Ministry of Health, Guyana

National Health Plan 2003-2007

The Strategic Plan of the Ministry of Health

March 2003

Introduction

Government is engaged in a programme of significant restructuring of the nation's health services and the health sector. This *National Health Plan (NHP) 2003-2007* outlines a strategy for the health sector over the next five years, which aims to achieve major improvements in services and the nation's health.

The *NHP 2003-2007* is a technical document for use by the Government of Guyana (GOG), our development partners and by all other stakeholders in the sector. The *NHP 2003-2007* focuses on the strategic intentions of government, the policy directions for change and the priority actions to be taken. Under the new structural arrangements proposed, service delivery and decision-making related to such services would be devolved to managers at regional and district levels.

The *NHP 2003-2007* has been developed from:

- Evaluation of the outcome of the previous health plans
- Estimations by the various technical programmes of the priority health needs
- The experience of the ongoing health sector reform programme which, over the last five years, has evaluated the performance of the Ministry of Health and made recommendations for the improvement of the health sector, including reform of the organizational arrangements
- A services review which has identified the key issues that need to be addressed for the modernization of health services
- Consultation with key stakeholders in the public, private and NGO sub sectors about the issues and challenges facing them in providing and receiving health services.

In addition, the Plan has taken into consideration the following policy documents:

- The National Development Strategy
- The Poverty Reduction Strategy Paper
- The Millennium Development Goal
- The CCHI
- Other international health charters to which Guyana is signatory.

The Ministry of Health has prepared this *NHP 2003-2007* with technical support from the Institute for Health Sector Development and with funding support from the Inter-American Development Bank. It aims to involve all players in the process of improving and maintaining health. It does not contain the technical details of the various health programmes like Maternal and Child Health, Malaria, and HIV/AIDS, which can be found in the technical documents of those programmes. Neither does it provide the details of the technical analysis that supported the process of agreeing on the overall direction and priorities for the next 5 years. These are provided in Technical Annexes to the NHP and are available on request.

Rather, the purpose of this document is to:

- Provide a strategic framework for the sector with coherent goals, objectives and targets for the next five years
- Indicate the level of investment and recurrent costs required for achieving those goals, objectives and targets
- Guide the participation of all stakeholders in health development
- Facilitate monitoring of the performance of the sector at all levels.

The *NHP 2003-2007* will be used to allocate new financial resources and to begin to reallocate existing resources in a more equitable, cost effective, information-based and target-driven way. It will support the technical programmes in the implementation of their activities and improve the integration of services across diseases and disciplines. It will refocus the Ministry of Health on strengthening its policy development role and support the achievement of the Poverty Reduction Strategy (PRS) goal of increasing access to social services including education, health, water and housing.

Implementation of the *NHP 2003-2007* has already begun and key steps are being taken to lay the foundations for a more modern health care system with complementary roles for public and private sectors. This new health plan seeks to encourage the fledgling leadership evident today in the public health sector and to enhance various public health initiatives for which Guyana is rapidly gaining recognition. For example, the Filariasis Elimination Initiative through which salt has been fortified with a therapeutic (DEC) intervention, the food coupon program to be introduced for mothers of children between the ages of 6 and 24 months, the provision of locally produced antiretroviral drugs for HIV+ persons and the PMTCT++ program, the registration process for laboratories and the Hospital Inspectorate and several other programs demonstrate the leadership role that the public sector has already began to play.

The NHP 2003 –2007 must be viewed as a dynamic document. It is subjected to annual review and there would be an annual report reviewing the progress in its implementation and also changes in the plan.

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Figures and Tables

Acronyms

ARI	
CCHI	
CE(O)	Chief Executive (Officer)
CPD	Continuous Professional Development
DP	Development Partner
GMC	Guyana Medical Council
GOG	Government of Guyana
GPH	Georgetown Public Hospital
GPHC	Georgetown Public Hospital Corporation
GSLC	Guyana Survey of Living Conditions, 1999
HIPC	Highly Indebted Poor Country Initiative
HIS	Health Information System
HMC	Health Management Committee
HRM	Human Resource Management
HSDU	Health Sector Development Unit (Ministry of Health)
HSEU	Health Sciences Education Unit
HV	Health Visitor
IDB	Inter-American Development Bank
IHSD	Institute for Health Sector Development – London
IMCI	
I-PRSP	Interim Poverty Reduction Strategy
MDG	
Medex	Medical auxiliaries
MMU	Materials Management Unit
MINISTRY OF HEALTH	Ministry of Health
NHP	National Health Plan 2003-2007
NIS	National Insurance Scheme
NDC	Neighbourhood Democratic Council
NDS	
NPP	National Priority Programme (combining certain vertical programmes)
PRSP	
PSM	
RDC	Regional Democratic Council
REO	Regional Executive Officer
RHA	Regional Health Authority
RHO	Regional Health Officer
PMU	Project Management Unit
PRSP	Poverty Reduction Strategy Paper
PSM	Public Service Management
SIMAP	Social Impact Amelioration Program
SON	School of Nursing
UGMS	University of Guyana Medical School

1 Executive Summary

The **overall objectives** of this *National Health Plan 2003-2007* (NHP) are to:

- Improve the nation's health, leading to increase of Life Expectancy
- Support the Poverty Reduction Strategy, and the goals of the National Development Strategy and the Millennium Development Goals (MDG)
- Achieve good value for money in the sector – public and private.

The **Specific Objectives** of the NHP are designed to address priority issues in the health sector. Services will target priority problems by identifying the critical health challenges, the main causes of ill health and the main groups of people affected by them. The NHP would address the PRSP's goal of decreasing inequities in the Guyanese society by the reduction of mortality, morbidity and disability, particularly among poor and marginalized populations. To do this, the NHP aims specifically to:

- Reduce excess mortality (deaths) and morbidity (illnesses) of mothers and infants, vital indicators of performance and achievement in the health sector. Special emphasis will be placed on the immunization, nutrition and ARI programs and on healthy growth and development. IMCI programs would be expanded.

- Reduce communicable diseases – these are leading causes of death, illness and loss of productivity, particularly HIV/AIDS, Tuberculosis, Malaria and Dengue. Specific programs for the elimination of Hansen's Disease and Lymphatic Filariasis by 2010 are to be accelerated. Targeted programs for the reduction of ARI would be introduced.

- Contain chronic non-communicable diseases, which are becoming even more important - specifically diabetes, heart disease, cancers and accidents.

- Manage mental disorders, especially depression and substance abuse. Specific programs for the reduction of suicide rates would be introduced.

- Enhance rehabilitation services and expand intervention services for the disabled.

- Ensure that poor people have equitable access to quality health services.

- Ensure optimal collaboration with other sectors, which have important roles in building an empowering health environment, including education, housing, security, water and sanitation, safe transport system and food safety.

- Promote healthy lifestyles and reduce risk factors to human health that arise from the environment, economic, social and behavioral causes. Special attention would be focused on reduction of behavioral and environmental risks, including occupational health hazards.

- Develop health systems that equitably improve health outcomes, respond to people's legitimate demands and are financially fair. In particular, to ensure universal access to integrated, equitable and sustainable health systems and ensure adequate provisions for disaster preparedness, management and response.

Important Links: Bad health keeps families in poverty. Better health gives them a chance of working their way to more prosperity. The NHP aims to ensure that poor people have access to good health services (a major goal of the PRSP and the MDG). But other sectors also have important roles including education, housing, security (personal and national), water and sanitation, safe transport systems and food security and the NHP seeks to establish greater inter-sector collaboration.

Accomplishing the objectives: The success of health services depends significantly on the organizational structures within which they are produced and delivered, and the management and staff that make them work to produce services cost effectively. Success also depends on the physical and technological infrastructure of the sector. To make the most of the resources available, the NHP aims to ensure that:

- Money is allocated to where it buys the most.
- Services are better managed and systems are established
- Governance is strengthened
- Empowering individuals and communities for greater participation in decision-making and the delivery of health services

1 Moving money to where it buys the most

The NHP aims to achieve changes in a number of areas by:

Identifying Priority National Programs: In the Ministry's efforts to ensure that a comprehensive health service is accessible to Guyanese, Guyana's health indicators are brought into consonance with her CARICOM partners and

that the country meets its obligations under the MDGs and the PRSP, the NHP has identified a number of priority programs, each with its own strategic program (Annex 1). These programs have been grouped as follows: Family Health, Communicable Diseases, Chronic Non-Communicable Diseases, STI/HIV/AIDS, Oral Health and Environmental Health.

National Priority Prog.	Component Programs
Family Health	MCH (including IMCI), EPI, RH/Family Planning, Adolescent Health, Elderly Health, Clinical Services for ARI and ADD
Communicable Diseases	TB, Malaria, Filariasis, Dengue, Leishmaniasis, Chagas, Hansen's Disease, Yellow Fever
STI/HIV/AIDS	STI/HIV/AIDS
Chronic Non-Communicable Diseases	Risk factors, Chronic Disease Management, especially cardiac Diseases, Diabetes, Hypertension, Cancer, Emerging CNCD Needs, Mental Health, Rehabilitation Medicine
Oral health	Dental and Oral Health Services
Environmental Health	Environmental Health, including Occupational Safety and Health, Disaster Preparedness, Vector Control (Non-Clinical Services), Veterinary Public Health

Special Projects: Special projects to alleviate sufferings of persons who could benefit from surgical and medical interventions are planned. These projects include the reduction of backlogs for cataracts, hydrocele, fibroids etc., cancer therapy, dental conditions, diagnosis and interventions for poor hearing and sight (low vision). The NHP aims to strengthen collaborative programs with international and local partners to enhance various clinical interventions, including hip and joint replacements and certain cardiac cases.

A state-of-the-art cancer treatment and a cardiac center would be established through collaborative arrangements. The existing Burns Center would continue to be enhanced.

Getting services adequately staffed (Developing a human resource plan): In the short-to-medium term, there is no way to realistically increase significantly the number of staff employed in the public sector. For the foreseeable future, many of them will continue to emigrate and our training capacity would continue to be limited. Instead, the NHP aims to make the best use of those staff available. The major problem is that staff is spread too thinly. In future, they will be consolidated into a smaller number of service units but with each providing a full staffing. For example, significant reductions in maternal and infant mortality will not be achieved unless the safety of labour and delivery are improved. This needs concentration of skills into fewer, better and busier units. Similarly, the quality and efficiency of surgery will not be improved unless services are concentrated into fewer units with better facilities, higher patient volumes and better-practiced staff. Whilst some patients will have to travel further to reach a health center or hospital, they will get a much better service when they get there.

The NHP aims also to increase production of those staff in short supply. Training programmes are to be modernized and recruitment methods improved, but the policy of consolidation is most likely to get results quickly.

In this regards, the NHP further aims to define the health team, in general, and for each level (level 1-5) of health care delivery. A workforce projection plan would guide existing and new training programs.

Improving the quality and incentives of staff: The NHP aims to introduce performance management. Under this, individual staff will work with their managers to set individual targets that link clearly to the targets of the HMC as a whole. What is expected of staff will be clearly spelled out, and rewards including promotions and training opportunities will be related to performance. In addition, a major new in-service training programme is planned – continuous professional development – that will become mainstreamed into the health service. The Ministry of Health, in collaboration with the London School of Tropical Medicine and the PAHO has embarked on a major post-graduate training program for public health administration. At least twenty persons would pursue distance learning for Master level training in Public Health Management, Epidemiology and Drug and Alcohol Policy. With better management, more clarity in performance, and better training – and with staff working in busy units where they know they are doing a better job – the NHP aims to improve the attitudes of staff towards patients, clients and the general public. This would contribute to the enhancing of the image of the health sector.

Improving physical and technical infrastructure: The physical and technical improvements to GPH have been appreciated by the public and have drawn in more patients.

Improvements elsewhere will have the same effect and the NHP aims to ensure that these improvements take place in those hospitals, leading to more efficient and effective service overall. Some hospitals would continue in the long term to be affected by staff shortage and several of these hospitals would also not be busy enough in the foreseeable future to offer a full, high quality service because there are not enough consumers to keep them busy. These hospitals would have their services modified to better provide services to people. For example, some community hospitals will be converted to polyclinics and some health centers to health posts. This would allow for the consolidation of hospital beds and staff. The following hospitals will be developed into Regional Hospitals: Lethem, Bartica and Mabaruma Hospitals. Hospital services at several hospitals, including Upper Demerara, Charity, Lenora, Port Mourant and Mibikuri Hospitals, would be reviewed. A new polyclinic would be built in South Georgetown as part of the service plan for the GPHC. New hospitals would be constructed to replace existing hospitals at New Amsterdam, Lethem and Linden/Wismar. A new In-patient facility would be constructed at the GPHC to consolidate all in-patient activities at the GPHC. Significant rehabilitation or reconstruction will be carried out, especially at Port Mourant, Bartica and Mabaruma Hospitals. Operating Theater, Laboratory, Radiological, Rehabilitation, Audiological and Dental services would be improved in all Regional Hospitals. Greater emphasis would be placed on the development of an efficient bioengineering department.

The Microbiology Laboratory at GPHC would be considerably strengthened through the CIDA project. Similarly, a Center of Excellence for Laboratory work would be established through the efforts of USAID and CDC at the GPHC. This lab would serve as the nucleus of the National Public Health Laboratory.

Improving the procurement, storage and distribution of drugs and supplies: To improve drugs and supplies, the Materials Management Unit (MMU) will be modernized and work has already begun on this. For the moment the procurement, storage and distribution of drugs will remain a central function supplying the services run by the HMCs. But the MMU will be run with a services agreement with Ministry of Health. This will specify the performance required from MMU and MMU will be required to produce a business plan setting out how it will meet its targets. An oversight committee chaired by the Minister and including the PS, the CMO, the Director of Regional Health Services, The Director of Standards, the CEO of the GPHC, a representative of the Ministry of Finance and three RHOs would serve to monitor the work of the MMU.

The MMU would be guided by the availability of an essential drug list (EDL) and would become part of the international drug pricing comparison initiative that compares costs of drugs in different countries. An attempt would be made to standardize equipment and supplies within the public sector and encourage the private sector in keeping costs down.

Efforts would be made to improve data within the MMU, including procurement and distribution data. Training would be provided to health care workers on the preparation of consumption reports to assist in information-based decision making in terms of procurement and planning.

The work of the MMU would benefit through a revised role for the Chief Pharmacist at the Ministry of Health and procurement, storage and distribution would be guided by pharmacists within the MMU structure.

Biomedical/Hospital Wastes: Major advances are planned to deal with biomedical wastes. The New Amsterdam Hospital would be equipped with an incinerator and this would deal with biomedical wastes from Regions 5 and 6. Biomedical wastes from Regions 3 and 4 would be dealt with through either the solid wastes program for the Municipality of Georgetown (a GOG/IDB Project) or if this project fails to materialize, through an incinerator project at the West Demerara Hospital. An incinerator would also be built as part of the new Linden Hospital.

Getting more out of the private sector: The NHP aims to encourage the private sector and to ensure that it provides good standards. The best way to do this is to out-source some services to the private sector and NGOs and to define the standards required. In time, it is envisaged that the HMCs will be able to do this. This will create healthy competition with the public sector. In addition, the enhanced role of the Ministry of Health will include regulation of the private sector to ensure minimum standards and to keep out untrained and unregistered personnel.

2 Getting services better managed

Delivering services that are more responsive to local needs, more efficient and more user friendly requires managers to have more authority over how they run services and to be more accountable for their performance. They must have incentives to utilise available resources better - including staff resources.

This means **effective decentralisation**. The 10 RDCs have not succeeded in providing this. For one thing, the health management skills available are limited and cannot be replicated ten times. Also, the RDC management processes are just not responsive enough. And as public sector employees, staff are still accountable to the PSC, not to managers.

Creation of Health Management Committees: The NHP will create 4 or 5 Health Management Committees (HMCs) to cover the country. Each will have extensive control over resources including staff. The Public Corporation Act will be employed for this, as it was for Georgetown Public Hospital Corporation (GPHC). The major difference between the HMCs and GPHC will be that the HMCs will be accountable for the health of their whole communities, not simply for the efficient running of a hospital. This means they will have to clearly establish needs and priorities.

HMCs will be phased in starting with the Berbice HMC and the Linden HMC. In the next 6 months, the system will be tested to ensure that, from the next financial year, budgetary flows and lines of responsibility have been agreed between MoF, MoLG, Ministry of Health and the RDCs. The HMCs will have boards and will receive technical assistance through the Ministry of Health as they begin their work. At the point of corporatisation, staff will transfer employment to the HMCs, as was done for GPHC.

