entire health sector; iii) co-ordinate donor assistance and projects; iv) monitor whether devolved authorities have clear and feasible goals, developed into long-term rolling plans; v) monitor whether annual operating plans are developed within the framework of these long-term plans; vi) establish monitoring and evaluation mechanisms to monitor policy implementation and the operation of all programmes and facilities in the health system; vii) require that all such plans demonstrate how volunteers and community groups will be utilised.

Economic/Financial Functions - i) The preparation of cost-effectiveness analyses; ii) evaluation of the efficiency of existing and new health services, and of new technology*;* iii) development of cost-effectiveness protocols; iv) evaluation of the equity, efficiency and effectiveness of health financing mechanisms; v) development and monitoring of new financing mechanisms.

-

Quality Assurance and Clinical Audits – The development of multi-disciplinary quality assurance programmes, including clinical and organisational audits.

Human Resource Planning and Management - Planning for the manpower needs of the health sector, in terms of both numbers and skills, especially for specialist and high-skilled personnel.

Leadership - The provision of effective leadership and the development of a national vision for the health sector, which can guide health sector providers and devolved authorities, empower groups delivering health care, and inspire continuous innovation.

Communication and Public Relations - Wide public education on the health goals and policies of the Ministry to ensure public input into and support for the policies.

The organisational structure will reflect the fact that the Ministry is to become an efficient strategic and regulatory body, with responsibilities for establishing policies, allocating resources, auditing health delivery management and services, and training. The following are examples of structured departments in the new Ministry along with their proposed functions:

Policy, Planning and Health Promotion: for needs assessment, planning, cost-effectiveness analysis, resource allocation, contracting and health promotion.

National Services Co-ordination: a technical unit responsible for ensuring the delivery of services that are not devolved to other bodies, including the national blood bank, and a national laboratory service.

Quality Assurance: for total quality management, monitoring and setting standards of care.

Human Resources: for manpower planning and development.

Finance and General Administration

.....B.The Reformed Health Sector Management Policies

Management policies within the public health sector will be reformed so that the new decentralised system might function effectively. The following steps will be taken:

Financial autonomy will be accompanied by corresponding authority and responsibility, and monitoring mechanisms will be developed in the various departments in the Ministry of Health.

-

For the Ministry of Health, the annual programme budgeting process will be developed into multiyear planning, indicating the annual outputs and results, and the resources necessary to attain them.

A comprehensive management information system will be developed. This will require careful planning since the success of a decentralised system will depend on how well the centre monitors that the achievements of targets by devolved authorities. A good MIS will also ensure that decision-making processes are based on objective and relevant data, resources are used effectively, and accountability occurs both downwards and upwards. Record-keeping systems by patient will be established to ensure that each patient does not have different records for visits arising from different ailments.

Standards and treatment protocols will be developed and updated, to bring them abreast of current medical practices and the changing epidemiological profile of Guyana, and a system of monitoring the quality of treatment based on those standards and protocols will be established. The Ministry's standards function will be strengthened for this purpose.

Responsibility for decisions and tasks will be allocated to the lowest level that can effectively handle them.

In addition to reforming management structures and procedures**,** salaries in the sector will be urgently increased. Special attention will be paid to the need to provide incentives for well-qualified medical and administrative personnel to serve in the hinterland facilities.

In order to increase the flexibility of the public health system, the salary structures of health personnel will be de-linked from the public service or, in the absence of such a measure, special categories for health personnel will be developed within the structure of the public service. Further improvement in salary conditions is a *sine qua non* for improving the quality of health care in the public sector.

All personnel in key management positions, e.g., programme managers, hospital administrators, district-level health officers, medical superintendents, and public health nurse supervisors, will be given adequate training in health administration. Better training in management and managerial tools will be developed. Periods of paid leave will be provided for the acquisition of the requisite training.

Performance review procedures, grievance procedures and disciplinary measures which ensure that lines of authority are respected and used will be developed.

Mechanisms to monitor the progress of individuals, organisational units and programmes will be established, by:

clearly defining roles at all levels, including job descriptions for all positions;

establishing, in consultation with staff, objectives and related work programmes against which performance can be measured, and

-

developing and implementing clear reporting relationships, guidelines for supervision, procedures for regular performance evaluation and staff meetings.

11. .....The following actions will also serve to enhance efficiency and accountability within the management of human resources in the system:

emphasise flexibility in the job descriptions, in order to avoid the inefficient utilisation of staff;

base promotions on performance rather than seniority;

define a career path for health workers, to increase on the job satisfaction and staff retention;

ensure that responsibility is matched with authority and provide supervisors with the authority to discipline staff;

develop and implement a supervision system and institute minimum standards of performance at all levels;

institute incentive systems, including salary incentives, to reward initiative and superior performance, and to sanction laziness and poor performance, and

institute time-recording systems for medical personnel, and link incentives to actual presence at the facilities.

C. .....Human Resources Development

The following new policies will be implemented to address problems of shortages and distribution of medical personnel. In this process, close collaboration between the public and the private sectors might be critical to achieving a solution through partnerships.

General: The MOH will develop and implement a manpower plan for the health sector that indicates ways to upgrade and improve staffing levels and analyses alternatives to overcome the shortage of specialist personnel such as medical technologists, pharmacists, dental technologists, radiographers and X-ray technicians.

