

Health Care in Guyana

Prem Misir, Ph.D., MPH, M.Phil, B.S.Sc.(Honours), FRSPH

Abstract

The paper is an overview of the Guyana healthcare system, its outcomes, health planning, health reforms, potential health reforms, and the government's contribution to the development of an efficient and equitable health system for the entire population. The current institutional arrangements for health system and service development in Guyana pose significant challenges requiring significant health planning to achieve meaningful health reforms. The Health Systems Assessment (HSA) reviewed the Guyana healthcare system's functioning on six modules consistent with the WHO's system building blocks - governance, health financing, service delivery, human resources for health (HRH), pharmaceutical management, and health information systems (HIS); these are in synchrony with WHO's concept of reform. The HSA review identified areas for health reform through the WHO's system building blocks. The paper reviews the history of health plans and reforms in Guyana to establish the influence of neoliberalism in the pathway toward universal health coverage and equity.

Introduction

Health policy globally has endorsed the twin goals of universal health coverage and equity in promoting better health for all. Jeffrey Sachs poign-

antly asserted that the notion of universal health coverage (UHC) is rooted in politics, ethics, and international law.¹ Sachs validated the roots of UHC in Article 25 of the 1948 Universal Declaration of Human Rights; this states that every person has a fundamental right to a standard of living adequate for health²; Sachs also invoked the WHO Constitution which states that: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic, or social condition."³

The consensus that every human should have adequate access to quality healthcare begins to unravel in many countries during the process of actually designing, managing, and financing healthcare. For instance, in the United States of America (U.S.), the objectives of the 2010 Patient Protection and Affordable Care Act (ACA or Obamacare) were to reduce the number of uninsured, improve access to affordable healthcare, remove the concept of imposing higher insurance premiums on people with pre-existing conditions, and reduce total healthcare costs through focusing on quality not quantity.⁴ U.S. conservative stakeholders rejected Obamacare and universal health coverage because they see health insurance as a commodity in a free market economy where neoliberalism is the dominant ideology.

The inefficiencies and inequities resulting from neoliberal healthcare reforms imposed by the World Bank and the International Monetary Fund in the 1970's and 1980's have been well documented.⁵ The fundamental principle governing neoliberal health reforms is the view that the private sector is more efficient than the public sector. This implied that the role of government should be minimal; the World Bank felt the neoliberal state should restrict government's role to regulating health while the private sector should be the provider of healthcare services.⁶ These reforms were carried out by two

Prem Misir, Ph.D., MPH, M.Phil,
B.S.Sc.(Honours), FRSPH
Executive Director
Health Sector Development Unit (HSDU)
Ministry of Health, Government of Guyana
Georgetown Public Hospital Compound
East & Lamaha Streets, Georgetown, Guyana
Tel: (592) 225-9287

Submitted: 3/12/2014

Accepted: 6/18/2014

Conflict of interest: None

Peer-reviewed: Yes

key processes: decentralization and privatization. In this way, governmental funds would be released to pay off the government's huge public debt, the reason the World Bank's loan had been initially sought.⁵ Reducing the government's commitment to provide health services was the quickest way to pay off the public debt, and decentralizing healthcare to the regions was presented as a way of transferring power away from an apathetic and inefficient central bureaucrats to the local people (as part of a process of improving democracy).⁷ These processes were not primarily designed to provide universal health coverage and equity in healthcare. Rather, they fulfilled the World Bank's self-interested mission in reducing the state's public debt.

The former WHO Director-General Dr. Gro Harlem Brundtland⁷ noted that health systems should reduce inequalities and adopt approaches that improve the health status of the worst-off; further, she indicated that in order to determine whether the goals of equity and equality were being met, countries should utilize WHO measures for the performance of health systems based on their four functions: service provision; providing human and physical resources to ensure delivery of services; procuring and pooling the resources employed to finance healthcare; and government's fulfillment of its stewardship role.

This paper reviews the development of health plans and reforms in Guyana to establish the influence of neoliberalism on the pathway toward universal health coverage and equity. This paper presents the historical context of health reforms from the colonial era through the post-Independence period. The paper then describes the current socioeconomic context of health reform focusing on Guyana's geography, social demographics, and economic indicators. In addition, this paper reviews the Guyana health system, health outcomes, health planning, and health reforms. Further, this paper discusses potential health reforms and the role of the government. In the final section, the paper examines the challenges of health reform within the neoliberal paradigm, and suggests that the health reform process should be a political project to counter the negative aspects of neoliberalism.