In time, the HMCs will receive their funding based on population needs and defined in service agreements with Ministry of Health. These will specify targets for services and quality standards based on the NHP. But within those targets, the HMC board will have much freedom to decide how best to use resources to solve local problems.

3 Strengthening governance

Modernization of the Ministry of Health: As the HMCs take on services management, the central Ministry of Health will change to perform a governance role to ensure that HMCs are all acting in the national interests. The ministry will be restructured to do this. It will introduce annual service agreements with the HMCs which will ensure funding is allocated to priorities and that targets are set for HMC spending.

Strengthening of public health leadership and advocacy capacity (Health promotion): The Ministry of Health will develop a national advocacy role – at policy level and with the population at large. At policy level, the Ministry of Health will work actively with other ministries like education to achieve national development targets. A nationwide health education capacity will be developed to improve peoples' knowledge and change their behaviours. This will impact on key health problems, for example:

- Better educated girls and mothers will reduce maternal and infant deaths and ill health
- Better educated children and adolescents of both sexes will reduce HIV transmission rates
- Better educated consumers will take some responsibility for their health: they will eat better, avoid being over weight and will not smoke – reducing diabetes, hypertension, heart disease and cancer rates.
- Better-informed employers and employees would reduce work place related illnesses, injuries and disabilities.

Success in reducing these rates will prevent much hospital expenditure and enable that money to be spent on unavoidable illnesses.

Defining a publicly guaranteed basic package of health care services: The Ministry of Health will increase its efforts to identify a basket of publicly guaranteed health care services so as to improve qualitatively and quantitatively the services provided using public resources.

Establishing an Ambulance Authority: Getting people to relevant and appropriate health delivery centers would be a major activity within the health sector. In this regard, we would establish a national ambulance authority.

Improving availability and access to information on epidemiological situation and system performance for policy and planning: Informed decision-making would represent a fundamental change in managing the health sector. The present gaps in information about health conditions in Guyana would be addressed. The CIDA surveillance system program would enable the sector to develop a strong surveillance system. Information would also be strengthened by the DSS and BSS that are to be pursued with the help of USAID, CDC, PAHO and UNICEF.

Improving legal and regulatory framework: Finally, the legal framework within which the health sector functions would be modernized. For example, the Public Health Act, which is approximately 70 years old, would be replaced. Similarly, the Food and Drugs Act would be modified and the old Pharmacy and Poisons Ordinance would be replaced. A new Health Facilities Bill is being prepared to replace the old Private Hospitals Act. The Hospital Inspectorate would be strengthened and would be required to

inspect all health facilities (private and public). All health professionals would be required to register and regulations would cover all health professionals. Efforts would be made to ensure comprehensive regulations are developed to regulate the various professions. Already registration mechanisms exist for doctors, dentists, pharmacists and nurses and veterinarians exist. Similar registration processes are being developed for paramedical professionals.

4. Empowering communities and individuals for greater participation in decision-making and delivery of health services: The creation of Health Management Boards for regional health services and management committees for management of individual health care facilities would expand the involvement of persons within the communities in delivery of health services in their communities. In addition, community advocacy groups would be established to provide feedback on performance of facilities and services within their communities. We will mandate engagements between health care facilities and the communities by making it compulsory for management and staff to have at least one meeting per year with the wider community to discuss issues affecting health care delivery in the community. In addition, a new program of community health monitor would be introduced. In this program, community members would be trained in providing certain home services for which community members would pay. These services include taking of blood pressure, measuring blood sugar by using the glucometer etc.

Summary: The *National Health Plan 2003-2007* aims to:

1. Allocate money to where it buys the most

- Develop and implement national Priority Programs
- Develop Special projects to reduce the burden of some common surgical and medical conditions.
- Develop a Human Resource Plan in order to make the best use of the staff available by consolidating services, defining the health team for each level of service, emphasizing team building and modernizing and expanding training programs
- Create more incentives and in-service training for staff including consumer relations, post-graduate studies through distant learning etc.
- Invest in technological and infrastructural improvements in those hospitals (and other units) that are really needed and are part of the national plan for services, including new hospitals at New Amsterdam, Linden and Lethem and a new in-patient facility at the GPHC
- Invest in laboratory and diagnostic services throughout the sector
- Modernize and create incentives for the MMU
- Enforce the Essential drug List
- Develop a medical waste program for the sector
- Encourage development of the private sector and, in future, the purchasing of services from it.

2. Improve the management of services and to enhance management systems

- Redesign the decentralization model presently in place
- Create HMCs to manage services better and with more accountability in order to enhance the decentralization model for health care services

3. Strengthen Governance

- Reform the role of the Ministry of Health for strengthen governance and advocacy and greater effectiveness in directing funding to needs
- Formalize health promotion program in order to strengthen advocacy role of the Ministry of Health and the health sector
- Define a publicly guaranteed package of health care services
- Establish an ambulance authority
- Strengthen IT in the sector and build a strong, reliable epidemiological information system
- Modernize the legal framework within which the sector operates

4. Empower communities and individuals for greater participation in decision-making and delivery of health care services

- Appoint community members to boards and management committees
- Establish community advocacy groups
- Introduce community health monitors to assist persons to assume greater responsibility for their health

2 Strategic Assessment of the Health Sector

2.1 Socio Economic Context

Political Context: Guyana, a former British territory, gained independence on 26th May 1966 and became a Republic in February 1970. An Executive President is both the Head of State and Government. There are several levels of government ranging from Parliament and Regional Democratic Councils (RDCs) to Neighbourhood Democratic Councils (NDCs) and Community Development Committees (CDCs). Members of Parliament comprise elected members, representing National Slates and Geographic Regions. The Ministerial system operates and the principle of collective responsibility prevails.

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

The State Planning Secretariat, Ministry of Finance is responsible for national planning. Sector plans feed into the national plan. A National Development Strategy for Guyana was formulated in 2000 by civil society and has set the policy framework for the development of national programmes and plans. The Ministry of Human Services and Social Security collaborates with other governmental and non-Governmental agencies in the management of social policy.

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

Economic Context: Guyana is the second poorest country in the Americas (after Haiti), with a per capita GDP of US$ 770.3 in 1999 and 35% of the population living below the poverty line – see Social Context below. From 1991-97, GDP grew at an average of 7.3% per annum but, following internal turmoil and external shocks, this growth trend has been difficult to sustain in the period 1988-2001: -1.8% in 1998; +3.0% in 1999; -1.4% in 2000; +1.4% in 2001 and 1.1% in 2002 (Table 1).

Agriculture, forestry and fishing accounted for 35.1% of GDP in 1999, with sugar being the main contributor. The mining sector accounted for 16% while services, manufacturing and construction accounted for 36.4%, 10.1% and 13.6% of GDP respectively.

In 1997 Guyana was declared eligible for debt relief under the Highly Indebted Poor Country Initiative (HIPC) and the Interim Poverty Reduction Strategy Paper (I-PRSP) was accepted in December 2000. Funds from debt relief are allocated to certain expenditures in the social sectors (education, health, housing and water) and to poverty alleviation programs.

Social Context: The last census for which information is available was held in 1991 and recorded a population of 718,000. Although the estimated mid-year population for 2000 is given as 743,004 (Bureau of Statistics), the country has been experiencing a stable birth rate and outward migration. Several surveys have estimated populations at levels closer to the 1991 census figure or less. The results of the 2002 census are expected in early 2003.

Approximately 29.8% of the population is under 15 and 9% less than 5 years old. The percentage of the total population over 60 is 6.7%. The *Guyana Survey of Living Conditions, UNDP, 1999* (GSLC 1999) states that approximately 29.7% of the population live in urban areas and of the 70.3% which live in rural areas, 61.3% live in the coastal parts of the country with relatively high population density and access to the urban centres. The rural interior is very sparsely populated. The GSLC 1999 also indicates that in 1999, East Indians represented 48.2% of the population, African/Black 27.7% and the Amerindian population 6.3%.

Table 1: Selected economic indicators 1992-2001

Indicators	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Per capita GDP in constant US$ prices	450	531	612	680	766	808.3	777.5	770.3	773	737.9
Total public social spending as a percentage of Total Expenditure	15.4	20.4	25.6	22.2	29.7	28.7	29.6	31.0	32.5	35.2
Annual rate of inflation	n/a	7.7	16.1	8.1	4.5	4.1	4.8	8.6	5.9	2.3

Source: Bureau of Statistics; National Development Strategy, Budget Estimates 1992-2001, MoF Reports.
Social Sector refer to expenditure in Education, Health , Housing&Water, Social Security (Youth & Culture not included).

Adult literacy is estimated as 98.3%-97.8% for females and 98.8 % for males in 1999. The gross enrollment rate for males at the secondary level was 67.2% and for females 68.9%. Enrolment at the primary ages was 92.8% and secondary 74.9%.

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

The lowest quintile accounted for 9.2% of total consumption and the richest, 39.2%, but this is an improvement over the situation in 1992/1993 when the figures were 4.0% and 55.1% respectively.

In 2003, Guyana ranked 92nd on the Human Development Index compared to a ranking of 103rd in the 2002 Report. Similar improvements were seen in the Gender-related Development Index (GDI) as Guyana improved from 80th position in 2002 to 74 in 2003. The GDP Index increased from 0.59 (2002) to 0.64 in 2003. The Gini coefficient for Guyana is given as 0.421 based on income and 0.413 based on consumption. (Human Development Report 2003, UNDP)

To address the social development of the Guyanese people, Government has very significantly increased its allocation to the social sector. For example, social sector spending as a % of total expenditure, which stood at 8.9% in 1991, was approximately 35.2% in 2001 (see Table 1). The estimated social sector spending for 2003 is 37.4%

The Poverty Reduction Strategy

The main goals of Guyana's Poverty Reduction Strategy (PRS) are:

- Sustained economic expansion within the context of a deepening participatory democracy
- Access to social services including education, health, water and housing
- Strengthening and where necessary, expansion of social safety nets.

To achieve these goals, the PRS rests on 7 pillars:

- Broad-based, jobs generating economic growth
- Environmental protection
- Stronger institutions and better governance
- Investment in human capital, with emphasis on basic education and primary health
- Investment in physical capital, with emphasis on better and broader provision of safe water and sanitation services, farm-to-market roads, drainage and irrigation systems and housing
- Improved safety nets
- Special intervention programmes to address regional pockets of poverty.

Table 2 shows the priority areas identified in the PRS.

The PRS budget is expected to increase allocation to health by about 30% of recurrent budget by 2002-2003. The NHP will be used to allocate this new money to key priority areas.

Table 2: Priority action areas in the Guyana Poverty Reduction Strategy 2001

Strategy Pillars	Priority action areas
Sustained economic growth	removing bureaucratic inertia through institutional and regulatory reforms reorienting the public sector to support private sector investment and improving infrastructure to complement economic growth
Governance	participatory democracy at the community level strengthening and deepening of the political dialogue strengthening of Parliament to conduct oversight supervision
Social Sector	improving access, relevance and equity
▪ Education	improving the quality of education and the conditions of service of teachers reducing overcrowding providing targeted subsidies to the poor
▪ Health	increasing access to quality health care by the poor improving the conditions of service of health care personnel taking measures to reduce the prevalence of STIs and HIV/AIDS reducing malnutrition
▪ Water	improving the poor's access to and the quality of water
▪ Housing	providing basic infrastructure in new schemes accelerating the processing of land titles setting up a revolving low income housing fund
Social safety nets	support of displaced workers due to restructuring of sugar and bauxite industries
Pockets of poverty	regions where extreme poverty levels are high programmes to support a sustainable livelihood

2.2 National Development Strategy

Chapter 19 of the NDS presents a proposed strategy for the development of the health sector to 2010. The following are the main strategic tasks identified in the NDS for the health sector:

- The restructuring of the Ministry of health to reflect a regulatory role and for the Ministry to divest responsibility for delivery of services
- Legislations to regulate all professionals in the sector, including paramedical personnel
- Establishment of a procurement agency
- Establishment of Regional health Authorities
- Training programs in management for senior health officials
- Providing incentives for personnel to serve underserved areas such as the hinterland
- De-link salary structure from the public service
- Develop a manpower plan, including making provision for all persons trained through government programs to serve in selected areas for a minimum of two years. The manpower plan will develop pre-and in-service recruitment programs
- Curricula reform and development would be a priority
- Develop a division of primary health care in the Ministry of Health
- Develop a strong epidemiology program
- Develop a quality assurance program for both the public and private health sectors
- Develop mobile clinics to serve under-served and un-served areas
- Modernize and strengthen the FDA
- An evaluation of the health care facilities in order to consolidate services for greater equity and efficiency
- Develop a rehabilitation and reconstruction plan for health facilities
- Enhance the ambulance service
- Provide greater capacity for communication through the provision of phones and radio sets
- Ensure all hospitals have backup power
- Enforce an Essential Medical Supplies List
- Improve bond and storage areas throughout the sector
- Rotating service to ensure doctors are available on a periodic basis for hinterland service
- Arrange for doctors with special skills to visit Guyana to provide medical services not routinely available in Guyana
- Establish a cancer center
- Establish a dialysis center
- Develop IT for the sector
- Health care funding will be raised to greater than 10% by 2010
- Cost recovery mechanisms would be introduced for such services as lab, x-rays etc.
- Develop a health insurance scheme
- Introduce a registration fee for everyone using the public health service
- Develop private services within the public sector
- Programs addressing gender specific health issues will be developed
- Adolescent health issues will be addressed

- Specific health promotion programs to reduce smoking and to develop health lifestyles will be developed
- Nutrition surveillance will be introduced
- The vector control program will be modified
- Implementation of strong STI and HIV programs
- Programs to address special needs of vulnerable groups will be developed

2.3 The Millennium Development Goals

Guyana is a signatory to the Millennium Development Goals Declaration. The health specific goals of the MDG are as follows:

- Reduce child mortality (Goal #4): the specific target is to reduce under-five mortality by two-thirds between 1990 and 2015. The specific indicators for this goal are reduced under-five and infant mortality rates and an increase in the number of children immunized before the age of one
- Improve maternal health (Goal #5): the specific target is to reduce by three-quarters between 1990 and 2015, the maternal mortality ratio. The specific indicators are reduced maternal mortality rate and an increase in the number of births attended by skilled health personnel
- Combat HIV/AIDS, malaria and other diseases (Goal # 6): the specific targets are to have halted and begin to reverse the spread of HIV/AIDS, malaria and other diseases. The specific indicators are to reduce HIV infection rates among 15 to 24 age groups, increased contraceptive and condom prevalence rates, reduction of the number of children orphaned because of HIV/AIDS, reduced malaria prevalence and mortality rates, increased use of prevention and treatment measures in malaria areas, reduced prevalence and mortality rates due to TB, increased level of DOTS

2.4 Health Profile of Guyana

In 1998, life expectancy (LE) at birth was 64.8, (males 61.5 and females 68.2). The LE rate has fluctuated over the period 1990-1998, between 63.0 in 1990, 65.0 in 1991 and 64.0 in the years 1993-1996. The estimated rate of population growth for the period 1998-2015 is 0.7%. It was 0.6% between 1975 and 1998. The dependency ratio (54.1 in 1998) is expected to be 41.3 in 2015. The expected trend in the distribution of the population is towards ageing. For the purpose of the NHP, the 1991 population estimate of 718,000 is used. While regional data is patchy, it is clear that Guyana's health profile is that of a country going through early epidemiological transition. Infectious diseases still dominate the morbidity pattern and include malaria, respiratory infections, sexually transmitted diseases, HIV/AIDS and an increase in tuberculosis (which mirrors the HIV/AIDS pattern). The major causes of mortality are predominantly non-communicable diseases - stroke, heart disease, and accidents and injuries - except for HIV/AIDS.

The profile is complicated because the transition is not uniform throughout the country. Broadly it reflects the socio-economic profile, which in itself is not simple. Although investments have been made during the last decade, improvements have been slow in part because of the emerging transition but also because of the inherent difficulties of targeting interventions to sub-populations, whether to a region or a high-risk community within a region.

Health Burdens: A number of health burdens plague persons around the country. For example, there is a significant backlog in surgeries for cataract, hydrocele, fibroids etc. Cancer patients are unable to obtain radiotherapy treatment and many persons with cardiac diseases are unable to benefit from surgeries. Screening and interventions for sight and hearing impairment are also important routine interventions that are not universally available. Mental health and disability issues are major contributors to morbidity and poverty and services in these areas are inadequate.