Hinterland Regions: Adequate incentives will be developed to stimulate voluntary service of health personnel in hinterland regions. In addition, all persons trained by the Government in medical disciplines and allied fields will be asked to serve an interior location for a certain period of time (e.g., one or two years). The training of local people such as Community Health Workers, Medex, and Dentex will be strengthened. However, given the likelihood that doctors and nurses will prefer to work in the Georgetown area, even if their origins are in interior locations, the Ministry will, if necessary, continue

using foreigners to fill certain positions, especially in the cases of general practitioners and specialised physicians. Finally, outreach activities will be further expanded to increase access to health services in remote areas.

Standards: Legislation will be introduced to require allied health field personnel to register with a Paramedical Professional Council in order to practise.

Salaries and Other Conditions: An action plan for various health personnel (nurses, doctors, technicians) will be developed within the general framework of the manpower plan, addressing key issues such as salary levels, working conditions, organisation of the service, management and models for patient care.

Recruitment and Training: Pre- and in-service recruitment and training plans will be developed and implemented in order to meet the manpower needs of the health system; at present there is no linkage between the needs of the sector and the structure of the training programmes.

Collaboration: Management personnel in the Ministry of Health and all hospital managers will be trained to work with the Community Hospital Associations. Physicians will be trained to understand the role of Medex (medical extension) personnel in primary health care; this training will be provided on an in-service basis when it is not otherwise available.

Curricula: The appropriateness of existing curricula and course requirements, will be evaluated and updated, and collaboration between the Liliendaal Annex, the University of Guyana, and the Ministry on the development of curricula will be ensured in order to guarantee consistency and relevance to the sector's needs.

Database: A comprehensive human resources database with up-to-date information on the location of staff and their qualifications will be developed and maintained.

D..... Operational Autonomy and Community Participation

The following specific actions will be taken with regard to Hospital Boards and Community Health Councils:

Autonomy of Boards: Since the Public Corporation Act is not tailored to the new and complex needs of the health sector, special legislation to permit the autonomous status of hospitals will be introduced.

Levels of decision-making and accountability: Hospital managers will be made responsible for day-to-day operational decisions and accountable for results achieved. The centre will continue funding annual operating budgets, and capital budgeting processes will require control mechanisms from the centre; for example, approval of all capital expenditures greater than a specified level. The management of the hospitals will

be empowered to raise funds via other mechanisms, and to retain and utilise them for their operations within guidelines set by the Ministry of Health for cost-recovery and other revenue- generating mechanisms. All operating decisions will be delegated to the appropriate operational level, including decision on procurement of supplies, hiring and assignment of personnel and, within specified limits, provision of incentive allowances to staff. The Ministry of Health will be responsible for undertaking annual needs assessments, and for supporting devolved authorities in similar annual exercises. The autonomous facilities will be supervised by non-profit Boards of Directors. The composition and appointment rules of the Boards will be worked out with input from the Regions and hospitals. The Boards will be accountable upwards to Regional Authorities and the Ministry of Health, and downwards to the communities. The primary roles of the Hospital Boards will include: (i) approving annual operating plans; (ii) approving requests for capital expenditure developed by the management of the facilities; (iii) reviewing and approving needs assessments; (iv) reviewing and approving training plans for staff; (v) raising supplementary funding for equipment and other special needs indicated in the annual operating plan. This format may apply to national, regional and district-level medical facilities. Health centres and posts will be provided as much operational autonomy as possible, subject to closer supervision by the RHA. Functional relationships between the RHA Boards and the hospitals Boards of Directors will be worked out to ensure an appropriate governance model.

Establishment of Community Health Councils: The establishment of community advisory-cum-supervisory boards has been found useful in many public services, from agricultural research to education or health. They help in defining the expectations of the community, evaluating whether services meet expectations, recommending improvements in the way the service is provided, and assisting in some maintenance or rehabilitation efforts for the facilities. In addition, they often help raise funds for the service, and thus become partial owners of the service, and acquire a deeper stake in its performance. This kind of local involvement will be promoted for all public hospitals by encouraging the formation of Community Hospital Councils affiliated with each facility, in the manner of parent-teacher associations. The CHCs will meet regularly to review the plans, budgets and progress of the facilities and to discuss operational and planning issues. Two members of each (selected on a rotating basis) will serve on the Board of Directors of the institution. The CHCs will be encouraged to raise funds locally for special programmes and equipment for the facilities. They will be one of the keys to better functioning of the health facilities, and through them, greater autonomy for the facilities will come to signify greater participation by communities. After five years, the experience of the CHCs will be reviewed to determine whether the model should be extended to health centres and health posts.

E. The Geographical and Hierarchical Structure of the Health Care System

The under-utilisation of most of the geographically-dispersed facilities and the persisting by-passing of the referral system necessitate the following actions:

-

A detailed survey will be carried out to verify whether all existing facilities are needed, and their status. The study will include alternative scenarios for the rehabilitation and development of the health facility system. Alternatives will be costed and traded off against each other. Possible alternatives include:

Equipping special aircraft and boats as air and water ambulances, and ensuring that radio communications networks are available in all localities.

Closing some hospitals that are currently underutilised. In this way, funds could be made available to upgrade other "strategic" facilities, as well as to provide the flotilla of ambulances mentioned above and finance an expansion of programmes of rotating visits.

Evaluating district hospitals to determine whether to move to a smaller number, well-equipped and staffed, coupled with air and water ambulances, in preference to eighteen hospitals at this level, many of which have inoperative equipment and under-utilised beds.