The historical context of health reforms

Guyana like many former British colonies experienced the full wrath of colonialism on the political, social, and economic fronts; the health sector also was not spared this fury. For instance, Turshen⁸ observed that pervasive ill health and chronic malnutrition were not simply domestic problems (just as poverty was not), but were the consequences of colonialism. Ramnath⁹ traced early health policy development in the colonial Commonwealth Caribbean (which included Guyana, Jamaica, and Trinidad and Tobago) as follows: the planters' and the colonial authorities' first priority was the sustainability of the plantation economy, initially under slavery and later under indentureship; the medical profession, through the presence of British physicians and surgeons, served to legitimize the plantation society; two significant developments in Great Britain - the British Public Health Act (1848) and the Sanitary Commission Report (1869) - impacted colonial health services; when the planters expressed their unwillingness to provide healthcare to the freed slaves, the colonial authorities with a new mandate in the crown colony system provided some semblance of public health services to them; and in the post-emancipation era, the mushrooming colonial medical profession controlled the practice of medicine and management of early public health activities that later evolved into local ministries of health.

Major health reforms did not come until 1945 when the Moyne Commission¹⁰ exposed significant health concerns related to poverty; these included high infant mortality and widespread morbidity, poor housing, inadequate sanitation, and undernourishment. The Commission also expressed concern that curative services were afforded higher priority than disease prevention. It recommended ameliorative measures vis-à-vis improvements in health, education, welfare, and housing. In 1947, rural health received a boost through agricultural workers' compensation and the organization of medical services on the sugar estates. Also in the late 1940's, the colonial government engaged in a malaria-control campaign that practically wiped out malaria on the coastland. Malaria, however, remained a threat to

the people in both the hinterland and coastland areas in the 1990's.¹¹

Health reforms in the post-Independence period (1970-1980)

In a study on health human resources policy and policy reform in the Commonwealth Caribbean, Ramnath⁹ reviewed policy reforms in planning, training, administration and management in Guyana between 1970 and 1980.

Reform Plans

The Ministry of Health in 1969 set up a planning unit that developed a 10-year plan called *A Blueprint for Action* in 1970. The plan employed regionalization to address five levels of care, with levels one and two intended to provide primary care services to the indigenous people in the hinterland and levels three, four and five to provide secondary and tertiary care services to the urban areas. Five health regions nationally were to be established to implement these services; and two administrative levels – regional and central - were set up. The Ministry of Health was the central body responsible for policy making and regulation. The proposed health reform was expected to provide an equal focus on preventive and curative aspects of diseases, with equal access to healthcare, and attribution of high priority to human resources development. These reforms had not been implemented by the close of the 1970s.

The Neal Report 1982 observed that human resource development devoid of planning and manpower development persisted without any connection to the needs of the healthcare system.

Human Resources Development

The 1970 health plan indicated that appropriate training programs would support human resources development. The Medex training program (to prepare local mid-level healthcare practitioners) was created in 1977, followed by the Community Health Worker training program in 1979. Both programs were weakened in the 1980s by reductions in healthcare spending driven by the Government's concern for its political survival. The health plan had also indicated that the Ministry of Health at the

central level should have jurisdiction over nurse workforce planning and training: it would provide guidance at the regional level. To ensure an adequate supply of physicians, the Ministry of Health's core policy was overseas recruitment. A small number of medical students were trained at the University of the West Indies, in North America, and the UK. Nonetheless, a shortage of physicians remained a problem.

Administration and Management

The 1982 Neal Report examined the administrative failure of the previous decade, pointing to the failures of planning, production, and management /utilization. The end result was a system lacking the ability to coordinate and properly staff the health service in the 1970s. In addition, bureaucratic politicization with its concomitant inefficiencies and incompetence, the devastating migration of health personnel, and inadequate backing for public sector non-People's National Congress (PNC) party supporters destroyed any hopes that the 1970 health plan might actually be implemented.

Summarizing Guyana's experience with healthcare reform in the 1970's, Ramnath concluded: "The parlous state of the health system at all levels - human, physical and material - by the end of the 1970s therefore reflected not only economic circumstances, but a clear case of neglect and lack of commitment to policy implementation by the regime. This neglect was partly understandable given the economic as well as political predicament facing the regime at that time. [...] Attempts at developing and implementing a comprehensive human resources policy for the health sector under these conditions were therefore limited and ad-hoc at best, and both negligible and negligent at worst."⁹

During the 1980's, the PNC Government tried to implement its socialist philosophy through a healthcare reform based on primary healthcare; the goal was to provide accessible care for all. But the 1980 budget allotted only 5% of funds to health, with as much as 10% going to security. The Government's priorities were clearly oriented more toward political survival instead of health reform.¹² The result was increased physician and nurse migra-

tion. Undoubtedly, nurses and physicians experienced work turbulence during the 1980-1990 period; Spinner¹² notes that some doctors communicated with the Minister of Health about gross shortages of everything that would make quality healthcare possible. In a context marked by worsening working conditions and inadequate emoluments, highly skilled nurses migrated as soon they emerged from nursing training programs.¹³

Notwithstanding the undemocratic and resource-scarce environment, the Government was interested in resolving the problem of physician shortage arising from migration.⁹ Since 1973 the Guyanese Government had sent only 5 students at full-cost scholarships to the University of the West Indies Medical School in Jamaica. This number was insufficient to produce an adequate supply of physicians, and so the Government decided to create a medical school within the Faculty of Health Sciences by September 1985. Today, the University of Guyana School of Medicine has provisional CAAM-HP accreditation.