Weak Health Information Systems: Data is channeled up to national level where it is collated and analysed for national purposes without much analysis at regional or facility levels. Data validation is a problem in terms of completeness and timeliness. No data is collated on hospital activity or from the private sector although the latter has become an increasingly important player in the last five years. Table 4 provides the key national mortality indicators adjusted for an estimated 30% under-reporting due to these data problems. It is impossible to track health status improvement for the whole country or by region. But there are obvious pockets of higher than average morbidity and mortality, some of which are mentioned in the previous paragraph, which can be targeted without better data, and it is important to begin looking at these subgroups systematically. Table 5 shows the major causes of death by age group. The populations in the Hinterland Regions and River Rain areas of the Coastal Regions are younger, and predominantly of Amerindian ethnicity (with large family sizes, small dispersed village communities, higher levels of malnutrition, and lower formal education achievement). These communities have health needs different from those of the Coastal and more urbanized Regions. Table 6 gives the broad health priorities by these broad groupings.

Table 3: Trends in health indicators 1993-1999

	1993	1994	1995	1996	1997	1998	1999
Crude birth rate	26.5	29.2	29.8	24.0	26.1	24.1	23.2
Total fertility rate	2.9	2.3	2.3	2.1	2.0	2.0	2.0
Crude death rate	6.7	7.1	7.1	6.5	6.8	6.5	6.6
Maternal mortality rate	190	190	190	159.9	105.9	124.6	ND
Infant mortality rate	34.9	28.8	27.8	25.5	25.5	22.9	ND

Source: Bureau of Statistics, Ministry of Health.

Table 4: Key mortality indicators, adjusted for under-reporting (by about 30%*)

Indicator	Reported rate per thousand	Source	Estimated rate adjusted
Stillbirth rate	18.2 17.1	Draft CMO Annual Report 2000 MCH Annual Report/Profile 2000	19.5-34
Neonatal mortality rate	13.5 18.1	Draft CMO Annual Report 2000 MCH Profile 2000	26-36
Infant mortality rate	(1999) 25.6 21.9 (2000) 18.0 54.0	Bureau of Statistics Sept 2001 Draft CMO Annual Report 2000 MCH Annual Report/Profile 2000 MICS 2000	30-54
Under five mortality rate	(1998) 31.3 72.0	Bureau of Statistics Sept 2001 MICS 2000	40-72
Maternal mortality (per 100,000)	122 133	MCH Annual Report 2000 Draft CMO Annual Report 2000	168
Crude death rate	5.4	Bureau of Statistics Sept 2001	7.5

* Refer Annex 2: Health Services Strategy, Section 1 Health Needs Assessment

Table 5: Major causes of death by age group nationally (regional data not available)

Age Group	Leading causes of death (Ministry of Health, CSU 1999)
Under 5	Perinatal, ARI[1], ADD[1], accidents/injuries
5-15	Accidents/injuries, ARI[1], ADD[1], cancer, malnutrition/anaemia
15-44	HIV/AIDS, accidents/injuries, suicide, ARI[2]/ADD[2]
45-64	Heart disease[3], cerebrovascular disease (stroke), diabetes, cancer

1 death usually due to co-morbidity with malnutrition, malaria and repeated episodes
2 death usually due to co-morbidity with HIV/AIDs, malnutrition, TB
3 probably over diagnosis at this stage of transition, associated with diabetes.

Table 6: Broad health priorities

Hinterland Regions / River Rain Areas	Coastal Regions
Infectious Diseases: Malaria, ARI, ADD, TB	Infectious Disease: HIV/AIDS, TB, Filariasis
Reproductive Health: maternal health, family planning, perinatal	Reproductive Health: maternal health, family planning, perinatal
Nutritional disorders: malnutrition, anaemia	Nutritional disorders: obesity, anaemia
Accidents and injuries	NCD: diabetes, vascular disorders
	Accidents, injuries and suicides

2.5 Key Issues for the Sector

The people of Guyana value access to health care as a social right and, in an attempt to maximise access and ensure equity, GOG developed a network of facilities covering the entire country. To encourage community involvement and empowerment, responsibility for health delivery was decentralised to the 10 Regional Democratic Councils when these were established in 1980.

A combination of economic constraints and organisational weaknesses has hampered development of the sector. Yet increased investment in the sector has resulted in the establishment of an impressive network of health care facilities. Table 7 summarizes the number of facilities by Region.

Table 7: Summary of population and health facilities by Region

	National	Coastal regions						Hinterland regions					
	Totals	**3**	**4**	**5**	**6**	**10**	**Total**	**1**	**2**	**7**	**8**	**9**	**Total**
Health Post	**182**	25	10	2	1	13	51	31	17	15	16	52	131
Health Centre	**112**	13	25	14	24	10	86	4	12	3	4	3	26
District Hospital	**18**	3	0	2	3	2	10	3	1	1	1	2	8
Regional Hospital	**4**	1	0	0	1	1	3	0	1	0	0	0	1
National Hospital	**5**	0	4	0	1	0	5	0	0	0	0	0	0
Totals	**321**	**42**	**39**	**18**	**30**	**26**	**155**	**38**	**31**	**19**	**21**	**57**	**166**
% total population	**100**	13.3	41.0	7.1	19.7	5.4	86.5	2.5	6.0	2.0	0.8	2.1	13.4
Private Hospitals	**5**	-	5	-	-	-	5	-	-	-	-	-	-
Private Doctors	**115**	5	80	5	20	4	114	0	0	0	0	1	1
Total Beds	**2,187**	183	951	37	554	146	1,871	85	107	56	28	40	316
Public Acute Beds	**1,631**	183	615	37	334	146	1,315	85	107	56	28	40	316

Attempts to improve access and equity have included:

- Acquisition of private health facilities from the sugar, bauxite and timber industries
- Pilot partnerships with NGOs to provide services
- Policies to stimulate the private sector
- Expansion of the facilities network in the Hinterland Regions
- Corporatization of the Georgetown Public Hospital (GPHC).

But there are underlying problems in the sector that continue to undermine performance resulting from these initiatives. These are considered below under the headings:

- Planning and Management
- Staffing issues and impact on utilisation
- High levels of attrition from the sector
- Quality of care
- Financing.

Planning and Management

The potential benefits of decentralisation to regions have not been realised. Reasons for this include:

- Regions have not been given authority over human resources
- Regions receive budgets (for all sectors) from Ministry of Local Government and health expenditure has sometimes suffered in favour of other sectors
- Regions have not been able to develop and maintain management capacity at this level sufficient to manage a fully integrated service.

In response, the following proposals have been under serious consideration:

Responsibility for service delivery is to be concentrated in four Health Management Committees (from the 10 Regional Administrations) to gain economies of scale and assist in the building of management capacity. However, for the Health Management Committees (HMCs) to achieve the strategic objectives of improved operational efficiency, they must be given real autonomy over human and financial resources (along the lines of GPHC). This will require negotiation with Ministry of Local Government, the individual RDCs, the Ministry of Health, the PSC, and the Ministry of Finance. Further, the HMCs will require technical support for management development and to ensure that new management and information systems are appropriate for a decentralised system.

Box 1: The example of Georgetown Public Hospital Corporation (GPHC)

The recent corporatisation of GPH may offer some lessons for achieving more effective autonomy for the HMCs. The objective of separating GPH from the Ministry of Health was to provide a higher level of managerial autonomy to improve operational efficiencies (technical and administrative). GPHC has greater control and flexibility over staff, resources and other inputs. The indications are that significant internal efficiencies are being achieved but there are doubts about whether this is also the case externally. The major bone of contention is that, as the national training facility for medicine (and the largest for all other professions including nursing) GPHC is in an advantageous position to recruit all the staff it needs to the detriment of the rest of the country. This is further aggravated by the fact that GPHC can offer favourable salaries and capitalize on the desire of staff to live in or near to Georgetown. A second problem area is the suspicion that, as GPHC has control over the services it provides, it may be moving towards tailoring these more to minimising its costs rather than to maximising public benefits. Neither of these problems are intrinsic or inevitable consequences of autonomy. The next stage for GPHC is for Government to institute an effective contract with GPHC which defines what it must do in return for its public funding. This is now being discussed and drafted.

Organizational reform of the central Ministry of Health would be pursued for it to assume a new role of stewardship of the entire sector, public and private. This includes forms of performance contracting with the HMCs as well as GPHC. At arm's length from the public service delivery function, the Ministry of Health will be able to focus on using the power of public finance and regulatory frameworks to provide an enabling environment for the achievement of the vision of the Government for a healthy and productive people. For the short to medium term, the role of the Ministry of Health will be critical in balancing the development of the HMCs, GPHC and other implementing or provider agencies, for example the Materials Management Unit. Quality based purchasing of public services from private sector providers can also be explored to introduce competition and innovation.

Although Government is interested in partnerships with NGOs and has attempted pilot initiatives in the Hinterland Regions and for some underserved populations on the Coast, there has been no formal assessment of the outcome of these pilots with which to learn lessons for expansion of this policy. Government contribution to projects has usually been in the form of a subvention or infrastructure or staffing but these have never been formally structured, clearly outlining the commitment of the NGO to the project and with clear lines of accountability for resources.

Staffing Issues and Impact on Utilization

Although public sector staff has demonstrated the ability to learn new skills and adapt to a changing and challenging situation, the absolute shortage of a skilled and experienced workforce remains a major constraint – in both public and private sectors.

This has affected the decentralisation strategy since it has not been possible to staff the Regional Health Management Teams appropriately. Staffing the services outside of Georgetown has remained problematic, particularly for the more highly skilled cadres of doctors, dentists, health visitors, and nurses.

The continued expansion of the services network has resulted in staff becoming more thinly distributed. There is no health centre or hospital that has its full team as the system was originally planned. Many primary care facilities share the same key staff (Medex, health visitor, nurse/midwife) so that one of the major complaints of the public is that often they cannot get care when they present for it.

Many facilities are now staffed with lower cadres of staff simply to maintain an institutional presence (nursing assistants in health centres and nursing aides in hospitals, for example), and many staff are working outside of their skill area and without support. Thus, proper teamwork, the heart of primary care, is not functionally possible. The Community Health Worker has become the custodian of the rural health post and in the eyes of the community is the front-line worker of the Ministry of Health and is expected to be the primary care provider for that community.

Apart from GPHC and the Regional Hospitals, hospitals do not have doctors on a regular basis. Even Regional Hospitals are able to maintain only a one-specialist staffing structure, so that when the one specialist is unavailable, the service is discontinued. District Hospitals in the Hinterland Regions are staffed by Medexes without routine clinical supervision as originally intended, and occupancy levels are consistently low in all facilities, resulting in the few staff who are there not using their skills enough to develop and maintain quality at a desirable standard. The effects of these shortages and maldistribution of staff include declining morale,

poor attitude towards patients, and attrition rates that are of crisis proportions. Patients bypass lower level facilities in favour of the nearest facility with a doctor (preferably) or Medex. In the Coastal Regions, health centres are bypassed for District Hospitals (if there is a doctor) or for Regional Hospitals and GPHC for inpatient services. This pattern is not as entrenched or obvious in the Hinterland Regions because of the difficult logistics and dispersed populations, so the problem of maldistribution needs to be addressed differently there.

Most of the private sector capacity is located in Region 6 and Georgetown, and all private hospitals are located in Georgetown. Whilst there is no formal data on private sector activity, it is reported widely that the private sector in Georgetown supplies mostly patients from outside of Region 4, particularly since the upgrading of the GPHC facility has made it more attractive to Region 4 residents. Yet the public sector outpatient data for Regions 4 and 6 shows that a significant amount of ambulatory care is being taken up by the private sector (in terms of reported incidence rates of common diseases like hypertension and diabetes).

The private sector suffers from quality problems and is not able to supply a significant proportion of need. Most primary care doctors work as individual practitioners unsupported by a clinical network of referral and there is no monitoring of standards and outcomes. Similarly, medical cover is provided at private hospitals as singleton practitioners or specialists although some informal peer review is done in the bigger facilities. Nursing and other professional shortages constrain operational efficiency.

The key to progress in staffing will be the implementation of a workforce development strategy and plan that addresses the critical human resources shortages combined with a realistic services delivery strategy and plan that addresses the critical quality of care issues to make the best use of available staff.

High levels of attrition from the sector

The problems affecting production of qualified professionals need to be separated from the constraints of recruitment and retention. As the Ministry of Health moves forward with the decentralisation policy, there will be distinct procedures and responsibilities for these two functions. Part of the personnel problem now, particularly after corporatisation of GPHC, results from the inability of the Ministry of Health to act on behalf of the Regions in negotiating employment contracts with nursing and medical graduates. This problem will need to be addressed by the new HMCs urgently.
The Ministry of Health will retain the responsibility for the Schools of Nursing through the HSEU and the issues of the quality of training and the qualifications of students need to be addressed in the short term, before production can be increased significantly and cost effectively in the medium to longer term. The high failure rate in the registered nursing programme has been documented since the late 1970s, and the response over time has been the lowering of entrance standards to increase recruitment and lowering of examination standards to facilitate production. The issue of staffing Hinterland Regions requires innovative approaches to help students achieve the entry standards and to attract them into the health sector.

Since 1991, the undergraduate medical school produces between 10-15 doctors a year (with a failure rate of about 30%) but less than half of these graduates are still in Guyana. About 200 medical scholarships in Cuba are being awarded for 2002-2003, and these doctors are expected back into the system by 2006-2007. No structured postgraduate medical training programme has been developed, either to support them as independent GPs or for further specialist training. Without this, there is very little incentive for doctors to remain in the country. More than 70% of the specialist staff are expatriates, largely resulting from technical cooperation programmes with Cuba, India and China.

Continuous Professional Development (CPD) or post basic training is fragmented and disease oriented rather than client focused, and neither linked to promotion nor performance appraisal systems. Most CPD is delivered centrally and eligibility criteria and selection for training are ad hoc and/or lack transparency. This reduces access for those who most need the training, and reduces intake based on merit. This affects quality and retention adversely.

In the short term therefore, the focus will need to be on:

- Establishing strong HRM systems in the new HMCs to streamline recruitment and retention practices
- Strengthening the capacity of the SoN
- Improving CPD programmes.

In the longer term, production needs to increase to compensate for the high attrition rate, and postgraduate medical programmes need to be implemented.

Quality of care: There is no systematic assessment of clinical outcomes and processes (ie. quality) in either public or private sectors. This makes it difficult to determine where to focus efforts to improve the intermediate outputs. No routine assessment is done of consumer satisfaction, health seeking behaviour, attitudes and practices, or risk factors to inform the development of programmes. Those ad hoc studies that are done are not used to influence the allocation of resources.

Sector Financing : Sector expenditure data is neither reliable nor up to date. A major effort is required to analyse current expenditure particularly that in the private sector. Total sector expenditure is estimated at US$ 33m or about US$ 45.5 per capita for 2003. The last year for which detailed figures are available is 1997, which indicates the sources of funding as shown in Table 8.

Table 8: Sector expenditure by major sources

Source of funding	% total	US$ total
Central and local government	58%	19.14
Donors	11%	3.63
Private	31%	10.23
Total	**100**	**33.00**

The primary source of funding for the public sector is government taxation. This is transferred from the Ministry of Finance to the Ministry of Health, to the Ministry of Local Government (and thence to the regions), and to GPHC. Generally, GOG has maintained a policy of services free at the point of access but limited user charges (at low tariffs) have been introduced on a facility basis with the primary aim to influence the use of higher level facilities. Revenue generated from charges is minimal – estimated as 0.16% of government health expenditure. Facilities are not allowed to retain this income and must transfer it to the RDC Treasury. There is no form of public financing of private health insurance for public sector workers.

In 2002, health expenditure amounted to 8.4% of total government expenditure (10.1% if debt payments are excluded) and trends for this, and for total sector expenditure are shown in Table 9. The country still receives significant technical cooperation support for the health sector and in 1999, donors accounted for 5.22% of government health spending (compared with 11% in 1997). All the funds are grants. The principal sources of external financing in 1999 and 2000 were the Inter American Development Bank, UN agencies, USAID and German Technical Cooperation. No reliable information is available on private health expenditure and no focused studies or surveys have been undertaken. The largest component of private expenditure is out-of-pocket payments by households for private health care in country and overseas – about 22% of total health expenditure. Figures for this are based on the results of a 1992/93 Living Standards Measurement Survey but international and regional trends would suggest that this is grossly underestimated and/or that it has risen significantly recently. The evident growth in private sector providers over the last five years (fuelled by University of Guyana production of doctors since 1991 and policies to encourage returning professionals) must be based on increased household expenditure. Also, the rising expectations of a public exposed to regional and North American developments in the health care industry would influence health-seeking behaviours both at home and overseas. Much of this can be funded from informal income from overseas remittances.

Private insurance, including the proportion of National Insurance allocated to health and paid by employers and employees, represents about 5% of total expenditure. No tax concessions are given to individuals when they purchase health insurance policies.