Closing some health centres, especially those in coastal areas, and using the funds released to strengthen selected district hospitals and place more health posts in remote areas.

Following the survey mentioned above, a master plan for the rehabilitation of facilities, including the acquisition and maintenance of an improved fleet of air and river ambulances, will be developed by the Ministry of Health.

Every regional hospital and other district hospital will have at least one ambulance for emergencies. All health centres will be equipped with a phone or radio for emergency calls. All hospitals will have adequate power generation supplies.

Health posts will be maintained and improved, as they are vital for the tasks of medical education, preventive care and arranging for medical transport to other facilities.

The programmes of rotating visits to the remotest facilities by physicians will be strengthened, so that villagers would know in advance when a doctor will be in the nearest health centre, for example, on specified days of the month. Arms-length and outreach activities will be strengthened, including the use of mobile clinics.

The referral system will be made effective through a system of incentives to ensure the use of facilities at the most adequate level. Penalties for bypassing the system will be clearly defined, both for users and for referring doctors. Moreover, procedures for referring will be clearly set out and communicated to all medical staff. They will also form part of the training of doctors and nurses.

Training in first aid or the provision of basic medical care for people living in rural areas will be developed, in order to minimise the need to refer to higher-level medical

-

institutions. Public-private sector collaboration, including collaboration with NGOs, will be sought for this purpose.

A detailed review and development plan for all health facilities will be designed by the Ministry of Health and devolved Regional Authorities, and a policy document including the above-mentioned development plan will be urgently prepared.

F.Policies for Financing Health Care

The following policies will be adopted for financing the reformed health sector:

General Principles

Financing and resource allocation mechanisms will be improved as a major instrument for addressing the inequity and inefficiencies of the present system. Financing mechanisms are an integral component of reform efforts and cannot be separated from any other measure to improve the equity, efficiency and effectiveness of the system. Financial reforms will therefore proceed in parallel to the institutional reforms, in order to make expenditures on health care more effective.

The Central Government budget will continue to be the principal source of funding for the public system of health care. According to the HIPC targets, Government health expenditure should reach 4.5 percent of GDP by the year 2002.

General taxation will remain the main funding mechanism for health care in Guyana.

The levying of earmarked health taxes will be investigated as an option.

Resources will be allocated from the centre to devolved authorities on the basis of a funding formula. Public resources will be prioritised to highly cost-effective services such as primary health care (e.g. immunisation, sanitation, vector control, diagnosis and treatment of tuberculosis, malaria, sexually-transmitted diseases, the provision of maternal and child care, health education, and public health interventions). “Public good” type health interventions will be subsidised. Allocations from the National Budget will maintain sufficient resources to target the vulnerable and indigent.

Cost recovery will not be considered for financing health needs for which the Government assumes a commitment, including priority services, public health services and health needs of the vulnerable. Such services will be financed through public resources. For other services, selective payments by patients will be considered.

If a system of selective fees for medical services is implemented, cost-recovery will never hinder access to health care and no patient shall be refused service because of inability to pay fees. A social assessment system to determine eligibility for exemptions will be

established. Until such a system is in place, means assessments will be carried out at public health facility level.

Financial contributions to complement the public budget will be sought from communities, as in the case of the Bamako initiative, or through Community Hospital Councils (described previously). This approach will also enable the communities to have a greater role in planning health services and monitoring their quality.

Health insurance will be studied thoroughly as a financing option and developed accordingly. Health insurance functions as a risk-sharing and pooling mechanism for the patients, and its coverage in Guyana will be further developed.

An extensive review of the NIS and a corresponding reform programme will be developed, in order to improve the NIS actuarial basis and strengthen its performance as a provider of social health benefits.

The collection of revenues from private insurance for public services provided to insured people will be investigated as an additional option.

. 2. The System of Selective Fees

....

Selective user fees will be introduced for well-defined services not currently charged at certain public health care institutions. Current fees include those charged at the PHG (use of private rooms; pregnancy tests, medical library and physiotherapy services); at two Regional Hospitals (x-rays, mortuary services; laboratory tests); at the National Dental Centre (all treatments); at the Ptolomey Reid Rehabilitation Centre (orthotic and prosthetic appliances and hearing aids); at the National Blood Transfusion Services Centre and at the Food and Drugs Administration. Other cost-recovery measures are currently under study for the Public Hospital Georgetown and at one of the Regional Hospitals.

The following objectives have been established for the use of fees charged in the public health sector:

Revenue generation: At the PHG, 3 percent of total operating costs is expected to be recovered by the end of 1999, and 5 percent by 2000. As to the overall system of public health care, one percent is expected to be recovered by the end of 1999, and 5 percent by year 2002.

Improvements of health care services: Quality improvements constitute one of the most important objectives. Revenues will be retained and invested in service development and financing of inputs like drugs, supplies and personnel.

Efficiency: Efficiency improvements will be achieved by discouraging frivolous demand for services and encouraging a greater use of the services by the poorest (exempted).

-

Efficiency in the utilisation of resources will also be achieved through improvements in the referral system, if fees are "cascading" and set to prevent the bypassing of the system.

Equity: Access to health services will be maintained and possibly increased. The impact of fees on access will be measured by examining the use of health services, reported through facility surveys. User fees will contribute to equity by charging those who can afford to pay and exempting the poor. If fee revenues are utilised for quality improvements, quality care will be available and more affordable than private care, and more accessible for those previously not seeking care due to high hidden costs.