Reflecting on the PNC record on health, several of the PNC Government's health reform policies between 1970 and 1990 were laudable, but many of them also were not implemented. As a consequence, health policy remained an ad-hoc affair as it had been during the colonial period.

The current socioeconomic context of health reforms

A paradoxical feature of Guyana is that despite its huge land space of 83,000 square miles (approximately 216,000 square kilometers), arable land is scarce. Geographically, Guyana is situated on the north-east coast of South America, with the Atlantic Ocean in the north, Suriname in the east, Brazil in the south, and Venezuela in the west.

Guyana is positioned between 1 degree and 9 degrees north latitude and 57 degrees and 61 degrees west longitude, and expands south to a depth of 450 miles. Guyana has four natural regions: the low coastal plain; the hilly sand and clay area; the highland region; and the interior savannahs. With about 90 percent of its population on the coastland, it may be accurate to not only see Guyana as the "land of many waters," but also as the "land of the coast-

line." Guyana's land boundaries measure 2,949 kilometers, with land borders of 1,606 kilometers with Brazil, 743 kilometers with Venezuela; and 600 kilometers with Suriname.

People of diverse ethnic origins arrived in Guyana to work on the sugar plantations, initially as slaves and later as indentured laborers. Based on the high variant assumption, Guyana's population is estimated at 808,309 for 2015¹⁴ with the following projected age distributions for 2015: 0-14 years: (male 102,438 (12.6%)/female 101,818 (12.5%)); 15-64 years: male 275,773 (34.1%)/female 271,094 (33.5%); and 65 years and over: male 25,461 (3.1%)/female 31,724 (3.9%). Indeed, Guyana has a youthful, but ethnically diverse population. The population distribution in 2002 was as follows: East Indian (43.46%); African (30.20%); Amerindian (9.16%); Portuguese (0.20%); Chinese (0.19%); White (0.08%); and Other (0.01%).¹⁵

Guyana's per capita income in 2012 was US\$ 3,340. In that year the Gross Domestic Product (GDP) grew 4.8%. The unemployment rate was 11% in 2007,¹⁶ and the literacy rate was 91%.¹⁷ In 2010, about 90% of the population had access to improved water and about 85% to improved sanitation.¹⁸

The country's stable macroeconomic fundamentals and improved sanitation are appropriate platforms for the health sector's take-off, the latter largely as a result of Guyana's gaining from Enhanced-Highly Indebted Poor Countries (HIPC) initiatives since 1997, producing a general decrease in its external debt from 122% of the GDP in 2002 to 38% in 2008; the country's HIPC status also enabled it to be the beneficiary of huge resources. How much have these social and economic factors impacted on the present health system?

The Guyana health system

The public and private sectors are the main providers of healthcare in Guyana. The Ministry of Health (MoH) is the major governmental provider and financier of healthcare. Guyana's health system is expected to be decentralized with the Ministry of Local Government and Regional Development man-

aging, financing, and providing healthcare through the Regional Democratic Councils (RDC) and the Regional Health Authorities (RHA) in 10 Administrative Regions. Currently, there is only one RHA in the country in Region 6. The MoH is expected to provide guidance to the RDCs and RHAs.

Additional government agencies – the Ministries of Education, Agriculture, Local Government and Regional Development, and Amerindian Development – support the MoH in healthcare provision.

In 2009, there were 9 National Hospitals, 6 Private Hospitals, 21 District/Cottage Hospitals, 5 Regional Hospitals, 2 Specialist Hospitals, 1 Geriatric Hospital, 1 Rehabilitation Center, 211 Health Posts, and 127 Health Centers.¹⁸ There is a private healthcare sector operating under the jurisdiction of the Health Facilities Licensing Regulation that determines overall standards of care and practices. Currently, there are seven private hospitals with their associated clinics. The private hospitals are St. Joseph Mercy Hospital, Davis Memorial Hospital,

Hospital, Dr. Balwant Singh's Hospital, and Anamayah Memorial Hospital. Several non-governmental organizations function within the private healthcare sector, but most tend to work within HIV/AIDS.¹⁸ The table shows the MoH and private sector health facilities in the 10 Regions.