No single management unit has overall authority over the financial resources allocated to health. Public Sector Reform has resulted in the Ministry of Health moving from line item budgeting to programme budgeting from fiscal years 1997/1998. This has facilitated the costing of health programmes and has given managers more control over the resources for their programmes. For the most part, however, budgets remain allocated on a historical basis, and no system has been implemented to allocate new resources to priority areas except for the HIPC initiatives.

For the foreseeable future, taxation is likely to remain the main source of public expenditure on health. Social insurance is not likely to be feasible or equitable with the significant informal employment and under-employment of Guyana. The main issue remains the effective spending of available sector finance through a system of knowledgeable 'purchasing' that is able to pressure incentives for efficiency in service providers, public and private. GOG will look at the possibility of creating a small technical office for this function outside of the Ministry of Health in the medium to long term. This office may also initiate studies of the prospects for a form of social insurance and may also commission some studies on health expenditure using a National health accounts approach and including an anonymous survey of private provider turnover.

Table 9: Sector expenditure 1992-2001

	1992	1993	1994	1995	1996	1997	1998	1999	2001	2002
Public expenditure on health ($GY ,000,000)	1,581	2,022	2,737	2,214	2,686	2,769	2,951	3,550	4,423	4,402
Public expenditure on health as a % of GDP	3.4	3.4	3.6	2.5	2.7	2.6	2.7	2.9	3.4	3.3
Public expenditure on healthas % of total public expenditure	6.5	7.9	9.0	6.3	6.8	7.6	6.8	7.6	7.4	6.9
Total per capita expenditure on health in US$	NA	29.1	34	39	43.4	45.4	45.4	NA	NA	NA

Source: Budget Estimates 1992-2001, World Bank, Ministry of Health.

2.6 SWOT summary of key issues for the sector

Box 2 summarizes the discussion above in terms of strengths and weaknesses of the health sector and adds possible opportunities and threats in a SWOT format.

Box 2: Summary SWOT Analysis of the Health Sector

Strengths:

- public delivery network covering entire country
- philosophy of decentralisation to Regions
- Government commitment to universal access
- many staff dedicated to improving health for Guyanese
- demonstrated capacity to learn new skills
- Ministry of Health with experience in working with de-concentrated provider units
- Guyanese people value access to health care as part of social rights
- improved internal efficiency at GPHC since corporatisation

Weaknesses (to be addressed):

staffing issues and impact on utilisation

- not enough doctors - specialists and public health
- high attrition rate among most skilled and experienced professions
- low staff morale and high levels of de-motivation
- low levels of activity at all levels of the system except GPHC
- recruitment and retention problems
- no incentives to work in hinterland and difficult locations ie. outside of Georgetown

planning, management and financing

- facilities and services added for political reasons rather than technical rationale
- not enough trained and experienced health managers; lack of managerial capacity at regional levels
- ad hoc planning and crisis management culture, not able to allocate resources to priority problems
- planning is disease focused and centrally managed; no regional targets set for health
- devolution of responsibility for health was not matched by authority over all resources
- budgets not focused on needs or performance

data and quality of care issues

- little formal regional health data available for monitoring and evaluation
- information flows fragmented and not integrated at either facility, regional or central levels
- no systematic approach to data collection from private sector
- no focus on quality and outcomes, only on inputs and shortages

Opportunities:

- improving health and access to health services agreed as a major strategy for overall poverty alleviation – growing political and public interest and commitment
- HIPC funding could increase overall health budget by 30%
- IDB funding available at highly favourable rates and conditions
- growing capacity of private sector as means to accelerate implementation
- improved overall education level in labour market
- advances in IT and communication technology
- globalisation in health services makes it easier to access experience and skills
- TC agreements from Cuba and China increasing pool of available specialist resources
- improving conditions and infrastructure in regions outside Georgetown
- increasing demand from households for information on health and choice of provider

Threats:

- high levels of out-migration major cause of attrition from health sector
- unstable socio-economic climate - high levels of unemployment, violent crime
- inefficient and ineffective tax collection system
- major proportion of household income informal and undeclared - from overseas remittances
- failure to improve quality of public sector and regulate private sector will increase household expenditure for little health gain
- investment income from loans and HIPC, may create unsustainable expectations and habits

2.7 Systems Analysis

A simple systems analysis of the situation separates some of the major causes and effects and identifies key interventions for a sector strategy that the *National Health Plan 2003-2007* will aim to deliver.

There are 'environmental' factors that the health sector must operate within. The key environmental influences are:

- The poor social and economic conditions of the country (including racial divisions)
- The inequitable geographical distribution of poverty (with significantly higher levels in the hinterland and in rural coastal areas)
- The attractions and 'pull' factors overseas for educated and trained personnel.

Within the health 'system', the strategy must make the best use of what resources are available and, realistically, will be available within the planning horizon. The central problem relates to mal-distribution of resources and staff:

- Available resources/services are not addressing priority health needs efficiently
- Most importantly, skilled and experienced health care staff is not distributed to achieve a cost effective result.

The principal ***effects*** of this central problem have been discussed in earlier sections. In summary:

- Although health indicators have been improving in the last decade, gains have been slow and the hinterland regions lag behind the rest of the country
- Consumers are dissatisfied as demonstrated by the bypassing of lower level facilities (and resulting long waiting times and overcrowding at OPD of the larger hospitals, including GHPC)
- The morale, motivation and performance of staff are low and attitudes to patient care are poor
- Expenditure in the private sector is increasing but may not be cost effective – consumption is supply driven and technologies are employed without adequate quality controls (and create demands for the public sector to provide similar services).

The principal ***causes*** of the central system problem (of available resources not effectively addressing needs) are summarised as follows:

1. Management does not control resources and lacks capacity

- Public sector staff are controlled by the Public Service Management (PSM) not by service managers and this effects promotion, discipline etc., and is excessively slow
- Authority is fragmented between RDCs, Ministry of Health, MoF and MoLG
- Management skills at regional level are limited and not geared to decentralised roles
- Central Ministry of Health has no culture of sponsorship, setting targets or linking planning to budgets.

2. Low productivity of public sector services

- Too many facilities for available resources (especially staff) and population
- Facilities are staffed with lower cadres just to maintain institutional presence
- Staff are thinly distributed with little or no team work and community interaction
- Activity levels at hospitals are too low to maintain clinical skill set (except for GPHC)
- Little regular clinical supervision
- Poor logistical support including access to transport and communication.

3. Chronic shortage of skilled staff - see environmental factors but also

- human resource planning is weak (needs and staff profiles are not known by region)
- production of qualified health professionals is declining
- in-service training (CPD) is inadequate – fragmented and not adequately linked to performance appraisal or promotion
- recruitment and retention practices are slow and unresponsive to local situations.

4. No systematic assessment of quality of care

- no clinical supervision at any level - neither in public nor private sectors
- outdated regulatory frameworks including those for professional self regulation
- data collection is poor and not seen as a priority (this includes data on health needs, quality, outputs and outcomes including the private sector)
- little emphasis on measuring consumer satisfaction or care seeking behaviour.

5. Finance does not follow needs

- allocations are based on historical budgets, not on needs assessment and performance
- most funding (75%) goes to public sector staff regardless of location or performance
- there is no agency responsible for and able to ensure cost effective spending of public finance
- little knowledge of private sector expenditure including overseas expenditure
- financial management systems cannot track spending against performance.

Figure 1: Systems analysis of the health sector

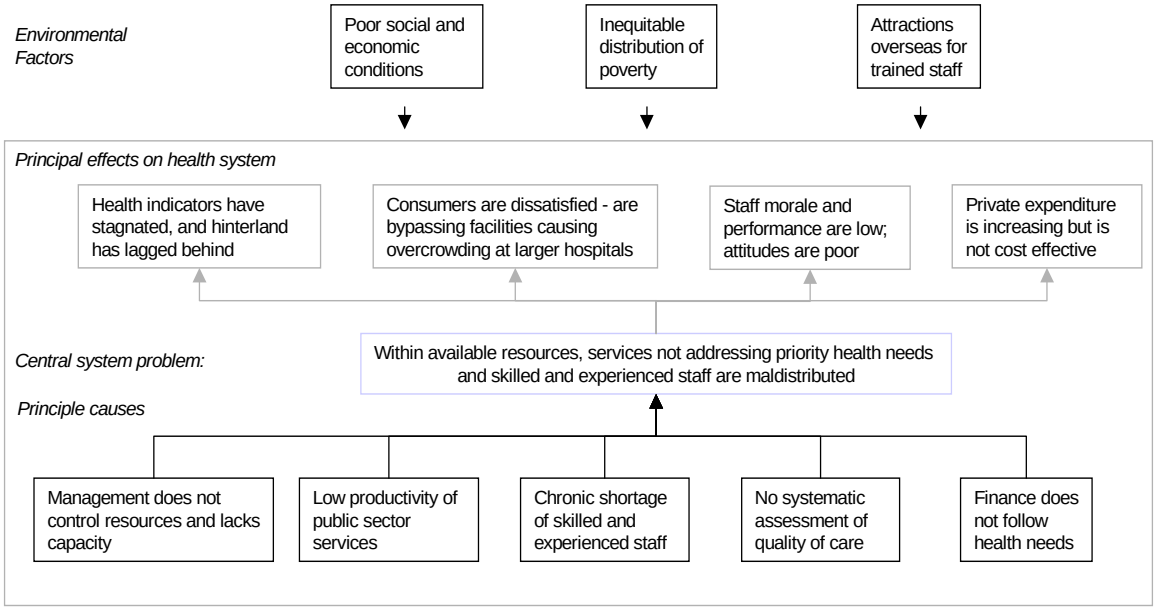


Figure 1 illustrates the cause and effect relationships as described above. The challenge is to identify the priority actions that, in the next five years, will reduce the causes outlined above and so ensure more sustainable development of the health sector. In doing so, they will contribute to the achievement of the goals of:

- The National Development Strategy (equity, efficiency, quality, sustainable financing and intersectoral collaboration)
- The PRSP (as poor health and expenditure on services are factors in causing poverty)
- The Millennium Development Goals

GOG recognizes that retaining skilled workers in the country is an issue beyond the influence of health sector management alone. Stemming the outflow requires economic recovery and growth and this requires a longer time horizon. Until such time, the health sector will focus on how to optimize the allocation of the available workforce and to improve the system so that staff is encouraged to stay in the health sector.

3 The Components of the NHP

3.1 Vision and Mission

The vision of the Government of Guyana is that Guyanese citizens be among the healthiest in the Caribbean and South America. In pursuit of that vision, the mission of the Ministry of Health states:

The Ministry of Health will create an enabling framework for the delivery of quality and responsive health services to improve the physical, mental and social well being of the Guyanese people. We will do this providing leadership, ensuring access to essential services particularly for the poor, and fostering enduring partnerships.

The Guiding Principles for the achievement of this mission and vision are:

- Equity
- Effectiveness and quality
- Efficiency
- Sustainable financing
- Inter-sector collaboration and community participation.

3.2 Strategic Goals and the NHP Objectives

Under the National Development Strategy and the PRSP, and consistent with the international Millennium Development Goals, the strategic goals of the Government for this decade include as priorities:

- Improving the health status of women and children - as indicated by reducing infant and child mortality rates by two thirds and maternal mortality rates by one third and sustaining vaccine coverage of > 95%
- Improving access to quality health care, particularly for the poor, with an emphasis on prevention and promotion through strengthened primary care

- Improving overall health services by strengthening and or developing national priority health programs such as family health, chronic diseases, infectious diseases programs etc.
- Reducing poverty by developing specific projects to deal with health burdens such as disability, cancer, cataracts, hydrocele etc.
- Improving procurement and delivery of drugs and medical supplies
- Improving the efficiency of health services through strategies of facility rationalisation and strengthening of management capacity
- Improve work terms and conditions for health personnel.

To achieve these strategic goals, the central 'purpose' of the *National Health Plan 2003-2007* is defined as:

- To improve the distribution of skilled and experienced staff (and other resources) so as to ensure an equitable access to quality care and strong health promotion and prevention strategies for all people of Guyana.

The *National Health Plan 2003-2007* has five major components or outputs to achieve this purpose. These are based on the systems analysis of Section 2.7.

1. Strengthening management control and capacity to create more responsive and accountable organisations capable of assessing health needs, particularly of the poor and vulnerable, and implementing prioritised action plans.

2. Modernising and rationalising the public sector health services, with a focus on prevention and health promotion, to improve the utilisation of services and the productivity of the available workforce.

3. Establishing workforce development and human resource management (HRM) systems so as to achieve the regional staffing targets of the *Health Services Strategy and Plan 2003-2007*.

4. Implementing a national quality framework so as to ensure a high quality of care for consumers and to improve satisfaction in the public and private sectors.

5. Directing finance to priority needs, and improving financial accountability and value for money performance for both public and private health expenditure.

Figure 2 summarises the strategic goals and objectives of the *National Health Plan 2003-2007*. The strategies included under the five components are designed to:

- Allocate money and resources for optimal results
- Improve management and establish and or enhance systems
- Strengthen governance
- Empower communities, groups and individuals to participate in decision-making and health care delivery

While the ministry strives to ensure that a comprehensive health service is available to all Guyanese citizens, priority National Health Programmes have been identified for action within the next five years. These are based on an assessment of health needs and the availability of cost effective interventions. They include:

- Maternal and Child Health including Expanded Programme of Immunization (EPI), family planning and Integrated Management of Childhood Illnesses (IMCI)
- HIV/AIDs including treatment of STIs and TB
- Accidents and injuries including suicide
- Chronic non communicable diseases including heart disease, hypertension, diabetes and nutritional deficiencies
- Infectious diseases including malaria, diarrhoeal diseases, and respiratory infections which dominate the health profile of the hinterland regions
- Programs to address mental health and disability

The PRSP offers opportunities for some additional resources for the health sector. The *National Health Plan 2003-2007* aims to address the critical organisational constraints and the rationalisation of services to ensure these additional resources are used to maximum effect.

4 Components of the *National Health Plan 2003-2007*

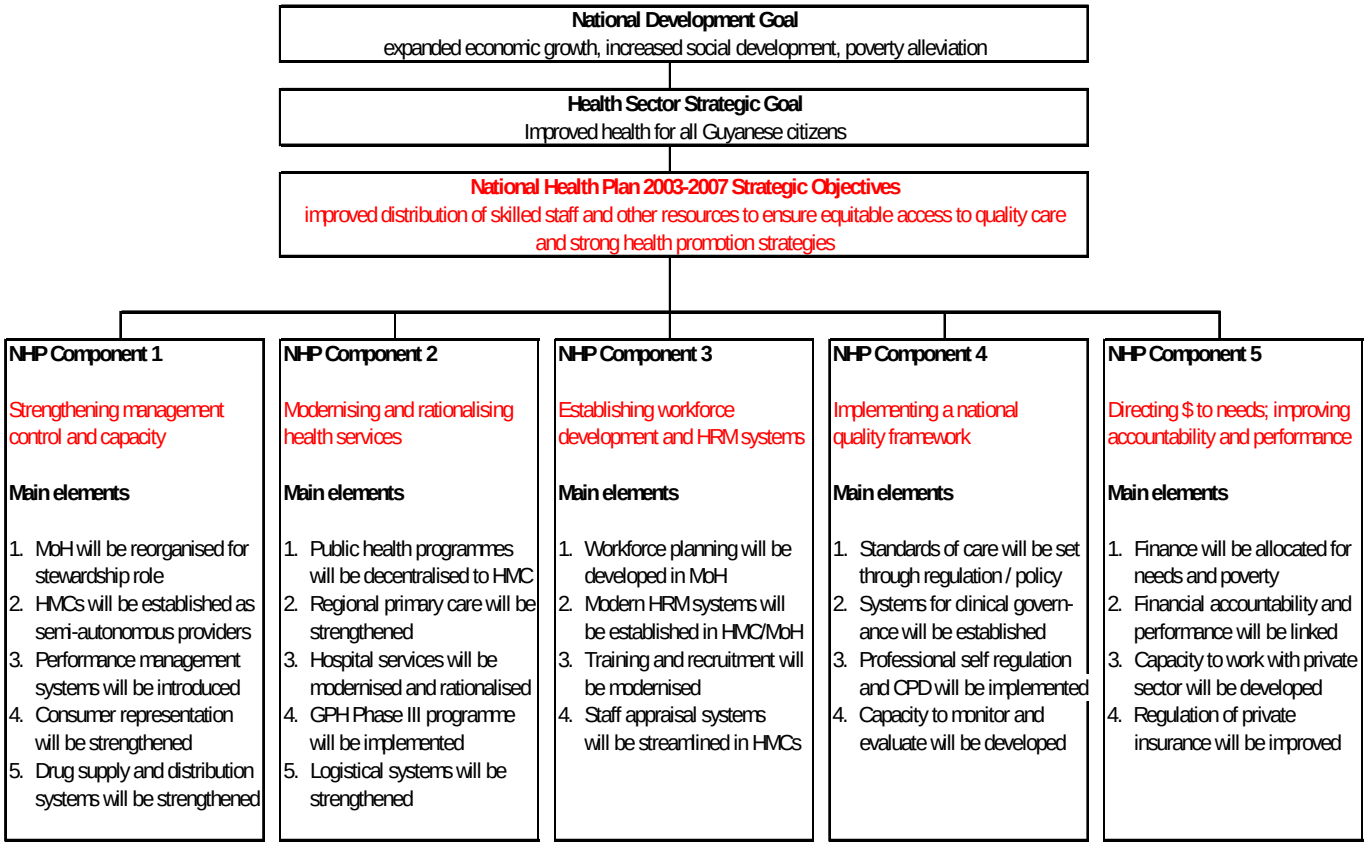
4.1 Component 1: Strengthening management control and capacity

The main objective of this component is to strengthen management capacity by creating more responsive and accountable organisations capable of assessing health needs, particularly of the poor and vulnerable, and implementing prioritised action plans.