Improved managerial responsibility: Improved responsibility will be achieved by making facility and service managers responsible for their budgets. The decentralisation of responsibilities and the creation of autonomous Regional Boards will allow revenue retention and financial autonomy, resulting in improved accountability.

The following classes of fees will be applied (and in part are already utilised). All of them have been implemented in other developing countries, and each of them generates different incentives for both users and providers.

User fees in hospitals (PHG, Regional and district hospitals).

A modest registration fee will be charged for both inpatients and outpatients at the Public Hospital Georgetown, and introduced in all district and regional hospitals. Registration fees are easy to collect, but are unpopular if quality of services is not guaranteed, for example, if drugs and other supplies are not available.

Fees for patients bypassing the referral system will also be charged in order to avoid the overuse of upper-level facilities for care that could be provided effectively at lower levels. Such a system of fees requires a definition of the rules governing the referral system and the establishment of correct incentives and disincentives for providers of services at lower levels.

At the Public Hospital Georgetown, already existing charges (e.g., physiotherapy, the use of private wards, the medical library, pregnancy tests) will be increased to reflect the real value of the resources necessary to provide the services.

User fees for drugs or medical prescriptions will be applied; these charges are generally more acceptable than registration fees as patients perceive a direct link between fees and the ready availability of drugs.
Fees will also be levied for other in and outpatient services, including laboratory procedures, x-rays services, other specialised diagnostic services (e.g., CT scan), specialist surgery, and medications.

b. Sale of services and public-private collaboration in health

-

Private and public collaboration in health will be sought, including for example, the sale of services to the private sector.

Existing charges for services sold to the private sector at the Food and Drug Administration and at the Blood Bank will be increased to reflect value for money.

The use of equipment and facilities at the ACSD unit at the Public Hospital Georgetown will be optimised by allowing private doctors to use them in public hospitals on payment of a fee, subject to scheduling their use so that priority is given to the public physicians. Charges for patients admitted to public hospitals while under the care of private physicians will also be considered.

Services for which excess capacity exists will be sold to the private sector. At the PHG these include, for example, non-clinical services such as the laundry, the kitchen, and the sterilisation unit.

c....User fees at community level.

While preventive and primary health care will be provided without charge to encourage the population to give greater emphasis to preventive care,community self-help financing initiatives such as the Bamako Initiative will, as outlined earlier, be encouraged, since they have resulted elsewhere in visible improvements in the quality of health care and better community participation in management, without increasing equity risks.

The establishment of cost-recovery measures poses serious challenges in terms of public sector “capacity”. Several administrative and legal issues need to be solved in order for the system described above to work effectively. The health sector will implement a process of institutional strengthening in order to tackle these issues.

G.Improving Access to Pharmaceuticals and Medical Supplies

The following fundamental reform measures, which will assure the availability, distribution and use of safe and effective essential drugs, will be adopted as part of the basic health policy:

The appropriate infrastructure for a transparent and credible Drug Management System will be adopted.

Procurement and distribution of pharmaceuticals and medical supplies for the public sector will be contracted out, and a Procurement Board will be established for this purpose. The Board will be autonomous and managed according to business principles. Private physicians and facilities will be able to purchase drugs and supplies from the Board, which will be required to carry out an assessment of needs for pharmaceuticals and supplies in the entire system, procure them, deliver them in required quantities to facilities in all regions of the country, and assure their quality and safe storage prior to

-

delivery to the purchaser. Adequate regulations and mechanisms will be introduced to guarantee accountability of the Procurement Board for the use of public monies, and a performance evaluation will be carried out annually.

All devolved Authorities will arrange their own purchases of drugs and supplies from the Board, and negotiate prices taking into account transport costs.

Policy regarding the supply and use of Essential Drugs in the public sector will be articulated and legislation adopted where necessary.

Interventions required to improve the effectiveness and efficiency in the use of pharmaceuticals will be identified and implemented.

An Essential Medical Supplies list will be formulated, outlining types and specifications of supplies that will be stocked.

Investments will be made to improve the storage facilities for pharmaceuticals in public hospitals, health centres and health posts. Donor assistance will be sought.

Further emphasis will be placed on management and human resources requirements for the pharmaceutical sector at all levels.

The institutional and functional capacity of the Government Analyst Department will be reorganised and strengthened so that the quality of drugs manufactured, imported and sold in Guyana is safe. All current legislation will be revised.

The Ministry of Health will formulate and implement a National Drugs Policy. Donor assistance will also be sought in this area.

The Ministry will launch a campaign of public education on the proper use of medications, through schools and non-formal educational channels such as radio programmes.

H.....Community Participation

....

In addition to those listed earlier, additional mechanisms to increase community participation are as follows:

. 1.The Guyana Consumers' Association, in collaboration with the Ministry of Trade, is organising consumer groups in the ten Regions by setting up a consumer desk at each Regional Administrative Office, with the objective of obtaining and giving feedback on healthcare services.[28] Such initiatives, and more generally the role of the Consumer Association in monitoring the efficacy and equity of health services, will be strengthened.

[28] National Health Planning Committee, The Teaching of Health Education starting from Primary School, pp 74-75.

-

.2.The Ministry of Health will develop a draft plan for community involvement in primary health care and carry out consultations in all Regions for the purpose of soliciting comments on the draft and refining it before implementation. The consultations will also serve to better identify the communities' existing perceptions and understanding of health-related issues, so that health programmes can address them in an appropriate manner.