Health outcomes

Over the last 20 years, Guyana has enhanced the health status of its population improving the infant mortality rate (IMR) and life expectancy. World Bank data suggest the following: life expectancy for males at birth was 59 years in 1992 and 63 years in 2011,¹⁹ for females it was 66 years in 1992 and 69 years in 2011²⁰; the crude death rate was 10 per 1,000 persons in 1992 and 7 per 1,000 persons in 2011,²¹ infant mortality per 1,000 live births was 29 in 2011 and 44 in 1992²²; percentage of children aged 12-23 months receiving immunization against measles was 73 in 1992 and 99 in 2012²³; and the percentage of children aged 12-23 months receiving

Table: Health Facilities, 2010
Source: Inspectorate Department, Ministry of Finance

	Region											Total
	1	2	3	4	5	6	7	8	9	10	George-town	
Health Post	43	19	29	8	1	3	24	16	51	18	0	212
Health Center	3	11	13	25	14	23	3	5	3	12	15	127
District Hospital	4	1	3	1	2	2	2	2	2	2	0	22
Private Hospital	0	0	0	0	0	2	0	0	0	0	6	7
National Referral Hospital	0	0	0	0	0	0	0	0	0	0	1	1
Regional Referral Hospital	0	0	0	0	0	2	0	0	0	0	0	2
Geriatric Hospital	0	0	0	0	0	0	0	0	0	0	1	1
Rehabilitation Center	0	0	0	0	0	0	0	0	0	0	1	1
Diagnostic Center (Hospital-based)	0	1	1	1	1	0	0	0	0	0	0	4
Total	50	33	47	36	18	33	29	23	56	33	24	382

Woodlands Hospital, Medical Arts Centre, Prasad's

immunization against DPT was 79 in 1992 and 97 in

2012.²⁴ There also is some control of the communicable diseases of Tuberculosis (TB), HIV, and Malaria, but with disproportionate resources allocated to the HIV and AIDS programs. The health system is still without a viable TB-HIV co-infection program.

There were reductions in mortality from non-communicable diseases (NCD) between 2007 and 2009,²⁵ as NCDs not only accounted for most deaths, but the rank ordering of NCDs as major causes of death remained practically unchanged during this period. Compared with 2007, there were reductions in deaths in 2009 from Ischemic Heart Diseases, Neoplasms, Diabetes Mellitus, and Heart Failure, and increases in deaths from Cerebrovascular Diseases and Hypertensive Diseases.

Guyana's control of TB, HIV, and Malaria does not compare well with the Caribbean region. In 2011¹⁸, for instance, the prevalence of TB was 121 per 100,000 population when the regional average was 35; the prevalence of HIV was 814 per 100,000 population when the regional average was 319; and the incidence of malaria was 6049 per 100,000 population when the regional average was 194. Information from the World Bank showed that Guyana's IMR as a health indicator was not as good as most of its CARICOM partners; for instance, in 2012, the IMR in Guyana was 29 per 1,000 live births while the IMRs for Barbados, Trinidad & Tobago, Jamaica, St. Lucia, Grenada, and St. Vincent & the Grenadines were 17, 18, 14, 15, 11, and 21, respectively.¹⁸

A shortage of health professionals reduces access to basic healthcare in the country. For instance, WHO data¹⁸ suggest that in Guyana in 2005, there were 2.1 physicians per 10,000 population; the regional average was 20.4 physicians. There were 5.3 nurses and midwives per 10,000 population; the regional average was 71.5.

The Health Systems Assessment (HSA) found no comprehensive service provision assessment, resulting in incomplete information on the quality and quantity of facilities and delivery of health services in Guyana.²⁶

Health planning

Notwithstanding Guyana's status as a low-middle income country with total expenditure on health at 5.9% of GDP in 2011²⁷, the Guyanese healthcare system has had some vital upgrading. Nonetheless, the current institutional structures of the health system and services development in Guyana pose significant challenges requiring meaningful health planning to achieve real health reforms.

Several multilateral agencies are on board in Guyana to assist its health sector development reform; these are: Inter-American Development Bank (IDB); World Bank (WB); Global Fund for AIDS, TB, and Malaria (GFATM); Global Alliance for Vaccines Initiative (GAVI); Canadian International Development Agency (CIDA); China; Cuba; European Union (EU); United States Agency for International Development (USAID); Japan's Development Cooperation Agency (JDCA); Presidential Emergency Program Fund for AIDS Relief (PEPFAR); US Centers for Disease Control and Prevention (CDC); PAHO/WHO, UNICEF, UNDP, and UNFPA.

While the multilateral agencies provide support, it is the MoH which is the key player providing an overall strategy and direction in the reform process. The MoH had implemented two previous strategic plans between 2003 and 2012. These were the National Health Plan (NHP) (2003-2007) and the National Health Sector Strategy 2008 – 2012 (NHSS). These plans support the Poverty Reduction Strategy (PRS), the National Development Strategy (NDS), and the Millennium Development Goals (MDGs).