The Ministry of Health will become the 'steward' of the Health Sector whilst operational

responsibility for services will be decentralized to four Health Management Committees (HMCs). Reorganisation of the Ministry of Health, RDCs and MoLG will be fully coordinated to ensure a smooth transition of essential services and flow of funds. Public Health capacity in the HMCs will be built up through the reorganisation of the Vertical Technical Programmes into four major groups, which will be led from the HMC. Over time, the HMCs will take over full responsibility for services delivery and ensure integration with primary or hospital based care.

Figure 2: Strategic goals and objectives of the *National Health Plan 2003-2007*



The major outputs of this component are discussed below under the headings:

1. Ministry of Health will be reorganized for stewardship role
2. HMCs will be established as semi-autonomous provider organisations
3. New performance management system and supporting MIS will be introduced
4. Consumer representation and communications will be strengthened
5. Drug supply and distribution systems will be strengthened.

Ministry of Health will be reorganized for stewardship role

Free of operational responsibility, the Ministry of Health will develop strong policy and planning capabilities and will be able to focus on achieving better national health outcomes by a combination of sponsorship and regulation of all providers: the HMCs, GPHC and the private sector. The Ministry of Health will set national health priorities based on objective assessment of health needs. In keeping with these national priorities, the Ministry of Health will promote new public health activities with other ministries and development partners and will negotiate packages of care with HMCs and GPHC - tailored for the local priorities of the populations served by the HMC.

The Ministry of Health will become concerned with outputs rather than inputs – patients and people before rules and regulations. By relinquishing responsibility for day-to-day operational decisions (which it is too far removed to make effectively), the Ministry of Health can

become focused on cost effectiveness and value for the taxpayer's money. It can concentrate on knowledge based planning and become a credible organisation commanding the respect and confidence of the HMCs, the GPHC, the private sector and the public. For the short term, the Ministry of Health will retain responsibility for delivering directly:

- Training (see Component 3)
- Drugs and supplies procurement and distribution to the HMCs (see Component 4)
- Advocacy for national priority programs
- Advocacy for special projects to reduce health burdens

This is because of their strategic importance, current funding arrangements and the economy of scale achievable if they are run as centralised functions, and because not all HMCs will be fully operational in the short term. The roles and responsibilities of the relevant implementing units – the Health Sciences Education Unit (HSEU) and the Materials Management Unit (MMU) – will be clarified and may evolve as decentralisation occurs and develops. Both will be significantly restructured and strengthened – see section 4.4 for HSEU and section 4.5 for MMU.

The key functional areas of the reorganized Ministry of Health will be:

- **Health policy formulation:** including policy, planning, legislation and inter-sectoral lobbying and action based on research and evidence based knowledge

- **Advocacy and health promotion:** including a major new capacity to commission modern communications aimed at behavioural change and monitoring results through surveys
- **Health financing and commissioning:** including the development of regional budgets based on needs, the negotiation of service agreements with HMCs and GPHC and the monitoring pf performance

- **Regulation and setting standards:** including the development, promotion and monitoring of a national quality framework, regulatory mechanisms including working with professional groups to promote self regulation, and developing legislation and regulations to ensure quality in the private sector

- **Workforce development:** including national workforce planning, human resource issues, supporting HMCs with HR systems, education and training including CPD under service agreements with HSEU, GPHC and SoN

- **Drug procurement and supply:** including strengthening the MMU to operate as a cost centre serving the HMCs, and ensuring adherence to the national Essential Drug Programme as part of the national quality framework.

The new Ministry of Health will influence the delivery of services by the HMCs and GPHC through the service agreement mechanism tying budgets to service volumes and quality targets. This mechanism will be based on joint reviews of progress and problems.

The vital technical/vertical programmes will be managed from the HMCs where they will be closer to needs and local delivery problems but will retain support in key areas from the Ministry of Health (for example, in national behavioural change aspects of HIV/AIDS/STI control). Details of how this will work are provided in section 4.2.

HMCs will be established as semi-autonomous provider organisations

There will be no less than four Health Management Committees covering the existing 10 regions. They will be Berbice, Demerara, Essequibo and the Hinterland. HMCs will be the providers of public health services for defined geographic populations. In time, they will be given full authority over staff and budgets to allow professional management free of the bureaucratic constraints of the public service. This will facilitate a more responsive system of health services in which managers and clinicians will be able to make decisions and be more accountable to consumers.

Figure 3 illustrates the proposed functional organisation of the HMCs and the relationship with Ministry of Health, the RDC (and MoLG), and the individual service provider units. Given international and regional experience with this type of reorganisation and the chronic shortage of skilled and experience staff and managers in the sector, HMCs will be phased in and provided with adequate technical support and finance.

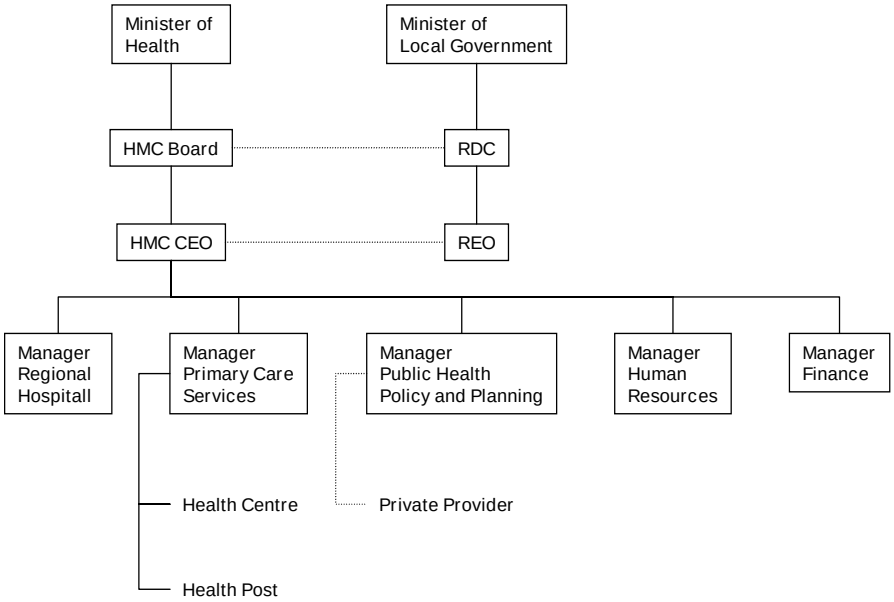
Beginning in 2003, pilot HMC would be established in certain Regions, specifically Regions 6,10 and 2 respectively.

In practice, Guyana has more decentralisation experience than its regional neighbours (this is the fourth reorganisation of decentralised management structures since the 1980s). In the 1970s, Ministry of Health services were

organised in six Ministerial Health Regions; in 1980, service delivery and environmental health functions were devolved from the Ministry of Health to MoLG and RDCs; and in 1999, GPHC was established under the Public Corporations Act.

The GPH reorganisation was significantly different in that GPHC was given relatively substantial autonomy over its staff and budget. Although no formal evaluation has yet been undertaken, this has resulted in GPHC establishing a management structure with a keen focus on increasing efficiency, improved terms and conditions for staff, improved staffing in some areas, and more complete data on activity. To some extent, however, the success of GPHC has caused problems for the regions by making it even more difficult to get staff to move out of Georgetown. This problem will be addressed by the system of service agreements between Ministry of Health and GPHC and the establishment of an HR Planning Unit in the new Ministry of Health. The phased introduction of HMCs will ensure that lessons are learned and acted upon – starting with the lessons from GPHC which in many ways is piloting management systems that can be shared with HMCs as they are established. Because it will remain the only tertiary care hospital in Guyana, GPHC will always have requirements different from the HMCs, but continued investment in the management team, structure and systems of GPHC will still have a useful roll-out effect on the development of the entire sector.

Figure 3: Functional organisation of the HMC



New performance management system and supporting MIS will be introduced

New systems of planning and performance management will be developed to ensure managerial accountability in a devolved system. Integrated Health Information Systems (HIS) will be designed and implemented, based on standardized data dictionaries and platforms with data collection, validation, analysis and feedback at HMC level. The Ministry of Health will collate these to form national planning data sets. Similarly, demographic and economic data will be collected once by the Ministry of Health and passed on to the HMC management teams. Data will include health surveillance, patient activity, quality indicators (process and output) and selected outcome measures.

Together with the HRM systems (Component 3) and financial management systems (Component 5), the Ministry of Health will use the HIS system to monitor the achievement of service, quality and financial targets set out in Services Agreements with the HMCs and GPHC. In this way, the Ministry of Health can perform its stewardship role effectively. Service contracting between Ministry of Health and HMCs will be developed further as this process becomes understood and as better data becomes available. Even in Phase I, however, HMC CEO (or REO for those Regions that do not yet have an HMC) and the Permanent Secretary 'sign off' on the services agreements to ensure personal commitment at the highest management level in each organisation.

The strategic objectives of the NHP will be translated into annual targets and included in the service agreements as appropriate. Whilst the budgetary cycle is annual, the planning cycle should be 2-3 years, breaking down the budget into one year allotments, with appropriate intermediate targets. GOG will ensure that financial flows follow the planning cycle and that MoF and MoLG are involved in this process.

Prior to the start of the full Phase I in January 2004, a Preparatory and Piloting Phase will be undertaken (see section 6). During this phase, the Berbice HMC and GPHC will complete two-year business plans for 2004-2005, based on the NHP and on more detailed Commissioning Plans that will be prepared by the Ministry of Health indicating expected service levels and quality. Technical assistance will be provided to assist this process. These documents will form the basis for the negotiations for the Services Agreements. For the regions that do not have an HMC, this will also ensure that the RDC is aware of what is expected for the year in terms of health activities. This begins to deviate from the existing standard of retrospective regional annual reporting.

Phase I implementation will focus on structural issues – roles and relationships and design of common databases improving the availability of regional data. Services agreements will focus on feasible and incremental changes in budgets and services delivery. New funds will be directed to priority areas for a specific region eg. safer motherhood, HIV/AIDS, or malaria. By Phase II, it is expected that the allocation of resources will reflect priorities and performance.

Consumer representation and communications will be strengthened

As the Ministry of Health devolves line responsibility, the HMCs will be required to:

- Involve their consumers in decision making, priority setting and improving client satisfaction e.g. patient charters of rights
- Participate in large-scale communication for behavioural change initiatives.

An elaborate system of local government exists, theoretically designed to build community participation. Whilst functionality varies by location, it is important that the HMCs work within existing community mechanisms as far as possible. At the most local level, that of a health post or health centre, community participation methods could be used to help involve local communities in priority setting for their area. This could also be utilized to share information about the changes in the system and the reasons for them.

Communication about health and health services can be quite complex. The issues are technical and can require in-depth knowledge. Whereas some functions can be contracted out to the private sector, the Ministry of Health should retain a communications capacity able to link health needs to communications activities and develop a clearinghouse for information. Surveys will be employed more routinely to assess people's knowledge, behaviours, demand factors and opinions. This will be done in conjunction with building the HIS.

Drug supply and distribution systems will be strengthened

Work has already begun on strengthening the Materials Management Unit of the Ministry of Health. The MMU faces significant challenges in improving the logistics of distribution to the Hinterland Regions and to primary care services. The MMU cannot by itself address all the problems of the supply chain, which starts from the prescription and how drugs get added to the formulary. The rational use of drug prescribing is essential since quality assurance mechanisms (including clinical governance, management protocols and CPD) are still weak.

For economy of scale reasons, GOG has decided that for the moment the procurement, storage and distribution functions are best centralised in the MMU, rather than devolved to HMCs. Phase I will explore the efficiency of this and whether regional storage and distribution could be totally devolved in Phase II. The MMU will produce a business plan for the period 2003-2005.

Although it is not proposed to set up the MMU autonomously within the short to medium term, a services agreement will be implemented with the MMU. This will set out performance objectives, including some process indicators such as delivery time, stock outs, and levels of wastage, so that there is transparency to the RDCs, HMCs and GPHC about how the MMU is funded and held accountable for performance on their behalf.

4.2 Component 2: Modernising and rationalising health services

The *National Health Plan 2003-2007* aims to improve the availability, affordability, quality and cost effectiveness of health care services. The key components of the *Health Services Strategy and Plan 2003-2007* (Annex 2 to the NHP) therefore include:

1. Public health / technical programmes will be decentralised to HMCs.

2. Regional primary care services will be strengthened by completing functional teams, improving skill mix, and integrating vertical programme delivery and linkages with hospitals, the private sector and the community.

3. Hospital services will be modernised and rationalised to handle an increased level of activity on an ambulatory basis, including increased levels of day surgery and outpatient diagnostics. This will be achieved by consolidation into fewer sites where quality can be raised. Some District Hospitals in the Coastal Regions will be converted to polyclinics, directly managing the local referral system. The Lethem, Bartica and Mabaruma Hospitals will be upgraded to Regional Hospitals. New Hospitals will be constructed to replace old hospitals at New Amsterdam (2003-2005), Lethem (2003/2004) and Linden Hospital (2005-2007).

4. A GPHC (Phase III) Development Programme will be implemented strengthening GPHC's role in the national *Health Services Strategy and Plan 2003-2007*. This will include the construction of a new in-patient facility at the GPHC.

5. Logistical support systems of transport and communication, including emergency ambulance systems and radio sets, will be strengthened to support effective supply, referral and supervision activities.

6. Diagnostic and clinical monitoring capacities will be improved with the improvement of laboratory and x-ray facilities throughout the sector. All Regional Hospitals will be equipped with X-rays and labs that have the capacity to perform routine biochemistry and haematology tests. The polyclinics will also be equipped similarly to support the health centres. All hospitals, polyclinics and some major health centres will be equipped with dental chairs and equipment.

Public health / technical programmes will be decentralised to HMCs

Management weaknesses at regional level have prevented further integration of vertical programmes. For the most part, services provided at health centres are confined to maternal and child health activities with other programmes delivered by different workers or by different units usually based at the District Hospital or in separate facilities (eg. vector control programme).

Table 10: Proposed National Priority Programmes

National Priority Programme	Existing vertical programme
Communicable disease	TB, clinical services for malaria, filariasis, dengue, leishmaniasis, Chagas, Hansen's disease, yellow fever
STI/HIV/AIDS	STI/HIV/AIDS
Family Health	MCH (including IMCI), EPI, RH/Family Planning, Adolescent Health, Elderly Health and clinical services for ARI and ADD
Chronic and Non communicable disease	Planning and Risk Factors, Chronic disease management, Mental Health, Emerging (CNCD) Needs
Oral health	Dental health services
Environmental health	Environmental health Vector control (non-clinical services) Veterinary public health

The establishment of HMCs will address these management weaknesses. This will allow primary care to be more comprehensive and not just focused on clinical services. Through the Services Agreements, HMCs will be encouraged to see public health as a pivotal function in fulfilling their roles.

Vertical programmes will be reorganised to make the best use of available public health doctors and nurses as functions are decentralised to HMCs. Vertical programmes will be consolidated into six National Priority Programmes (NPP) as shown in Table 10. For the short-to-medium term, Dental and Environmental Health will remain as currently managed, through the Dental School and the RDC respectively. A technical

Manager of Health Policy and Planning will lead each of the four other programmes located at HMC/Regional level.

The role of the Manager of Health Policy and Planning is to:

- provide technical expertise and input to the policy making process
- ensure the services provided are efficient and cost effective
- provide technical expertise and input to the basic and continuing educational process
- have an overview of clinical quality in the NPP
- act as an advocate for the NPP at the national level
- promote research, where appropriate.