.3.The Ministry will also develop a programme for sharing existing health information with the communities on an ongoing basis, and for meaningfully involving them in finding solutions to health care needs both inside and outside the hospitals.

.4.Health staff and individuals from the community will be trained in strategies for community participation.

.5.Community members will be represented on the Boards of hospitals and Regional Authorities.

.6.A public forum for discussion on health programmes implemented by Hospital and Regional Authorities Boards will be established, in order to ensure periodic accounting by the Boards to the communities.

..... I. Gender Sensitivity

Gender sensitivity requires not only the development of specific programmes addressing gender-specific health issues, but also the development of an approach that cuts across all health programmes. Adequate legislative changes might also be needed. Actions will include the following:

1. .Programmes addressing gender-specific health issues will be implemented, for example, in the areas of reproductive health, the impact of STDs and HIV/AIDS, and cancer.

2. .Gender analysis will inform the planning, implementation, monitoring and evaluation of all health programmes.

3. .Information systems will be designed to provide adequate gender-differentiated information in support of policy and decision-making processes.

4. .Issues of confidentiality in health care delivery will be taken at the highest policy-making point of the system, for example:

a. .Privacy Act: Adequate and separate facilities will be provided for women during delivery for maximum privacy, thereby giving family members the opportunity to participate in the natural event of childbirth.

b. .Family Leave: There will be an amendment to the Labour Act allowing for maternity

-

leave for both male and female parents.

....

.....J.Vulnerable Groups

1. .The Ministry of Health will examine ways to improve service provision and delivery to the most needy. A health development strategy centered on the objectives of Primary Health Care and Health Promotion would be cost-effective while addressing the needs of the most vulnerable.

2. .As emphasised throughout this document, while institutional reforms in the public health sector pursue objectives of equity, access and quality improvements of health services, an explicit stance will be taken to target the most needy. The following strategies were developed out of an analysis of poverty profiles of the population and the health needs of the most vulnerable:

a. .Policy documents addressing the health needs of each vulnerable group and detailing the action plans as well as institutional responsibilities will be prepared through processes of national consultation involving all major social actors. This has been the case, for example, of the National Consultation on HIV/AIDS, which took place in November 1998 and was developed into a policy document and the National Plan for HIV/AIDS Prevention, 1999-2001.

b. .Besides a basic package of services targeting Primary Health Care interventions to be made accessible to the entire population, the Ministry of Health will design extra basic packages for needy groups. Institutional responsibilities for the delivery of such packages will be assigned through a process of consultation.

c. .Financing mechanisms, including cost-recovery, will not be implemented unless accompanied by exemption policies and mechanisms targeting the most needy (the elderly, disabled, Amerindians, etc.), other categories of the medically indigent, and the poor (e.g., the employed poor falling in the group of people at minimum wage; the unemployed; single-parent or single-earner households; the homeless; youth with no formal education and no job). This issue is also addressed in the section on health care financing.

d. .Special health needs of vulnerable groups will be identified and attributed adequate priority. For example, the availability of drugs and access to physicians for the elderly poor, is essential for the wellbeing of this vulnerable category. Targeting groups with certain well-identified health needs will help address their poverty status.

.....K. Policies by Stages of Health Care

....

. 1. Primary Health Care

As is made clear throughout this Annex, a well-designed primary health care service operated by a full complement of well-rewarded staff is the key to real improvement in the nation's health services. The policy objective is to ensure greater emphasis on Primary Health Care activities and their co-ordination, utilising the strategy of Health Promotion,

-

education, and the empowerment of the individual to take responsibility for his or her health. The Primary Health Care philosophy adopts a holistic approach that encompasses a full range of services, including preventive, curative, supportive and rehabilitative, and is founded on a thorough understanding of the broad determinants of health. The PHC philosophy also incorporates services delivered at all levels of the health care system, including those at the secondary and tertiary care levels. In fact, it emphasises the need to carry out awareness-raising activities on the importance of "preventing" rather than "curing" at all levels of the health care system.

The Ministry of Health has recently adopted a programmatic structure, in which responsibility for Primary Health Care now lies within the PHC and Health Education and Disease Control Programmes. As already mentioned, PHC priorities have been identified in the areas of immunisable diseases and prenatal problems, malnutrition and diarrhoeal disease and the problems of maternal mortality. Improved Primary Health Care will help greatly in reducing the incidence of all these syndromes.

Another central point of the analysis in this Annex is that in order to strengthen PHC services, it is essential to increase emphasis on improved delivery in the hinterland, which includes the most disadvantaged areas. Resource allocations will reflect the existence of inequities due to the geographical features of Guyana. For example, disadvantaged areas will be allocated adequate resources to purchase transportation for the delivery of preventative services and emergency cases. New modalities such as contracting out of transportation services, purchasing of external transportation and renting of vehicles will be investigated.

The public health sector will benefit from synergies through collaboration with Non-Governmental Organisations. Such collaboration, which will also include contractual agreements between the Government sector and NGOs, will help to solve the resource and managerial bottlenecks that the public health sector faces when delivering services in hinterland areas. Moreover, inter-institutional co-ordination will be strengthened, for example, with the school systems, the water management authorities, immigration officials, and the GDF.

Besides these general strategies in PHC, the following specific ones apply:

Health Education

(i) Health education will become an integral part of the day-to-day health services given to patients and the community. This will include the strengthening of counselling and informational services given to patients.

(ii) .....The curricula of schools will be reviewed to ensure that health education forms an integral part of their content.