The NHP's objectives²⁸ were to reduce maternal and infant mortality and morbidity rates; reduce prevalence of HIV, TB, Malaria, and Dengue; limit non-communicable diseases such as Diabetes, Heart Disease, Cancer, and Accidents; manage mental disorders such as depression and substance abuse; improve rehabilitation and intervention services for the disabled; assure that the poor have equitable access to quality healthcare; foster intersectoral collaboration with the MoH; support healthy lifestyles; decrease risk factors contributing to poor health; and produce appropriate health systems to generate equitable health outcomes.²⁸

The vision of the NHSS was to enable “*Guyanese citizens [to] be among the healthiest in the Caribbean and South America.*”²⁸ The NHSS’s objectives were to offer equitable access to quality consumer-friendly health services. It focused on increasing life expectancy to 68 years for both adult males and adult females; achieving the MDGs through reducing maternal mortality to 80 per 100,000 live births, infant mortality to 16 per 1,000 live births, child mortality to 25 per 1,000 live births; decreasing HIV prevalence to 1%, TB prevalence to 75 per 100,000, and Malaria incidence to 5,000 cases per year; providing better access to quality health services to reach 90% immunization coverage of all antigens; assuring 95% access to healthcare within one hour from place of residence; having professionally-trained attendants at 95% of births; satisfactory provision of medicines with 95% availability of all items on the Essential Drug List; and reducing disease burden from communicable and non-communicable diseases. The NHSS hoped to achieve these targets through five strategies aimed at strengthening the health system. These included decentralization, skilled workforce, leadership and regulatory responsibilities of government, sector management performance, and management information systems.

The MoH’s current strategic plan is called *Health Vision 2020, “Health for all in Guyana”: A National Health Strategy for Guyana, 2013-2020.*²⁹ Health Vision 2020 will strive to advance the health of Guyanese, lessen health inequities, and develop the management and delivery of evidence-based, people-responsive quality healthcare. The MoH expects to pursue these goals through universal health coverage and action on the social determinants of health.

While Vision 2020 mentions some of the challenges faced by prior plans, it fails to address several of NHSS 2008-2012 unmet key health indicators. World Bank data demonstrate that several NHSS 2008-2012 key health indicators were not met: by 2011, life expectancy at birth for adult male/female was 63/69, infant mortality at 29 per 1,000 live births, under-five mortality 35 per 1,000 live births; HIV prevalence was 1.3; and maternal mortality

ratio was 250 per 100,000 live births.³⁰ In 2009, professionally-trained attendants were present at 92% of births.³¹ WHO data³² shows that other NHSS health indicators were not met by 2011: Tuberculosis prevalence at 121 per 100,000, and incidence of Malaria at 6049 per 100,000 population. By 2013, the NHSS exceeded its targets on immunization for children aged 12-23 months for DPT (98%)³³ and Measles (99%).³⁴

The many persisting challenges in Guyanese healthcare underline the urgent need for health reform. Consumer demands and expectations for better healthcare are increasing as a result of greater health consciousness, unacceptable life expectancy, and changing demographic patterns. Here are the challenges in the implementation of the NHSS 2008-2012 that the Health Vision 2020 elucidates: limited healthcare coordination failed to adequately strengthen the health system; inappropriate selection of key interventions generated poor funding and inefficient usage of scarce human resources; lack of a management information system adversely affected health programming and strategic interventions; limited integration between the strategic plan, the annual work plan, and lack of monitoring and evaluation resulted in a disconnect between the strategic objectives and their outcomes; and disproportionate financial resources were allocated to disease-focused programs to the disadvantage of capacity building. These challenges resonate with the problems of coordination in the 1970s, as indicated in the above section on “Health reforms in the post-Independence period (1970-1980).”

Health planning since 1978 has targeted efforts to increase equitable access to quality healthcare through its focus on primary healthcare and universal health coverage.³⁵ The Government’s policy on health is guided by the Poverty Reduction Strategy Paper with health outcomes from 28 core poverty indicators, sustaining total health expenditure at about 5.9% of GDP since 2011,³⁶ as well as by the Millennium Development Goals, CARICOM Nassau Declaration, the Port of Spain Declaration on Non-Communicable Diseases, Health initiatives of Union of South American Nations, and the WHO Constitution.

Health reforms

The WHO sees reform as raising the efficiency, effectiveness, quality, equity, and financial strength of health systems.³⁷ In 2010, the HSA reviewed the Guyana healthcare system functions based on six modules consistent with WHO's health system building blocks: governance, health financing, service delivery, human resources for health (HRH), pharmaceutical management, and health information systems (HIS).³⁸ These six modules are in synchrony with the WHO's concept of reform. The author uses the HSA report 2010 on these six modules to identify areas for health reform.