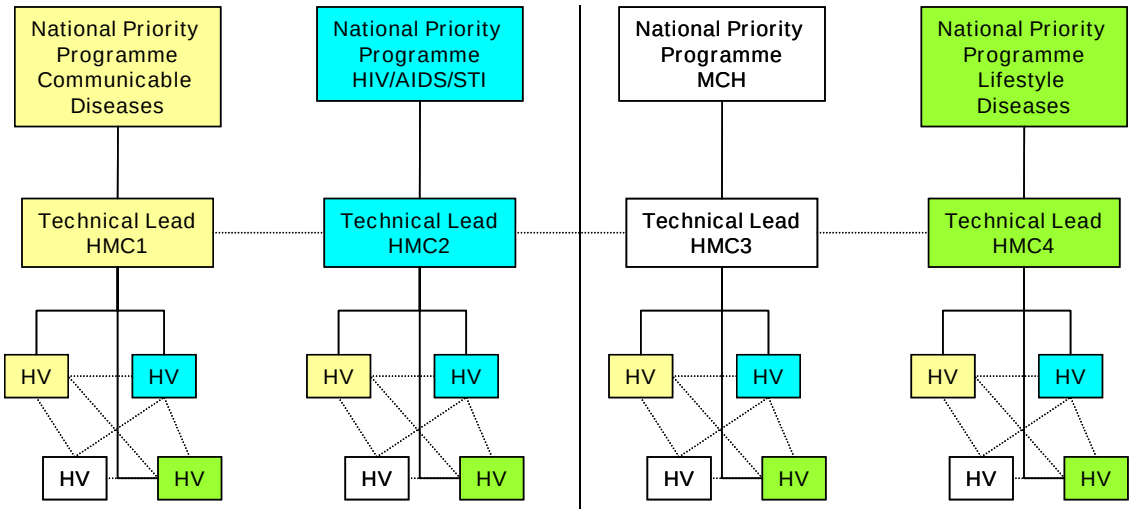
These National Priority Programmes will have their policy frameworks developed under guidance of a NPP National Committee to ensure programmes are meeting needs, standards and cost effectiveness criteria. Membership may include Ministry of Health directors, HMC Manager of Health Policy and Planning, consumer representation, and representation from regions. The Technical Programme Director, located in the Ministry of Health, reporting to the Chief Medical Officer, would have overall responsibility for the coordination of these national priority programmes.

The role of the Health Visitor (HV) will be reviewed. These are highly trained staff, whose role will be refocused to work to the RHOs with each HV taking responsibility for a geographical area and a NPP within each region. They will be responsible for the supervision of staff in their geographical area, including Medexes (doctors will be responsible directly to the RHO), and for the delivery of the NPP in their region. They will also have overall responsibility for community education, health promotion and prevention initiatives, ensuring that these are coordinated at the implementation level.

Budgets for the NPPs will be allocated to HMCs/regions for integration with regional primary health care budgets. This will facilitate the horizontal integration of services management and delivery at regional and facility levels. The Services Agreement mechanism will ensure high priority for these services, that resources are directed to communities with the greatest need, and that they are really spent for these purposes. Strategic plans and programmes have been developed and costed for HIV/AIDs, Malaria, MCH/EPI and IMCI, Nutrition.

Support will be provided for the establishment of this capacity in the HMC and to develop working linkages between the HMC Manager of Health Policy and Planning and the Technical Director of NPP in the Ministry of Health. This will ensure that there is no disruption of essential services during the reorganisation.

Figure 4: Proposed Establishment of Public Health Capacity at HMC levels



The HMC Manager of Health Policy and Planning is key in the development of Regional Health Plans and the roll out of the NHP. They will be responsible for the integration of management guidelines and training events, and for ensuring appropriate allocation of resources to avoid duplication of effort at community level. As part of the HMC Executive (but separate from the Manager of the Hospital and Primary Care Services) the HMC Manager of Health Policy and

Planning also has a key role in developing partnerships with and ensuring quality standards in the private sector. In the short-to-medium term, the HMC is not expected to be a purchaser of private sector health services and will focus instead on improving quality through sharing of national guidelines, regional based training events and encouraging private provider participation in improving regional data collection.

Regional primary care services will be strengthened

Health centers and posts provide good coverage but there are too many sites in the more densely populated areas and this exacerbates current staffing difficulties. Health centre staffing is well below expected levels, and patient attendances are low in some areas. By-passing (and consequent overcrowding elsewhere) will be reduced by consolidation and strengthening of lower levels of the system. In the short-to-medium term, where access is easier, some rationalisation or combination of facilities into single management units will be required to improve productivity so that staffing and supplies can be increased and the role of clinical supervision strengthened.

District Hospitals have never met their inpatient service objectives as conceptualized in the late 1970s. Although many were equipped with diagnostic and surgical capacity, staffing with doctors and technicians has remained problematic and inconsistent, and some facilities have never commissioned these services. Although medical technologists are generally more available now, specialists remain a serious constraint on the development of inpatient and surgical services.

Achieving adequate staffing norms is more important and more difficult than achieving numbers of health centres or health posts. To achieve the service target of 2.6 primary care attendances per capita, primary care staffing will need to be increased by 84% from current levels of about 550 to 990. Realistically, this increase in staffing levels can only be achieved by consolidating inpatient services and strengthening the capacity of hospitals to provide outpatient services.

In regions 2, 3, 6 and 10, inpatient services will be consolidated in the existing regional hospitals. The district hospitals will be converted to polyclinics, providing outpatient and MCH services. The polyclinics will be staffed with doctor(s) and complete primary care teams on a full time basis, with responsibility for clinical support and supervision of the primary care referral network. Kit-based laboratory services and basic radiological services will be available. The health centre and health post network will be reconfigured around this format.

In regions 1, 5, 7, 8 and 9, fully staffed inpatient services will be concentrated in a single community (or district) hospital for each region, with the remaining hospitals converted to health centres. Observation beds may be retained at these and other rural health centres, but without formal 24-hour staffing.
In the Hinterland Regions, health posts will network to a central (sub-regional or district) health centre in terms of clinical supervision and support, connected by radio communication. The health post will be staffed by a CHW and the health centre by a Medex and a CHW. The Hinterland health centre will be supported and supervised by the Senior Medex and doctor at the district hospital, who will authorise all transfers to the district hospital or directly to the regional hospital or to GPH. This model is already in place in Region 9.

HMCs will be responsible for setting up a process of rationalisation of health centres and health posts around the rationalisation of District Hospitals beds. The rate of progress in each Region will differ and this will be negotiated in the Services Agreements.

Capital funds will be made available to convert district hospitals for their new role, in particular for the integration of full preventive MCH clinics. Primary Care Development Funds will be set up for each region for preventive maintenance and selective upgrading of those health centres designated for complete primary care teams. Criteria will be established and a programme of upgrading works agreed for each annual Services Agreement.

Primary Care Training will focus on increasing the production of Health Visitors and strengthening public health skills; developing integrated regional based primary care training (starting with IMCI and nutrition); developing community psychiatry nursing; and developing a GP training programme (which will include working with existing practitioners).

Hospital services will be modernised and rationalised

Hospital admissions per 1,000 population are below the expected level, and ambulatory visits are significantly lower than expected. Hospital beds are not well used with occupancy below 20% at most district hospitals and often around 30% at regional hospitals eg. West Demerara and New Amsterdam.

A major strategic objective for future hospital services is to balance access, cost effectiveness and clinical effectiveness. This dictates that units need to be busy with enough caseloads to maintain clinical competences ie. they must serve sufficiently large populations. As hospital technology has become more specialized and more expensive, small inpatient units are no longer viable in terms of quality of care and costs, even if they provide easier access. Larger units are able to maximise day case work in surgery and diagnostics. Strengthened primary care is necessary for appropriate follow up and support.

The scale of inpatient services in district and regional hospitals will be reduced and some nursing and other staff redeployed to primary care. Even so, staffing in regional hospitals needs to be strengthened – the skill mix must change by the addition of more qualified staff. With efficient bed management, a total of about 1,150 acute beds is required to serve the estimated 2001 population (1.6 beds per 1,000 population) compared with a current complement of 1,844 public sector beds, including 260 extended care beds. No significant growth in total population is expected and the population trend in the more rural regions is downwards.

The main constraint on increasing hospital productivity is the number of doctors and specialists so, in the short-to-medium term, it is not feasible to support a completely decentralised hospital service. The community hospitals in Regions 1, 5, 7, 8 and 9, the Regional Hospitals of Suddie (2), West Demerara (3), New Amsterdam (6) and Linden (10), and GPHC will be required to work in close collaboration with each other. As a requirement for the accreditation programme for specialisation, clinicians will rotate through the smaller and less-busy units and back again into GPHC to maintain clinical skills.

Table 11: Projected Public Sector Acute Beds and Admissions by Region

Region	Population	Beds	Cases
1	18,294	14	879
2	43,139	48	2,864
3	95,276	113	6,417
4	294,494	606	32,387
5	51,274	54	2,917
6	141,455	233	11,476
7	14,682	13	778
8	5,574	6	344
9	14,947	13	734
10	38,851	50	2,949
Total	**717,986**	**1,150**	**61,745**

Overall, staff numbers in district and regional hospitals should be reduced from around 1,430 to about 1,170, with reductions in junior and untrained nursing and ancillary staff numbers but increases in specialist doctors, senior nursing and technical staff. Details of the range of services required at each hospital and the staffing norms are provided in *Annex 2: Health Services Strategy and Plan 2003-2007.*

The HMCs will develop the regional plans for the rationalisation of hospital beds and upgrading of remaining hospital sites based on this national strategy. Any deviation from the strategy will have to be justified and negotiated within the Services Agreement. A capital development plan will be implemented for these hospitals once agreement has been reached on the final configuration. For example, a new hospital is being planned for New Amsterdam plans are not based on the strategy of consolidating inpatient services into this site. The HMC will need to consider this and understand the implications for future development of this hospital.

A Mental Health Services Plan will be developed during the next five years, which amongst other things will inform the Development Control Plan of GPHC. Although Fort Canje is the designated psychiatric hospital, acute psychiatry cannot be provided here for the entire population. Acute beds will be developed at GPHC, and community based psychiatric care introduced at the new polyclinics.

Hospital training will include establishment of a post graduate medical training programme, general nurse training, specialist nurse training, maintenance programmes, management development.

GPH Development Control Plan (GPH Phase III) will be implemented

Bed occupancy at GPH is 80% on average, but beds in some specialties are overcrowded whilst those in others are not well used. Average lengths of stay are generally longer than good practice suggests. Within the national total of 1,150 acute beds required (see above), GPH requires about 605 beds, and a staff of around 1,180. This is little change overall from the current size overall, but some significant changes are required in the balance of beds by specialty including increases in provision for maternity and psychiatry and reductions in beds for surgery and medicine. Table 12 provides the detailed projections.

GPHC will remain the only medical training facility, and specialists will either have joint clinical appointments across HMCs or GPHC will maintain management of the total medical workforce, as an extension of their key role in postgraduate medical training. In either scenario, as the postgraduate apprenticeship medical training programme is established at GPHC, consideration will be given to how the doctors currently working in regional hospitals can be included in the programme.

The Services Agreement for GPHC and the Development Control Plan (DCP) for GPHC Phase III modernisation will be based on the bed need projections and the role GPHC will play in medical workforce development. DCPs are needed for the other regional hospitals in keeping with the new roles projected for them, including shifts to more day surgery and ambulatory care. This should be done as a single capital-planning project together with the DCP for GPHC to ensure coherence and to facilitate prioritisation of investment.

Table 12: Projected bed and case configuration for GPH

	Required				Current			
Specialty	**ALOS**	**OR (%)**	**Beds**	**Cases**	**ALOS**	**OR**	**Beds**	**Cases**
Surgery	4.4	77	124	9,908	7.4	49	246	5,942
Medicine	8.3	83	96	4,222	11.9	107	129	4,236
Paediatrics	3.7	66	48	3,272	7.3	71	58	2,050
Psychiatry	31.6	91	164	1,742	25.3	114	25	403
Maternity	3.4	64	132	9,332	5.5	176	72	8,520
Gynaecology	3.8	72	32	2,902	2.7	45	42	2,599
Ophthalmology	2.7	70	9	1,009	8.0	40	43	776
Totals	**6.0**	**77**	**605**	**32,387**	**7.3**	**80**	**615**	**24,526**
Totals ex Psychiatry	4.3	73	442		7.0	79	590	

Logistical support systems of transport and communication will be strengthened

Responsive primary care and referral systems require reliable and consistent logistical support. In Guyana's diverse and expansive context, transport and communication are important components of a health care delivery system. Experience in a range of other countries has shown that the implementation of a comprehensive transport management system, which includes proper communication systems, can support up to double the health services activity within the same budget.

As part of the establishment of the HMCs, particularly for the Hinterland Regions, transport management systems will be developed to cover operating guidelines for transport within the HMC, planned preventative maintenance and a rolling replacement schedule. The key elements to good transport management are the planning, scheduling, control and recording of transport use. Health teams must plan their work in advance and set priorities for transport use. Work will start on a transport management information system that will support decision making and continuously improve the management of transport as a important health care resource. The HMC databases will be fed to national level, where a focal point for transport management will be established, so that appropriate decisions can be made on allocation.

The first step in this process is to consolidate the national inventory for vehicles (four wheeled, motorcycles and bicycles). As vertical programmes are decentralised to HMCs, policy on the acquisition and use of programme vehicles will be revised. This will be shared with Development Partners so that joint action can be taken.

The Ministry of Health will develop a coherent national transportation policy for implementation by the HMCs. This policy will guide the allocation of transport budgets, and the acquisition and disposal of vehicles. The Ministry of Health and the HMCs will develop a proactive system of preventive maintenance rather than one of reactive maintenance based on repair. The

policy also will cover transportation of patients, for emergency and non-emergency care. Appropriate communication systems will support the transport of patients as integral component of managing the referral system and improving clinical supervision.

At the same time, a system of radio/telephone communications is to be introduced at the RHO level. This will provide the backbone for collecting data and improving clinical supervision in the hinterland and river rain areas.

4.3 Component 3: Establishing workforce development and HRM systems

The goal of the Workforce Development Strategy 2003-2007 (WDS) is to establish workforce planning and HRM systems in order to improve the allocation of available staff and the capacity of the sector to recruit and retain skilled and experienced personnel (see Annex 3).

In the next 5 years, the WDS will focus on four main action areas (within the context of the decentralisation and rationalisation of services strategies outlined earlier):

1. Workforce planning capacity will be developed in the reorganized Ministry of Health, in collaboration with the HMCs, GPHC and the private sector, so as continually to refine workforce development targets and strategies.

2. Modern and responsive human resources management (HRM) structures and systems will be established in the new HMCs, GPHC and the reorganized Ministry of Health.

3. Training programmes and recruitment processes will be modernized so as to increase production of appropriately qualified and skilled staff - priority areas include health visiting, nursing and medical training including family medicine.

4. Staff appraisal and reward/promotion systems will be streamlined for the new HMCs, GPHC and the Ministry of Health and continuous professional development (CPD) programmes will be integrated with performance appraisal systems.

Workforce planning capacity will be developed

The Ministry of Health will retain responsibility for strategic workforce planning and ensuring the equitable allocation of staff in the country, while devolving the personnel management role and functions to the HMCs and GPHC. This Ministry of Health role is critical to achieve national health targets, particularly with the phased development of HMCs and GPHC.

The performance of this role is dependent on the design and implementation of HRM systems in the HMCs and GPHC. These will collect the data for assessing the current situation and modelling future demand and national responses to that demand.

Working with Public Sector Reform, Ministry of Education and the private sector, the Ministry of Health will assess national labour market trends so as to forecast attrition rates and future supply issues. NHP strategies will begin to make the health sector a more attractive place to work, and to prioritise staff development taking into consideration private sector capacity.

To date, the key strategy for recruitment into the service has been to manage the entry into basic training and the absorption of the training output into the services. As shown with the GPH corporatisation, this is no longer sufficient. With increasing devolution, the functions of planning, training and personnel management (which includes managing the employment contract and relationship) will be clearly separated. Also, the processes and skills required for these different functions will have to be developed in the relevant organisations.

Currently, workforce planning involves little more than setting the establishment, a function that falls under Public Service Management (PSM). A key responsibility of the new Ministry of Health Planning function will be to develop a systematic approach to reviewing these establishments and adjusting them to meet needs and services development plans. Except for the new Ministry of Health structure, the PSM will be less involved, as the HMCs will be established outside the public service.

The Ministry of Health will also be responsible for the design of strategies and incentives for the achievement of these targets by the HMCs. This is not purely a HR policy issue, but the workforce plan must influence, as well as be aware of, the health priorities and the requirements of the various technical programmes. This type of joint planning is currently not done in the sector.