(iii) .....Adolescent health issues will be tackled through educational programmes within schools, in collaboration with school welfare departments and social workers.

-

(iv) .....Public awareness programmes to sensitise people about the dangers of smoking will be strengthened.

a. .Nutrition

Education on nutrition and healthy lifestyle will be brought into schools. Campaigns to reach the entire population will also be strengthened.

Improved nutritional care will be provided in hospitals, through recruitment of dieticians and provision of diet counselling.

Materials on nutrition and healthy lifestyles will be incorporated into all health education programmes.

Monitoring of the nutritional status of the population, especially the most vulnerable groups, will be carried out on a regular basis.

Environmental health services

An environmental health information system will be developed to support programme planning, monitoring and evaluation in this area.

Educational programmes on environmental health will be inserted in school curricula.

The number of Environmental Health Officers will be increased, and training programmes on environmental health updated and improved.

Environmental legislation will be reviewed and regulations drafted in the following areas, which yield high risks to health:

Building Codes (both for private and public buildings and the work environment), in order to establish safety standards, ensure the availability of facilities for persons with special needs, and promote healthy environments. All offices and factories will have no-smoking zones.

Waste disposal, provision of facilities for the collection of litter and used batteries, aerosol cans, old refrigerators, etc.

Levels of noise pollution.

Use of insecticides and pesticides in agricultural activities.

Public Transportation Code, to ensure safety standards.

-

Food manufacturing and sale, even in the smallest cottage industries, in order to set minimal standards and avoid food contamination.

Enforcement of legislation/regulation will be improved. Interagency collaboration, including for example, administrative bodies, policing groups, and Public Health Inspectors, will facilitate drafting and enforcement of regulation.

The environmental health education programme will deal not only with issues such as contamination of food and water, vector control, and the role of diet, but also with the need for behavioural change aimed at reducing deaths and injuries due to traffic accidents, occupational accidents, and other violence.

Co-ordination will be sought with city and local governments on improved programmes of drainage and spraying.

Maternal and child health

In addition to programmes already outlined, regular medical visits, and dental and hearing care checks will be made throughout the country's primary school system, in collaboration with the education sector.

. 2. Secondary and Tertiary Health Care

Strategies in secondary and tertiary health care have already been fully covered.

....3. Vertical Programmes

a. . Vector control

(i) A National Policy Paper on the approach to the control and surveillance of vector-transmitted diseases and a three-year Plan on Malaria Control will be prepared.

(ii) .....The vector control programme will be revised and modified to become a National Advisory Board with the tasks of monitoring, research, emergency and crisis response, and the preparation of technical guidelines for guidance in the execution of programmes. Execution of programmes will occur at various sections of the national (private and public) health care system.

(iii) .....Wide inclusion of the community in the management of these diseases and vectors will be organised.

(iv) .....A national policy concerning the control of vector-transmitted diseases will be prepared, containing national strategies and technical guidelines for the control of the diseases.

(v)Other measures to reduce the incidence of vector-borne diseases will include improved

-

environmental health and specifically designed campaigns. For example, the Ministry of Health will launch a campaign for the eradication of filaria in the near future. The implementation of the campaign will be facilitated by support from donor agencies.

b. .Sexually-transmitted diseases

STDs and HIV/AIDS constitute priority areas for health intervention in Guyana. The "National HIV/AIDS Prevention Plan, 1999-2001" recently prepared by the Ministry of Health will be thoroughly implemented, and funding from local and international organisations will be secured accordingly.

c. .Chest diseases/Tuberculosis

Measures to treat the entire population suffering from acute respiratory infections will be strengthened in all affected areas.

d. .Dental care

Outreach activities will be strengthened and mobile clinics created. Continuous efforts will be made to expand these activities, including improved oral health education.

e. .Veterinary public health

(i) Current food legislation will be amended. Increased training and continuing education will be organised for the veterinary public health staff and widespread transport will be made available.

(ii) .....Quarantine provisions will be introduced as required.

VI. Legislative Changes

Health legislation in Guyana is either non-existent or outdated and thus, ineffective. The absence of legislation affects standards and norms with respect to the monitoring of health situations and activities. Appropriate legal instruments will be reviewed, updated and developed to support the implementation of health policies. Revision of existing legislation will ensure that the Ministry of Health has the legal mandate to operate and create the legal framework within which the public and private sectors operate.

New legislation will to be drafted to reform and strengthen the institutional aspects of the sector. The juridical basis for the establishment of Regional Health Authorities and for greater autonomy of the hospitals will be laid. The establishment of the Hospital Board at the PHG, and its composition, are mandated under the Public Corporation Act (Public Hospital Georgetown Order, No. 3/1999, laid in Parliament on July 1, 1999). The Board

-

composition and governance structure of hospitals and RHAs will influence the degree of autonomy, independence and accountability of devolved organisations, and therefore the degree of success of this type of decentralisation strategy. An appropriate legislative framework will be specifically laid for the health sector rather than adapted from the Public Corporation Act.

A draft Health Facility Accreditation Act has been completed and is now being reviewed by the Parliamentary Counsel. The accreditation Bill will be complemented by a Health Facility Act, aimed at establishing rules for licensing health facilities; standards to be met by health facilities, both private and public; periodic visits and inspections to be carried out at hospitals to verify that the standards are met.

Management reforms require legislative changes. Currently public service rules constrain flexibility in the health sector. De-linking devolved authorities from public sector rules requires adequate legislative support.