Governance

The National Health Sector Strategy 2008-2012 provided leadership in the growth of healthcare in the six modules, all having aspects of governance. In the first module on Governance, the MoH is recognized as the central authority controlling the technical facets of health, and where administrative authority resides at the regional level. The move in 2006 to integrate administrative authority with technical oversight produced a pilot Regional Health Authority in Region 6, which still does not have authority over many aspects of health. Nonetheless, the RHA brought some new components to the table including the creation of regional health management committees that provided citizen input on health delivery and service agreements. The HSA recommended the assigning of RHAs to the Regions. In 2015, Region 6 remains the sole region with a health authority.

Health financing

Governmental funding flows through the Ministry of Finance to the 10 Regions (via RDCs and regional health offices) and to the Georgetown Public Hospital Corporation (GPHC). Other funding sources are external donors, private expenditure through the National Insurance Scheme, and out-of-pocket family spending. Government health expenditures have doubled since 2005, with increased capital expenditures on new facilities and for rehabilitating old facilities. Considerable funding flows are

available for HIV and AIDS. The HSA recommended that:

*Health financing could be strengthened in Guyana by strengthening the existing need-based budgeting system; empowering the new RHA structures by handing over control of health expenditures to RHAs; strengthening the Financing Technical Working Group (TWG) to coordinate improved resource allocation across the health sector, including between the MoF, MoH, and development partners; and ensuring data availability for decision-making, such as regular data from National Health Accounts estimations.*³⁸

Service delivery

The health system with responsibility for service delivery has shown improvements in these areas: equity in service delivery, attracting skilled human resources, and updating infrastructure and technology. These improvements have occurred largely through a network of laboratories, publicly guaranteed services, and the strong response to HIV and AIDS. Gaps in service provision are in the lower levels of care and in the hinterland.

Human resources for health (HRH)

To counter high attrition rates in the health sector, the Government has been increasing the number of health workers. There are some successes in providing overseas education of doctors, and a similar approach may be necessary to increase the nursing numbers and reduce the nurses' attrition rate. There is need to enhance worker retention and quality through incentive systems, improving continuing education programs, and formulating more efficient human resource management protocols. One of these protocols could be the availability of information on health worker movement, training, and salaries; such information would support evidence-based healthcare worker retention programs.

Pharmaceutical management

The Government's engagement with external donors such as The Global Fund and others has improved its capacity to procure, store, manage, and distribute medicines and medical supplies. The

USAID-funded Supply Chain Management System project has provided support to the MoH's Materials Management Unit. For instance, MoH now has patient care protocols and a revised Essential Drugs List. There are, however, challenges relating to monitoring of drugs, facilities, and dispensaries at regional storage outlets, inappropriate coordination of donors' pharmaceutical management activities, and better streamlining of the Logistics Management Information Systems on requisitions, communications, and supply management. Resolution of these challenges would enhance quality assurance of drugs and provide timely delivery to health units.

Health information systems (HIS)

The MoH has several Health Information System-related initiatives such as the Guyana Health Information System (GHIS), Computerized Maintenance Management System, Warehouse Management System, HRH databases, and e-health initiatives. The NHSS 2008-2012 propelled these initiatives. The new strategic plan in 2013 will need to develop a monitoring and evaluation database.

Potential health reforms

The HSA report in 2010 outlined several challenges to delivery including the need to improve coordination between programs, quality assurance monitoring, and client feedback; better management of health facilities and incorporation of standard operating procedures; and enhancement of the National Referral System with the introduction of standard treatment guidelines. The need-based budgeting system could be improved and the National Health Accounts could also provide regular information to the health sector. In terms of the need to reduce inequity in quality healthcare, there is growing urgency to provide better access to the poor and vulnerable and particularly to people in the hinterland region where access and geographic mobility pose momentous challenges. The Government of Guyana also faces enormous challenges in terms of human resources for health; there is a current concern over the shortage of nurses, analogous to the 1980-1990 period. (see above).

The health system needs effective mechanisms to monitor and coordinate drugs, facilities, dispensaries at regional storage outlets, donors' pharmaceutical management activities, and improved organization of the Logistics Management Information Systems on requisitions, communications, and supply management.

The HSA report also alluded to the need to institute RHAs with control over their own health expenditures and general autonomy for regional healthcare in the 10 regions of Guyana. For about eight years now, there has only been one RHA.

The Government's contribution

The Government of Guyana through Health Vision 2020 has a pivotal responsibility to promote the well-being of the Guyanese people, decrease health inequities, and upgrade the management and delivery of quality healthcare. Two strategic pillars - universal health coverage and the social determinants of health - speak to these responsibilities. The universal health coverage pillar would facilitate a renewal of primary healthcare while the social determinants of health pillar would focus on building strategic partnerships and health promotion.