Modern HRM structures and systems will be established in the HMCs

The staff of GPH was transferred out of the civil service to the employment of the new GPHC as it was established. However, the transfer of staff to the new HMCs will require more careful and sensitive handling as it will involve one or more

RDCs as well as Ministry of Health and PSM. Further, because of the delays in convening the Public Services Commission, there is a backlog of confirmation of appointments and promotions. A Human Resources Manager and HR Unit will be established at both the Ministry of Health and HMCs to oversee the transfer and ensure that the rights of staff are safeguarded in the transition.

HRM systems are now being designed and implemented at GPHC in keeping with its new role. It will be important that common HRM systems be implemented across the HMCs and GPHC, as professionals will need to be tracked as they move from one entity to another. A joint project will be set up between GPHC and a Phase I HMC to ensure complementarity in the specification and design of the system. In the meanwhile, manual collation of workforce data in each HMC will be started. A Human Resources Management Advisor will be recruited to oversee these developments.

Training programmes and recruitment processes will be modernised

A long-term goal of the WDS is to increase production of professional staff. In the short-to-medium term, constraints in the production chain will be addressed in order to improve recruitment into the training programme as well as the quality of the training programmes themselves. This will involve working with the private sector to determine if using private sector capacity can increase the rate of production of trained workers. In the short term, this type of collaboration can also involve review of the nursing curriculum, working towards setting minimum standards for training in the private and public sectors. As the functions of employer and trainer are separated, the HRM processes that are being set up in the HMCs to recruit staff will also make it easier to recruit from outside the public sector training schools.

The Ministry of Health will retain the responsibility for training to ensure a concentrated effort to improve quality. A services (training) agreement will be set up with the training schools (the HSEU, the UGMS and the SoNs) to begin to clarify the roles and responsibilities of the training institution - as distinct from those of the Ministry of Health, the HMCs and GPHC as service providers. The role of the PSM in the recruitment process will also be clarified. The automatic subvention of public sector training schools will be revisited in order to develop more targeted support for recruitment from hinterland regions and rural sub regions.

Information systems will be developed with the training institutions to provide information on the profile of student applications by region of origin, ethnicity, gender and outcome of application and training. High failure rates have been documented for over 25 years and are reported to be as high as 50% per class currently, yet no data is available about the profile of these students and the reason for this remarkable failure rate.

Strategies will aim to improve the quality of entrants and to ensure their success - rather than to lower the entrance qualifications. Ongoing programmes of review and upgrading will be implemented starting with the basic nurse curriculum and other specialist nursing programmes.

Special incentive programmes will be designed and implemented for:

- supporting students to obtain sufficient CXCs particularly those students who have some demonstrated experience in the health sector eg. as volunteers
- providing financial assistance for those who cannot afford additional training or those from prioritised regions or sub-regions
- training of trainers
- public health training eg. restructuring of the health visitor training and clinical supervision activities.

A structured post-graduate medical programme will be developed as one of the main strategies to improve the retention of medical workforce in Guyana. The vocational training programme will be improved and priority given to the basic specialties. These include general practice, public health, internal medicine, paediatrics, obstetrics and gynaecology, surgery, radiology and anaesthetics. Sub-specialties will continue to be provided through technical cooperation agreements or recruitment from overseas. Special consideration will be given to the existing group of doctors who have been working at registrar level and who have not yet achieved specialist status. A post-graduate dean of medicine will be added to the university staff (or GPH) to lead this development. This will be linked to initiatives to improve the level of clinical supervision of under-graduate students.

Staff appraisal and reward/promotion systems will be streamlined

Although the HMCs and GPHC are being established as semi-autonomous state entities, operationally independent of the public service and the PSC, linkages will be made to Public Sector Reform particularly for support in management development and performance appraisal systems. Coherent development is

needed for the performance appraisal system, tying in career pathways, promotion and reward with CPD opportunities. These are the areas identified for priority development by PSR and the health sector will use the systems developed by PSR.

4.4 Component 4: Implementing a national quality framework

A national quality framework for assuring quality of clinical care is an integral part of the NHP. This will include lay as well as professional perspectives and cover:

- the continuous monitoring of care provided by teams
- incentives to facilitate individual practitioners to keep up-to-date, develop professionally and fulfill the requirements of their regulatory bodies
- processes to engage patient and their representatives.

The framework will be based on principles of 'clinical governance'. This aims to ensure overall accountability for the quality of clinical output – just as corporate governance aims to deliver managerial and financial accountabilities. The four main areas for development under this component include:

1. Standards of care will be set through regulation and policy guidelines
2. Organisational systems for clinical governance will be established
3. Professional self regulation and CPD will be implemented
4. Capacity to monitor and evaluate the framework will be developed.

It is essential that the quality framework is seen by health professional staff as supportive in their daily struggle to improve their practice and professional development. Systems that adopt a "policing" approach, which may be appropriate for the monitoring of buildings and machinery, will not work with people-based systems.

Standards of care will be set through regulation and policy

The Ministry of Health will work with professionals and representatives of patients to define standards of clinical care. To the extent possible, these standards will be evidence-based, measurable, related to desired outcomes and feasible to implement. For example, the MCH Programme has a range of established indicators against which performance of the primary care services are assessed.

The legal framework will be modernized to emphasise these clinical quality standards. Licensing and accreditation will remain the responsibility of the Ministry of Health and are important tools for ensuring compliance to these standards.

The patient perspective will be incorporated through, for example, systematic reviews of complaints. Structured engagement between patients and health professionals could be considered, but it is recognised that this dimension of quality often provokes professional concerns and fears and needs to be done well. The Ministry of Health will explore the implications of current and proposed consumer protection legislation for the health sector and will ensure appropriate information is available to providers and consumers about their responsibilities and rights.

Organisational systems for clinical governance will be established

The clinical team is the organisational unit for service provision. Quality initiatives will be linked to the management of service delivery and the health needs and perceptions of the communities. Ideally, clinical teams should meet regularly. Each year they should set out a team development plan linked to the key issues that staff feel could improve quality. Issues identified should be investigated using appropriate, but uncomplicated methods. Examples might include a clinical audit of the treatment of Acute Respiratory Infection (ARI), and a review of referrals to the regional hospital or GPH. There will be scope for the involvement of patient and community representatives in these exercises.

This approach is not new, and models exist for assessing impact and quality in MCH, EPI and other vertical programmes. In these programmes, guidelines and standards are set and monitored against comparable process and outcome indicators. Individual practitioners could use this approach to develop their own personal professional plan that would enable them to update their practice and target their continuing professional development needs.

This clinical governance framework will be led from the Ministry of Health and integrated into the management systems. The Ministry of Health will identify one pressing national quality issue each year (eg. prescription patterns for a category of medicines, maternal mortality, perinatal mortality) and adopt this as a national theme promoting it to health care teams. The reporting mechanism used by the Regional Health Officers (RHOs) and MCH annual reports offer a context where health care themes could

be developed. Once a theme is agreed, a specific audit will be undertaken across all health regions. Local regional teams could also select a local theme based on their assessed needs.

Quality initiatives will be integrated into the emerging arrangements for performance management (see Component 1). Themes should be realistic, ideally generated by consensus and with the likelihood of early successes, so that staff can see the connection between their efforts and improved outcome.

A key issue for review is supervision for the provision of care - it is vital to ensure that all persons carrying out clinical care are under clinical supervision within a clear chain of command of accountability. This includes the supervision of doctors post-registration, the supervision arrangements of Medexes by doctors and the supervision of CHWs in their curative roles. This is a valuable theme with which to initiate a quality review between the three levels of primary health care.

Clinical governance should be established in the private sector and practitioners will be encouraged to established voluntary systems.

Professional self regulation and CPD will be implemented

Internationally, regulation is demanding the periodic revalidation of competency in the primary medical degree and in accreditation of specialist status. Guyana will move towards this too. Professional self-regulation based on career development plans and targeted continuing professional education will be at the heart of this and will minimise the needs for external regulation. They will cover public and private sector professionals.

The re-establishment of the GMC, and location outside of the Ministry of Health is a good start and the basic CME programme provides the basis for further developments. In conjunction with the professional bodies, the Ministry of Health will agree a programme of continuing professional education for each category of staff. The development of a Post-graduate Medical Unit could lead this initiative and access to CPD programmes in the public sector could be extended to private practitioners. A link across registration systems will be established to identify and help doctors whose performance is causing concern and procedures will be developed to share evidence collated in clinical governance systems and for its assessment by the GMC. For regulation of medical specialties (including family practice), joint development with the GMC will ensure formal recognition of those qualifying from the vocational training programme. There was a previous initiative in the GMC where graded specialist accreditation was given to doctors participating in a specialist-training programme in Cuba.

Similarly, recommendations on the further development of the Nursing Council and nursing regulation will be implemented. The main challenge for establishing professional self regulation in nursing is that nursing management, training and regulation have traditionally been so interwoven and centred in the Ministry of Health, that it is more difficult to separate the various roles – particularly when there are severe shortage of nurse managers and leaders. However, this is a critical step for the overall development of nursing in Guyana and for the establishment of a quality framework covering both public and private sectors.

The regulation of other professionals including the Medexes and ancillary workers has also been traditionally located in the Ministry of Health and for similar reasons as above, efforts to devolve this responsibility should be prioritised and follow closely the development of the Medical and Nursing Councils.

Capacity to monitor and evaluate the framework will be developed

The aim of clinical governance is an integrated quality framework based on:

- Agreed common themes
- The setting of common standards and guidelines by programme
- Support by team development plans at regional and PHC level where local priorities could be considered.

The framework will be an integral component of the process for monitoring the performance of service agreements. It will be based on the practical concerns of health professionals and their willingness to critically review their practices, and address problems in a multi-disciplinary manner and within a learning environment.

A diagram of how these elements relate within a whole system is given as Figure 5.

4.5 Component 5: Directing finance to needs; improving accountability and performance

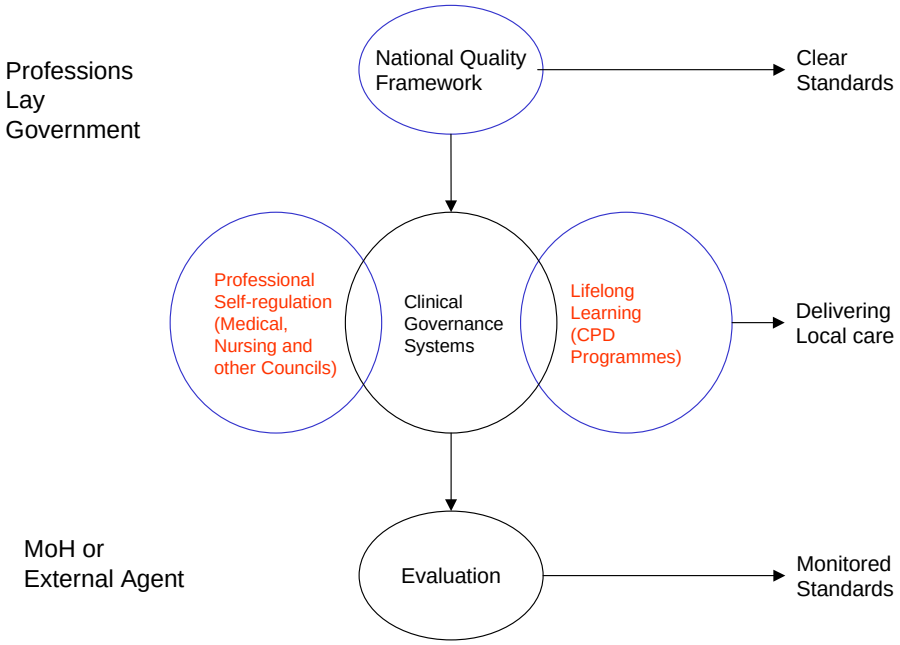
The PRS and the HIPC programmes provide an opportunity for GOG to increase public sector spending on health - perhaps by as much as 30% over current levels. Whether or not there is such an increase, the main objective of the financing

component of the NHP is the creation of mechanisms for directing finance to priority needs and improving financial accountability and value for money performance - for both public and private expenditure.

The main outputs under this component include:

1. Finance will be allocated using a formula weighted for health need and poverty
2. Financial accountability and performance management systems will be linked
3. A capacity for working with the private sector will be established
4. Regulation of private health insurance will be improved.

Figure 5: Schematic model of the major components of a quality system



Finance will be allocated using a formula weighted for health need and poverty

Despite the introduction of programme budgeting, resource allocation mechanisms still rely upon incremental increases to historic budgets. Formulae have been developed for allocating resources on a per capita basis, weighted for health need (age and sex structure, and differences in health care costs because of special needs) and deprivation or poverty. For Phase I of the NHP, new HIPC or PRS funds will be allocated using these weighted formulae, starting with funds earmarked for MCH and HIV/AIDS, and using the 2002 population data that will be available by early 2003. As financial management systems are built up to ensure financial accountability and as the management capacity of the HMCs are established, increasing proportions of existing budgets will be allocated using this mechanism.

By Phase II, the Phase I HMCs budget should be totally allocated based on the adjusted formula and depending on the success of Phase I, possibly also the budgets of the Phase II HMCs. Performance management will be assured through the Services Agreements.

Allocation to GPHC will depend on whether it is incorporated into an HMC or vice versa. If it remains a standalone institution, better cost data will be available to determine what services Government will fund and what will have to be funded by other mechanisms eg. user charges or health insurance for catastrophic care. A feasibility study will be conducted in Phase I on user charges at GPH for selected services. The

outcome of this study will be used to determine options for financing GPH in Phase II.

Financial accountability and performance management systems will be linked

It is important that HMCs be given full authority over their budgets in order to bring about technical and administrative efficiencies at the operational level. However, freedom to manage within global budgets is not without its problems. Sound financial management systems must be implemented to ensure financial accountability. These will be based on commercial practices, including external audit. By Phase II, it is intended that the financial flows to the HMCs will be streamlined, and that at least the Phase I HMCs will proceed to corporate status and be required by law to produce audited financial statements.

Cost accounting systems will be implemented so that, as the system moves to assessing outputs rather than tracking line item inputs, details are available to managers and the Ministry of Health about costs and performance. This will link to the performance management framework (or planning processes), so that the underlying chart of accounts and cost centres are aligned to the key performance measures that are included in the services agreements.

A capacity for working with the private and NGO sectors will be established

A well functioning private sector (which includes not for profit NGO providers) can create stimulation and competition for the public sector to perform better, especially if Ministry of Health and/or HMCs can spend some of their budgets on these services for public patients. On the other hand,
private sector investments in health are often granted import or profit tax concessions. This loss of government revenue amounts to a subsidy for the better off users of private care and may also increase supplier induced consumption resulting in unnecessary and undesirable care. It may also introduce technologies that then create cost-ineffective demands in the public sector.

Policies should aim to minimise duplication of resources across public and private sectors and be supported by a rationalisation programme in the public sector. In practice, this is difficult to achieve because of the lack of knowledge about capacity, activity and expenditure in the private sector, including utilisation of overseas care. It is important to know more about the private sector.

In Phase I, the Ministry of Health will establish a focal point for the development of a strategy for working with the private and NGO sectors. Linkages will be set up with the Ministry of Finance, and Development Partners (DPs) working directly with NGOs, and with the lead for development of the national quality framework (Component 3). Processes and systems will be implemented for the routine monitoring of private and NGO sector capacity and expenditure. This will be a joint activity with the development of health information systems (under Component 1).

Technology assessment and cost effectiveness methodologies will be used to determine an investment policy for the health sector. Pilot projects with the private sector will be designed and implemented, including exemption mechanisms for the poor and/or selected high-risk groups. Based on evaluation of the outcome of these developments, the strategy will be implemented in Phase II.

Regulation of the private health insurance will be improved

Whilst there is continued interest in social health insurance as a means of pooling finance and increasing value for money in public and private sectors, it is recognised that current conditions are not conducive to the successful implementation of such an initiative. With high levels of unemployment, under employment, and informal employment, contributions would fall disproportionately on the formally employed including public sector workers. As a tax on jobs, social health insurance contributions could distort the labour market and force more people into under employment or the informal sector.

However, coverage by private health insurance is increasing – mostly of the formally employed – and whilst this is neither an equitable nor efficient method of funding care, it is a reality. The regulation of the private health insurance industry is weak: no consumer protection mechanism is in place, not even information about what constitutes a good insurance package and about the pitfalls of insurance coverage. Regulatory mechanisms fall under those for general and life insurance in the Ministry of Finance.