Legislative changes in the Hospital Administration Act are also necessary for hospitals to enjoy greater financial autonomy. The autonomy granted to health institutions and RHAs will include the possibility of retaining revenues raised. The Hospital Fee legislation (Hospital Act) will also be updated to ensure a more effective system of managing revenues and fees. Lastly, legislation will be necessary for developing health insurance mechanisms, including a revision of the role and functions of the NIS.

Supporting legislative mechanisms are necessary for restructuring the procurement and distribution of pharmaceuticals. Existing legislation in this area is outdated and implementation is defective. A Materials Management Order has recently been drafted. An Act will also regulate pharmacists' practice within both the public and the private sectors.

Regulation will also be required for the Ministry of Health to assume its new steering role. Effective mechanisms to regulate prices, quantities and quality will be needed in a reformed health sector. The degree of regulation required within the Guyanese health sector has to be ascertained. The Ministry of Health will have to trade off the benefits of regulation against its information and enforcement costs.

-

In Guyana, competition among providers is limited, and does not effectively determine quality, prices and quality. Market mechanisms may therefore not be able to exert effective disciplinary pressures. The need for regulation in a number of areas is therefore strong. Ultimately, if the standards of care in the public facilities improve, disciplinary pressures on the quality and standards of private practice might follow simply from competitive pressures.

Regulation is necessary in the following areas:

Quality: Minimum standards of care for the private sector; licensing and accreditation of facilities and professionals; private practice by public physicians; staff regulation at facilities and minimal information to be disclosed to patients.

Prices and Quantities: Controls over the purchase of equipment and the expansion of capacity in order to contain costs; and regulation of the manufacture, distribution and sale of drugs.

Lastly, the updating or drafting of specific legislation is needed in other areas, including the Food and Drugs Act, the Public Health Act, the Mental Health Act, and the Hospital Administration Act. Legislation related to HIV/AIDS, privacy, and family leave needs will also be drafted or revised. A list of proposed legislative changes is included at Appendix.

-

Appendix A

PLAN OF ACTION, FINANCING HEALTH CARE

	Technical Expertise required	Action planned	Time frame	Executing Agency & Responsibilities
Legislative requirements				
Revision of hospital fees regulation RHAs Act Revision of NIS	- Legal expertise. - Policy makers within the health sector. - Technical staff.	- Regional Health Authorities Act will have financial autonomy within MOH guidelines and accountability systems. - Revision of hospital legislation and financial legislation to allow cost recovery and revenue retention at the corporatised PHG, other hospitals, and RHAs.	- RHAs Act by year 2000 - Other legal requirements tackled by year 2001	- Minister - Cabinet - Parliament Challenges: 1. Revision of Financial Administration and Audit Act 2. Revision of the Constitution of Guyana

-

Managerial and institutional issues				
1. Establishment of administrative, financial and accounting systems 2. Establishment of monitoring mechanisms	- Financial accounting, financial management and information technology - CEO and financial managers of relevant institutions - Technical Assistance	- Administrative and managerial strengthening through institutional reforms and Technical Assistance - IDB TC Project - UNDP TC Project	- by year 2001	- MOH - PHG
3. Establishment of managerial systems and development of expertise	- Management expertise - Technical Assistance	- Managerial strengthening through institutional reforms and technical assistance - IDB TC - UNDP TC	- by year 2001	- MOH - PHG
Preparation of fee schedules and cost-recovery strategies for each health facility	- MOH officials - Management staff at each institution	- Ad hoc cost-recovery strategies for each programme	- on-going	- MOH - PHG - Managers of departments / services

-

PLAN OF ACTION, FINANCING HEALTH CARE				
	Technical Expertise required	Action planned	Time frame	Executing Agency & Responsibilities
Policy issues				
1. Determination of exemption policies	- Health Planning & Health Economics - MOH technical and policy-making staff - Technical Assistance	- Formulation of guidelines for exemption policy at PHG and other health programmes	- Policy framework by the year 2000	- MOH - SIMAP
2. Development of policy documents including alternative modalities for financing health care (health insurance)	- Health Planning, Health Economics. - Policy-makers and technical staff, Ministry of Health	- Studies on alternative modalities of financing health care and improve resource allocation mechanism	- Presently under way - Policy framework for finan	- MOH - Technical Assistance

-

		s.	cing healt h care by end of 1999	
3. Decentralis ation	- MOH technical and policy staff - Technical Assistance	- Establishm ent of RHAs & hospital Boards	- By year 2001	- MOH - Techn ical Assist ance

Appendix B

Guyana Sugar Corporation (GUYSUCO) Health Services

The health services of the sugar industry were established in 1838. Since then the Corporation has undergone various changes. Today, it provides health care services to 20,000 employees and

-

80,000 dependants.

The mission of the organisation is to maintain "A healthy and productive workforce", through "Health Promotion and Disease Prevention".

Objectives

a). To place the employee in work suited to his or her physical, mental and emotional capacities and which can be performed without danger to the worker, or fellow employee or damage to property.

b). To protect the health and well-being of the worker against stress and potential hazards in the work environment.

c). To provide emergency medical care for injured or ill workers, as well as specific care and rehabilitation for persons with work-generated injuries or illnesses.

d). To maintain and improve the health of the worker and family through educational and informational activities, preventative health measures in the community, and clinical reviews.

Physical Facilities

The Corporation consists of eight grinding factories extending on the coastland of Guyana from Skeldon on the Corentyne of East Berbice to Uitvlugt on the West Coast of Demerara. There are 16 Primary Health Care Centres and 2 Diagnostic Centres (one in Berbice and the other in Demerara).