The World Health Report 2000³⁷ pointed out that governmental stewardship of health involves: health policy formulation where the vision and policy direction are defined; framing regulations to govern the behaviors of employees within the health system and make sure that they are in compliance with the rules; and establishment of a strong information management system which would allow for better information and understanding of the total health system. In Guyana, the responsibilities of the government are in policy formulation, regulation, information management, financing, and the delivery of strategic public health. Health Vision 2020 notes that strategic and policy formulation will be coordinated through a National Health Policy Committee, and the implementation of the other four functions through an Administration and Management Directorate and a Technical Health Directorate; and data will be gathered largely through the Monitoring and Evaluation (M&E) framework and an M&E plan.

Conclusion

Over the last decade, Guyana's health policies set forth in the National Health Plan (NHP) (2003-2007) and the National Health Sector Strategy 2008 – 2012 (NHSS), and most recently Health Vision 2020, have supported the goals of universal health coverage and equity. However, with no formal evaluation of these plans' health outcomes, it is difficult to evaluate the reality of universal health coverage and equity in the health sector. Without performance evaluations, even the potential and role of the lone 8 year-old RHA as the overall driver of major transformation of the Guyana health system remains indeterminate.

The underlying principle of the RHA approach was that decentralization would enable popular input to guide the healthcare system. However, if the RHA approach is embodied within a neoliberal ideology with the ultimate outcome of privatization, then the lessons of failure from Latin American neoliberal health reforms in the 1970s and 1980s will have been lost to the Guyanese health planners. For instance, Colombia which complied with the World Bank neoliberal reform blueprints and even with its high health expenditures found that a huge part of its population had no health coverage and the poor endured enormous difficulties to access healthcare.³⁹ In the neoliberal model, privatization emerges through government-sanctioned decentralization; but experience shows that privatization ends up hurting historically disadvantaged groups. To be effective the RHA approach would require direct government strategy and direction, particularly given the presence of a large number of neoliberal multilateral agencies in Guyana helping with health sector development reform.

In addition, in the World Bank's neoliberal model, the health sector attains maximum efficiency through privatization under government regulation; but in many poor and even some advanced nations, governments may not have adequate regulatory capacity.³⁹ And so, privatization with a decentralized framework (like the RHA) could be deleterious in the setting of inadequate state control. While decentralization is intended to mobilize the people's input in healthcare, it could also be fully controlled by

privatization within a neoliberal framework. The health sector reform process in Guyana, thus, has to be a political project if it is to avoid the harmful neoliberal consequences because many people do not have health coverage and in some cases, limited real access to healthcare. The poor and vulnerable will become victims of privatization as they may not have sufficient social assets, such as, education, income, and health to compete in a privatized system dominated by a neoliberal ideology which sees healthcare as a commodity in a free market and not as a fundamental human right.

References

1. Sachs JD. Achieving universal health coverage in low-income settings. *Lancet*. 2012;380:944-7. doi: 10.1016/S0140-6736(12)61149-0.
2. United Nations. The Universal Declaration of Human Rights: [Internet]; 1948 [cited 2012 May 1]. Available from: <http://www.un.org/en/documents/udhr/>.
3. WHO. Constitution. Geneva: WHO, 1989: [cited 2014 Mar 15] Available from: <http://apps.who.int/iris/handle/10665/36851>.
4. Savel RH, Munro CL. Current state of health care reform: Dysfunctional government, divided country. *American Journal of Critical Care*. 2014;23:100-2.
5. Homedes N, Ugalde A. Why neoliberal health reforms have failed in Latin America. *Health Policy*. 2005;71:83-96. doi: 10.1016/j.healthpol.2004.01.011. PubMed PMID: 15563995.
6. Ugalde A, Homedes N. La clase dominante transnacional: su rol en la inclusión y exclusión de políticas en las reformas sanitarias de América Latina. *Cuad méd soc(Ros)*. 2002;95-110.
7. The world health report 2000 - Health systems: improving performance. [March 18, 2014]. Available from: <http://www.who.int/whr/2000/en/>.
8. Turshen M. The impact of colonialism on health and health services in Tanzania. *International journal of health services : planning, administration, evaluation*. 1977;7:7-35. PubMed PMID: 319069.