In Phase I, options for regulating the private health insurance will be developed. This will be informed by the databases on private sector expenditure and activity outlined earlier and in collaboration with the work on modernizing the regulatory framework for health services. At the end of Phase I, studies on user charges at GPHC, exemption systems for the poor and/or high risk, and private health insurance will be synthesised to reassess options for financing of

the health sector. Whether or not the country decides to move forward with social health insurance, private health insurance will remain an option and mechanisms for improving the regulation of private health insurance will be implemented in Phase II.

5 Costs and Financing of the National Health Plan

Recurrent Costs 2001

Public sector services including GPHC cost GY$4.43 billion in 2001. Table 13 summarises budgets by Ministry of Health, Regions and GPHC.

Table 13: Summary of public sector budget Ministry of Health, regions and GPH 2001, GY$000

	Central Ministry of Health	Regions	GPHC	Total
Pay	436,913	897,807	739,973	2,074,693
Non Pay	1,063,564	458,841	833,920	2,356,415
Total	**1,500,567**	**1,356,648**	**1,573,893**	**4,431,108**

Excluding administration costs, the total available for services amount to GY$3.5billion.

Projected Costs of Services: 2003-2007

The *Health Services Strategy and Plan 2003-2007* is based on strengthening primary health care and rationalising inpatient facilities so that, if all else were kept constant, recurrent expenditure levels would rise only 7.5% for a projected 107% and 17% increase in primary care services and hospital admissions activity respectively.

By controlling the hospital network, staffing would have to increase by 8% (instead of 44% if the current bed complement and distribution were maintained). New funding can be allocated to:

- Public health programmes
- Improvements in terms and conditions of health staff particularly incentives for rural postings
- Logistical systems support
- Establishment of management capacity (people and systems)
- Essential drugs and supplies
- Contracting of essential clinical services from the private sector.

Given the constraints in workforce production, recruitment and retention, the emphasis in this NHP is on the redistribution and retraining of current staff and improvement in the entire production cycle of skilled professionals. The targets described in the *Health Services Strategy and Plan 2003-2007* are projected as 10 year targets, with very little increase in numbers of staff in the first 5 years.

For illustrative purposes, cost projections are made for 3 scenarios:

- The NHP without wage increases
- The NHP with a 10% increase in wages
- The NHP with a 2% pa increase for new services.

Scenario 1: the NHP without wage increases

Although sector expenditure is low as a percentage of GDP, the NHP does not project large increases in recurrent expenditure for the next 5 years. The main emphasis in this period is the redistribution of staff, major development initiatives in management development (skills and systems) and further decentralisation. With facility rationalisation, the cost of services is projected to rise around 7.5% from current levels within 10 years at constant prices.

Scenario 2: the NHP with a 10% increase in wages

The workforce development strategy proposes increases in wages but geared to improving the ability to recruit and retain skilled staff in the rural areas. Projections indicate that an average 10% increase in pay (at the managerial discretion of the HMC as to how and to whom this should be applied) will result in a 2% increase in public sector services cost in the first 5 years. As the skill mix of the workforce is improved in the next 5 years, total expenditure will rise by 12%. In practice, this increase will only be available during Phase II or year 3-5 of the NHP period, when the HMCs are established and have the autonomy to apply new salaries outside the public service (similar to the GPHC experience).

Scenario 3: the NHP with a 2% pa increase for new services

The rationalization and consolidation of services outlined in the NHP will achieve better value for money than the way services are currently provided and staffed. But neither of the above two scenarios include costs for needed new programmes including major public health promotion. An increase of 2% pa of total budget to cover new or improved priority programmes

results in an increase of 12% by year 5 and 37% by year 10.

These projections are shown in Table 14. The reductions shown for the early years in Scenario 1 result from the modelling assumptions that rationalisation can be achieved immediately. In practice, the pace of change will depend on many factors. Projections have been made for allocations by region but these will be refined during the Preparatory and Piloting Phase (see section 6.2) as HMC/regional services plans are developed with regions and Services Agreements are negotiated.

Capital expenditure 2003-2008

During the Preparatory and Piloting Phase, a programme of technical support, institutional development (structures, process and system) and infrastructure will be developed and costed.

Table 14: Recurrent Cost Projections 2003-2013

Year	2001	0	1	2	3	4	5	6	7	8	9	10
Scenario 1: the NHP without wage increases												
Total pay cost	1,222	1,322	1,326	1,329	1,333	1,336	1,340	1,387	1,436	1,487	1,540	1,595
Total cost	3,474	3,403	3,402	3,402	3,401	3,400	3,400	3,464	3,530	3,597	3,666	3,735
Change re 2001		-2.0%	-2.1%	-2.1%	-2.1%	-2.1%	-2.1%	-0.3%	1.6%	3.6%	5.5%	7.5%
Scenario 2: the NHP with a 10% increase in wages												
Pay rise	10%											
Total cost		3,535	3,535	3,535	3,534	3,534	3,534	3,603	3,674	3,746	3,820	3,895
Change re 2001		2%	2%	2%	2%	2%	2%	4%	6%	8%	10%	12%
Scenario 3: the NHP with a 2% pa increase for new services												
New services	2%											
Total cost		3,535	3,606	3,677	3,751	3,825	3,902	4,058	4,220	4,389	4,565	4,748
Change re 2001		2%	4%	6%	8%	10%	12%	17%	21%	26%	31%	37%

6 Implementation Arrangements

6.1 Our Partners

The Development Partners

GOG recognizes the significant support provided through our development partners (DPs). Many of the inputs are already in train but it is hoped that the NHP will facilitate a more prospective planning cycle. Table 15 summarises these partnerships (in alphabetical order).

Table 15: Development partner (DP) support

DP	Area of Support
CDC	HIV/AIDS/STIs
CESAM	Communicable Diseases
China	Medical workforce
CIDA	HIS HIV/AIDS/STIs, TB Financial Management (MoF)
Cuba	Medical workforce Training
GAVI	EPI
GTZ	HIV/AIDS
IDB	Nutrition Health Sector Reform
India	Training
JICA	New Amsterdam Hospital
PAHO/CAREC	Technical Programmes: Communicable Diseases MCH/IMCI/EPI Non Communicable Diseases Environmental Health Health Sector Reform
USAID	HIV/AIDS Adolescent Health
UNAIDS	HIV/AIDS
UNDCP	Mental Health (Substance abuse)
UNDP/UNICEF	MCH/EPI
UNFPA	Family Planning HIV/AIDS
World Bank	HIV/AIDS

The Private and NGO Sectors

Consistent with GOG policy to stimulate the private sector so as to accelerate the pace of economic and social development, GOG has begun to openly encourage investment and provision of private health services (which covers both commercial private sector and NGO providers). To date, however, the process of approval lacks consistency and transparency - two essential elements for sustainable public-private partnerships – and has consisted of reactions to one-off projects proposed by the private and NGO sector and considered on a case by case basis.

As the Ministry of Health develops its stewardship role, a coherent strategy will be elaborated for working with the private and NGO sectors. This will be based on national and international experience. As regulator of the health market and protector of the public health, the Ministry of Health will seek to enhance demand-driven incentives to counteract the supplier domination of the market. Strategic objectives will include:

- to increase coverage of products and services with a public health benefit, particularly to the poor and those at high health risk
- to limit harmful practices and improve technical quality of care
- to contain unnecessary, supply-driven expenditure.

The Ministry of Health will drive the achievement of these objectives working with other key ministries, the DPs, the private sector, providers (of services and products), and consumers. Strategies will include regulatory controls over quality, sharing of information and training opportunities, community education programmes, contracting with providers for specific health services and introducing exemption plans for priority target groups.

6.2 Phased Implementation

Implementation of the NHP will be phased to ensure integration of the organisational development agenda with the strengthening of the delivery of services. This will allow a level of flexibility and the ability to evaluate progress at critical checkpoints so that the plan can be adjusted. This means that interim targets can be moved forward as well as back, within the overall objective of achieving the five-year targets. Implementation will occur in three phases as outlined below.

Preparatory and Piloting Phase: November 2002 to September 2003

The main objective of this phase is to set up two pilot HMCs, specifically to:

- Establish the Berbice HMC (as a single-region HMC) and agree the scope of the Berbice HMC Services Agreement and the legal status of the HMC

- Explore options for establishment of the Hinterland HMC (as a multiple-region HMC).

The outcome of the Berbice HMC 'pilot' will include:

- Appointment of the Board and CEO
- Agreement on the management structure and appointment of management team
- Delineation of the functions of the HMC (the board, executive and health facilities), the those of the RDC, the Ministry of Health, MoLG and MoF
- Agreement on financial flows to the HMC and the interim arrangements about management of staff and authority over budgets
- Completion of the Berbice HMC Services Agreement (including completion of a capital development plan for the HMC for the next 5 years)
- Agreement on a management structure of New Amsterdam Regional Hospital and relationships with the HMC Executive
- Implementation of a management development programme for the HMC.

In addition to setting up two pilot HMCs and supporting early development activities, this phase will also cover:

- Capital development planning for GPHC and other hospitals
- Completion of the Ministry of Health restructuring plan
- Refinement of the GPHC services agreement and support its implementation
- Completion of regional health plans with the HMCs/regions
- Communications to inform the public
- Completion of the NHP monitoring and evaluation framework.

NHP Phase I: October 2003 to Mar 2006

Phase I Implementation will run for about 2 years of the NHP. During this time, there will be several different organisational entities at various stages of development in terms of structures, systems and functions. Additional human and financial resources will be provided in terms of technical support for management and systems development. The focus in Phase I will be mostly structural in nature: clarifying roles and relationships, selection and orientation of Boards and executive teams, agreeing the precise legal status of the HMCs, drafting required legislation and establishing accountability mechanisms.

At the end of Phase I, the Ministry of Health reorganization will be completed and the new structure in place and operational. The Phase I HMCs will be fully established and operating under services agreements with the Ministry of Health, with complete autonomy over operating budgets and staff. Technical Programmes will be led from the HMCs and will be monitoring regional as well as national health targets. Regional health services plans will have been agreed and the Phase I polyclinic development programme completed. Ongoing training programmes will be in place for the reorientation of hospital staff for primary care and for ongoing management development of the new HMCs and the Ministry of Health. Detailed hospital redevelopment plans for the four regional hospitals will be completed. A private sector development strategy will be completed in keeping with the progress on rationalisation and health financing initiatives.

NHP Phase II: April 2006 to Mar 2008

Phase II will involve the Ministry of Health assuming full responsibility for implementation of the remainder of the NHP and completing the decentralisation programme to HMCs. Continuation of the programme will depend on the outcome of a full evaluation in September 2004. Phase II Implementation will involve substantial changes in the way decisions are made at regional level and focus more on systems development rather than structures. It is important to have managerial capacity in place before systems are implemented. More operational autonomy will be handed over to the HMCs and the annual planning and budgeting cycle will begin to align organisational targets to those of individual managers and the HR performance management framework.

6.3 Managing the transition

The scope of the changes proposed presents implementing the NHP with significant challenges. Moreover, the planned reorganisation must be managed in a way that does not detract from or cause significant disruption of essential health services. Experience elsewhere suggests that it is difficult to drive significant change from within an operational Ministry of Health when staff is naturally preoccupied with services. At the same time, an external project management unit can fail to build capacity during the change process.

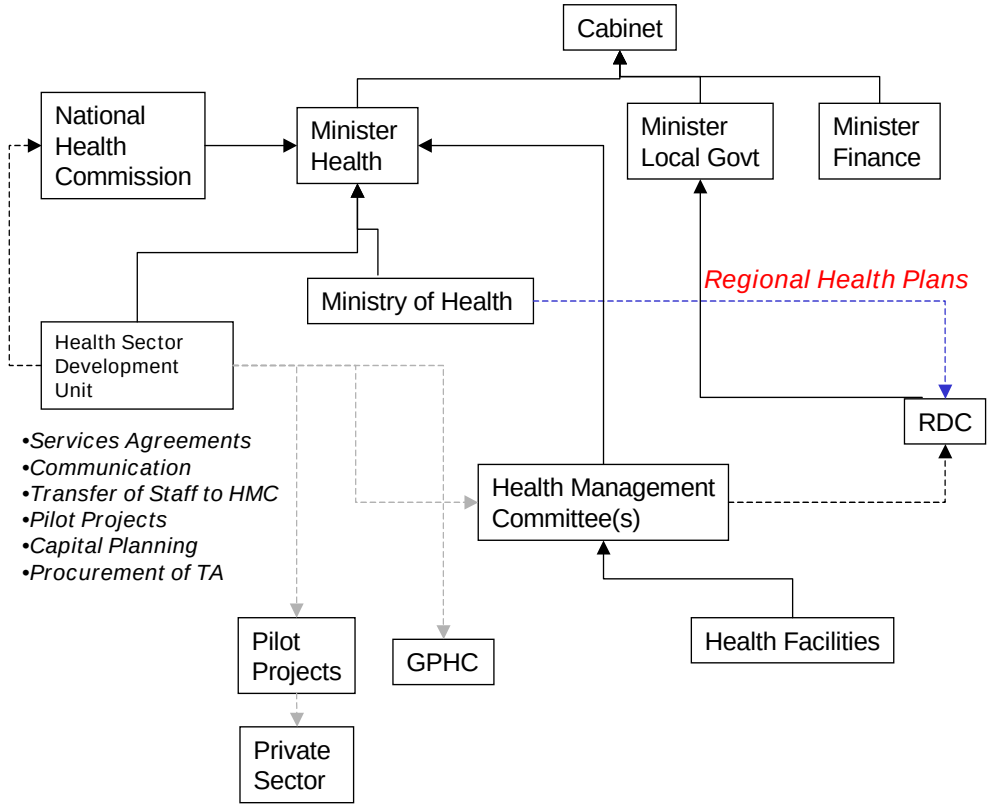
To achieve a balance, a Health Sector Development Unit (HSDU) will be set up as the HMCs are being established and the Ministry of Health reorganized. The HSDU will report to the Minister of Health, its director will be a member of the Ministry of Health Executive Team, and it will be time limited (its functions will transfer to the Ministry of Health as the relevant components of

the reorganisation are in place). Initially, the HSDU will undertake the tasks of the Preparatory and Piloting Phase as outlined above. During Phase I it will undertake or coordinate the following functions:

- Performance management of the HMC(s) through the implementation of the services agreements
- Procurement of technical assistance
- Human resource management including transfer of staff to HMCs and establishment of HR functions within the HMCs
- Communications
- Capital planning
- Coordination of technical cooperation to ensure complementarity with the NHP
- Monitoring and evaluation of the NHP.

Figure 6 illustrates the proposed relationships.

Figure 6: NHP Phase I Management Arrangements



The NHP will require new systems of accountability and to establish new systems of consultation and planning. It is proposed that a National Health Commission be established (comparable to the National Education Commission) as a policy forum to stimulate active participation by civil society leadership in the development of the sector. In Phase I, the Minister of Health will chair the Commission and the HSDU will act as secretariat. By Phase II, as the capacity of the Ministry of Health and Commission is improved for policy development, the Commission will move to a rotating Chair system and the Ministry of Health will assume the secretariat function.

Key skills required in the HSDU include: Health Management, Health Financing, Capital Planning, Communication, and HR Management. The HSDU unit will be staffed with full time managers in these areas supported by a technical support team on an interim and workplan basis. The Director of the HSDU will work as part of the Ministry of Health Executive Team and have a reporting relationship directly to the Minister of Health. As the Ministry of Health is reorganized, HSDU functions and skills will be absorbed into the new structure. By the end of Phase I, the HSDU will hand over line authority to the Ministry of Health, or the HMCs, and assume a project management and technical advisory role for Phase II of the NHP.

The phased approach allows for flexibility and building of ownership of the change process as well as incremental development of the management and technical capacity needed to sustain the new organisations and services. However, the scope of the change as well as the severe shortage of skilled and experienced managers will require transitional technical support in the Preparatory and Piloting Phase and Phase I stages. The nature of this support will change in Phase II as institutional capacity is built up. The phasing out of interim structures is an important benchmark for progress.

6.4 Monitoring and Evaluation of the NHP

Monitoring and evaluation of the NHP will be built on the establishment of the new performance management framework between the Ministry of Health and the HMCs, GPHC, HSEU, MMU and the private sector. This framework will integrate services and health targets by region. Specific indicators will be set up for monitoring technical support and capital development projects as interim process indicators to achieving the plan's objectives and these will be managed by the HSDU. Otherwise, data will be collected by the HMCs, GPHC and the Ministry of Health as part of the development of the health information system and collated as required by the HSDU for submission to the National Health Commission and the Minister of Health. Adjustments to the NHP targets will be made based on this ongoing monitoring and evaluation process and reflected in the allocation of financial resources as well as the content of the annual services agreements.