Programmes:

Occupational Health and Safety

Evaluation studies at the workplace – noise, light, dust and heat

Environmental surveillance

Accident investigations

Education and Training

Health Promotion

Fitness – e.g., walking, jogging, diet and nutrition

Stress Management – meditation

Organised Sports programme e.g., cricket, football, athletics, cycling, etc.

-

Health activities at Community Centre and schools

Health Education

a) Information dissemination on chronic illness, e.g., diabetes mellitus and hypertension

b) Healthy lifestyle – diet, weight management, etc.

c) Infectious Disease – diarrhoeal disease, etc.

Diagnostic Service

X-ray, laboratory, ECG, spirometry, audiometry, vision testing, etc.

Curative

a) Ambulatory Care

b). Special clinic for chronic illness

Emergency Care

Minor accidents and illness

Referral by ambulances to external health facilities

Preventative

Medical Surveillance Programme

Pre-employment and Pre-placement Medical Examination

Annual Medical Examination for senior and junior management staff - approximately 1200

Annual Medical Examination for all employees above 40 years – approximately 8000

Biannual Medical Examination for high risk workers – approximately 2000

Example

-

- . Chemical Workers

Drivers and Chauffeurs

Workers exposed to noise, heat, varying light intensities, dust and fumes
Food handlers

Security workers

Workers above 60 years

a) .Immunisation against tetanus

b) .Maternal and Child Health Programme for workers and spouses

- . Ante-natal Care, Post-natal Care
- . Domiciliary delivery
- . Family Planning Services
- . Health Education in breast feeding, diet and nutrition

There are very limited rehabilitative services in GUYSUCO in the form of educating patients to perform basic active physiotherapy and hydrotherapy at home. Those needing specialist care are referred to external facilities.

Occupational safety and health and sport services are separate units. There is, however, close collaboration between these units and the community through the Community Centres located in all estate communities.

Human Resources

GUYSUCO's medical services are headed by a Chief Medical Officer, with five Estate Medical Officers covering the peripheral Health Centres.

The Health Centres are manned by a Medex (physician assistant), Staff Nurse/Midwives and Nursing Assistants. All cases are seen by the Medex. Simple cases are treated by the Medex and the complicated cases are referred to the Medical Officers. Each Medical Officer covers between 3-4 Health Centres. The Medical Officers refer to the two Diagnostic Centres for further investigations and treatment.

Secondary and Tertiary Care are extended to managerial employees through a Contributory Medical Insurance Scheme.

The Corporation bears the cost for the Medical Services and have found them

-

very cost-effective in terms of maintaining a healthy work force, increasing productivity and production, reducing mandays lost through illness and accidents, and generating fewer medical expenses for its employees.

The Medical Services are continuing their quest to provide optimum quality care to their clients and reduced costs to the Corporation.

Total costs for 1998: .....
No. of Workers in Industry: .....
Costs per worker: .....
Employees' Contribution to Medical Scheme: ..... G$9,01

-

Appendix C

Status of Health Legislation

LEGISLATION	STATUS
1. Regional Health Authority Act	Policy paper completed, which includes draft legislation. Consultation for possible revision or implementation is in progress.
2. Georgetown Public Hospital Order	Placed in Parliament on July 1, 1999.
3. Materials Management Order	Draft ready
4. Health Facilities Accreditation Act	Draft ready. Consultation completed. Draft being reviewed by the Parliamentary Counsel
5. Public Health User Fee Regulation	Not done
6. Allied (Paramedical) Health Practitioner Act	Initial draft ready.
7. Amendment of the Medical Practitioner Act (1991)	Draft sent to medical practitioners. Changes agreed to. Now being readied for presentation to Parliament.
8. Amendment of the Registration of Nursing Profession Act (1953)	Draft being discussed by Nursing Council
9. The Guyana Food Inspection Agency Act	Not done
10. Public Health Act	Not done
11. Amendment of the NIS Act	Not done
12. Guyana Cancer Board Act	Draft ready
13. Mental Health Act	Not done
14. HIV/AIDS	Draft ready
15. Centre for Disease Act	Not done

-

Chapter 19

LIST OF ACRONYMS

ACDS	Ambulatory Care Diagnostic Surgical
Bermine	Berbice Mining Enterprise
CAREC	Caribbean Epidemology Centre
CARICOM	Caribbean Common Market
CH&PA	Central Housing and Planning Authority
CIDA	Canadian International Development Association
CT	Computerised Tomography
ECG	Electro-Cardiogramme
EPI	Expanded Programme of Immunisation
EU	European Union
GAHEF	Guyana Agency for Health Science Education, Environment and Food Policy
GDF	Guyana Defence Force
GDP	Gross Domestic Product
GUM	Genito-Urinary Medicine
GUYSUCO	Guyana Sugar Corporation
GUYWA	Guyana Water Authority
HIES	Household Income and Expenditure Survey
HIPC	Highly Indebted Poor Country
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
ICD	International Classification of Diseases
IDB	Inter-American Development Bank
IMF	International Monetary Fund
Linmine	Linden Mining Enterprise
MOH	
NGO	
NIS	

1
-
....

PAHO	
PHC	
PHG	
RDC	
REO	
RHA	
RHO	
SIMAP	
STD	
UG	
UN	
UNDP	
UNICEF	
USAID	
WB	
WHO	

1
-
....