9. Ramnath K. Regime Characteristics and Health Policy Reform in the Post-Colonial State. Kingston upon Hull: University of Hull; 1998.
10. West India Royal C, Guinness WE 1st Baron Moyne. West Indian Royal Commission Report. London: His Majesty's Stationery Office; 1945.
11. Merrill T, editor. Guyana and Belize: country studies. Washington, DC: Federal Research Division, Library of Congress; 1993.
12. Spinner TJ. A political and social history of Guyana, 1945-1983. A Westview replica ed. Boulder: Westview Press; 1984. xv, 244 p. p.
13. Ramnath MK, Cantab MP. REGIME CHARACTERISTICS AND HEALTH POLICY REFORM IN THE POST-COLONIAL STATE. 1998.
14. Beale ST. Population Projections: Guyana: 2005 – 2025 Georgetown: Bureau of Statistics; 2006. Available from: <http://www.statisticsguyana.gov.gy/pubs/Guyana Population Projections 2005-2025.pdf>.
15. Guyana at a glance: Population distribution by nationality background/ethnicity Guyana: 2002. 2002: [cited 2014 Mar 16] Available from: <http://www.statisticsguyana.gov.gy/census.html>.
16. Guyana Unemployment rate. Index Mundi, 2015: [cited 2014 Mar 16] Available from: http://www.indexmundi.com/guyana/unemployment_rate.html.
17. Ethnologue. [March 16, 2014]. Available from: <http://www.ethnologue.com/country/gy>.
18. WHO. Guyana Health Profile. 2014: [cited 2014 Mar 26] Available from: <http://www.who.int/gho/countries/guy.pdf>.
19. Life expectancy at birth, male (years) [March 17, 2014]. Available from: <http://data.worldbank.org/indicator/SP.DYN.LE00.MA.IN>.
20. The World Bank. Life expectancy at birth, female (years). [cited 2014 Mar 14] Available from: <http://data.worldbank.org/indicator/SP.DYN.LE00.FE.IN>.
21. The World Bank. Death rate, crude (per 1,000 people). [cited 2014 Mar 17] Available from: <http://data.worldbank.org/indicator/SP.DYN.CDRT.IN>.
22. The World Bank. Mortality rate, infant (per 1,000 live births). [cited 2014 Mar 17] Available from: <http://data.worldbank.org/indicator/SP.DYN.IMRT.IN>.
23. The World Bank. Immunization, measles (% of children ages 12-23 months) [cited 2014 Mar 2014] Available from: <http://data.worldbank.org/indicator/SH.IMM.MEAS>.
24. The World Bank. Immunization, DPT (% of children ages 12-23 months). [cited 2014 Mar 17] Available from: <http://data.worldbank.org/indicator/SH.IMM.IDPT>.
25. Ministry of Health, Government of Guyana. Statistical Bulletin. 2014: [cited 2014 Mar 17] Available from: http://health.gov.gy/MOH/Publications/Statistical Bulletins 2004-2008/moh_stats_bulletin_09.pdf
26. Guyana health system assessment 2010. [March 18, 2014]. Available from: <http://www.healthsystems2020.org/content/resource/detail/85822/>.
27. The World Bank. Health expenditure, total (% of GDP) 2014.
28. National Health Plan 2003-2007: The Strategic Plan of the Ministry of Health [March 17, 2014]. Available from: health.gov.gy/national_health_plan%202003-2007.pdf.
29. Health Vision 2020“Health for all in Guyana” A National Health Strategy for Guyana 2013 - 2020 [March 2, 2015]. Available from: file:///C:/Documents%20and%20Settings/Administrator/My%20Documents/Downloads/Guy%20HealthVision%202020_Final_19Dec.13.pdf.
30. IBRD.IDA. Maternal mortality ratio (modeled estimate, per 100,000 live births) [March 1, 2015]. Available from: <http://data.worldbank.org/indicator/SH.STA.MMRT>.
31. IBRD.IDA. Births attended by skilled health staff (% of total) [March 1, 2015]. Available from: <http://data.worldbank.org/indicator/SH.STA.BRTC.ZS?page=1>.
32. WHO. Guyana: health profile [March 1, 2015]. Available from: <http://www.who.int/gho/countries/guy.pdf?ua=1>.
33. IBRD.IDA. Immunization, DPT (% of children ages 12-23 months) [March 1, 2015]. Available

- from:
<http://data.worldbank.org/indicator/SH.IMM.IDPT>.
34. IBRD.IDA. Immunization, measles (% of children ages 12-23 months) [March 15, 2015]. Available from:
<http://data.worldbank.org/indicator/SH.IMM.MEAS>.
 35. National Health Plan 2003-2007: The Strategic Plan of the Ministry of Health [March 2, 2015]. Available from:
file:///C:/Documents%20and%20Settings/Administrator/My%20Documents/Downloads/National_Health_Plan_2003-2007.pdf.
 36. National Health Sector Strategy 2008-12 [March 2, 2015]. Available from:
file:///C:/Documents%20and%20Settings/Administrator/My%20Documents/Downloads/National_Health_Policies-Guyana_2008-2012.pdf.
 37. WHO. The World health report 2000 : health systems: improving performance. [March 3, 2015]. Available from:
http://www.who.int/whr/2000/en/whr00_en.pdf?ua=1.
 38. Guyana Health System Assessment 2010 [March 3, 2015]. Available from:
<http://apps.who.int/medicinedocs/documents/s19790en/s19790en.pdf>.
 39. Homedes N, Ugalde A. Why neoliberal health reforms have failed in Latin America. Health policy. 2005;71(1):83-96. doi: 10.1016/j.healthpol.2004.01.011. PubMed PMID: 15563995.
- 1.

