



Ministry of Public Health

GUYANA 2016 HEALTH ACCOUNTS – MAIN REPORT

September 2018

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CONTENTS

Contents	i
Acronyms	iii
Acknowledgments	v
Executive Summary	vii
1. Introduction	1
1.1 Importance of Health Accounts Data in Guyana.....	1
1.2 History of Health Accounts in Guyana.....	2
1.3 Study Objectives.....	2
1.4 Data Sources.....	2
1.5 Health Accounts Process.....	3
1.6 Capacity Building.....	4
1.7 Accomplishments and Limitations.....	4
2. Health Accounts Key results	7
2.1 Summary of General Health Accounts Findings.....	7
2.2 General Health Accounts Findings.....	10
2.3 Analysis of HIV and AIDS spending.....	19
3. Policy implications and Recommendations	22
3.1 Assess the efficiency and sustainability of domestic health financing.....	22
3.2 Allocate more funding to prevention of NCDs.....	24
3.3 Strengthen financial and programmatic commitment to HIV prevention services.....	25
3.4 Strengthen the Health Information Management System (HIMS).....	25
3.5 Institutionalize Health Accounts to ensure timely and regular data for decision-making.....	25
Annex A: Key Health Indicators for Guyana and Comparator Countries	27
References	28



List of Tables

Table 1: Primary data sources for Health Accounts 2016.....	3
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List of Figures

Figure 1: Regional Comparison of Source of Total Health Expenditure (THE).....	10
Figure 2: THE by Source of Financing.....	11
Figure 3: THE by Manager.....	12
Figure 4: Managers of Health-Related Resources	12
Figure 5: THE by Provider	13
Figure 6: Government THE by Provider	13
Figure 7: Household OOP Spending by Type of Provider	14
Figure 8: Household OOP Health Spending by Function	14
Figure 9: Household OOP Health Spending by Health Condition/Disease	15
Figure 10: THE by Function	15
Figure 11: Health Spending on Prevention, by Type.....	16
Figure 12: Prevention Spending, by Disease/Health Condition	17
Figure 13: THE by Disease/Health Condition	17
Figure 14: Disease Burden for Guyana, 2016.....	18
Figure 15: HIV and AIDS Current Health Spending by Source of Financing	19
Figure 16: HIV and AIDS Current Health Spending by Manager	20
Figure 17: HIV and AIDS Current Health Spending by Provider	20
Figure 18: HIV and AIDS Current Health Spending by Type of Service	21

ACRONYMS

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
CSO	Civil society organization
DALY	Disability-adjusted life year
GDP	Gross domestic product
HA	Health Accounts
HFG	Health Finance and Governance
HIMS	Health information management system
HIV	Human immunodeficiency virus
IHME	Institute for Health Metrics and Evaluation
MOPH	Ministry of Public Health
NCD	Non-communicable disease
NGO	Nongovernmental organization
NIS	National Insurance Scheme
G\$	Guyana dollar
OOP	Out-of-pocket
PAHO/WHO	Pan American Health Organization
PEPFAR	President's Emergency Plan for AIDS Relief
PrEP	Pre-exposure prophylaxis
SDG	Sustainable Development Goal
SHA	System of Health Accounts
STD	Sexually transmitted disease
TB	Tuberculosis
THE	Total health expenditure
UHC	Universal health coverage
UNAIDS	Joint United Nations Program on HIV and AIDS
USAID	United States Agency for International Development
US\$	United States dollar
WHO	World Health Organization



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The MOPH is grateful to the United States for the financial and technical support of the United States Agency for International Development (USAID) and to the Pan American Health Organization (PAHO/WHO) for its in-kind contributions and engagement in this effort. Technical assistance for the health accounts estimation was provided through the USAID-funded Health Finance and Governance (HFG) project by Abt Associates. Contributors include Rachel Rosen, Sarah Insanally, Tesfaye Dereje and Lisa Tarantino.



EXECUTIVE SUMMARY

Overview

Health spending data is a critical input into monitoring the progress of Guyana's commitment to achieving universal health coverage (UHC) and the Sustainable Development Goals (SDGs). The Guyana Ministry of Public Health (MOPH), with the support of the United States Agency for International Development's (USAID)-funded Health Finance and Governance Project (HFG), and in collaboration with the Pan American Health Organization (PAHO/WHO), conducted its first Health Accounts exercise covering the fiscal year 2016 (January 1 - December 31, 2016).

Using the System of Health Accounts 2011 (SHA 2011) framework, the Health Accounts captures health spending from all sources within an economy: the government, nongovernmental organizations (NGOs), donors, private employers, insurance companies and households. The analysis presents a breakdown of spending into the standard classifications defined by the SHA 2011 framework: sources of financing, financing schemes, type of provider, type of activity, and disease/health condition. The 2016 Health Accounts Statistical Report provides supplementary information on the SHA 2011 framework and the methodology used in the 2016 Health Accounts exercise (Guyana Ministry of Public Health, 2018). This Main Report summarizes the results of the Health Accounts exercise and discusses the policy implications of the key findings.

The 2016 Health Accounts study (HA) in Guyana occurs at a time of significant change in the health financing landscape. The Government of Guyana has dramatically increased its investment in the health system and for HIV programming in particular, to offset declining donor funding. The MOPH continues to manage the transition from donor funding to full national ownership of the HIV response, even while facing rising demand and costs for health services due to an aging population, increasing incidence of non-communicable diseases (NCDs), and continuous threat of communicable diseases. To prevent the loss of health improvements, Guyana will need to focus on increasing domestic resource mobilization and improving the efficient use of available resources.

The completion of the HA estimation in Guyana is timely, as HA are designed to provide data to support decisions that ensure value for money and efficient and effective allocation of limited resources. The HA data provide the evidence base for planning and implementing interventions that meet the needs of the population. Understanding spending in areas such as the HIV response, can inform critical decisions on resource mobilization and sustainability. It is therefore important that the information generated by the HA meets standards of accuracy and completeness.

Key findings

Total health expenditure (THE) in Guyana in 2016 amounted to G\$ 28,595,303,655 (US\$ 138,476,047), of which 99 percent was recurrent spending. Recurrent spending is the spending on health goods and services consumed within the year of the Health Accounts analysis. The balance of spending of 1 percent was for capital investment, which includes goods and services whose benefits are consumed over a period longer than one year. Health care-related items such as social care for people living with HIV totaled an additional G\$ 28,772,368, and pre-service training and research and development account for an additional G\$ 580,768,200; these amounts are not included in THE.

Who funds health care? During the 2016 fiscal year, the Government of Guyana made the largest contribution to health spending, by spending 81 percent of THE (G\$ 23,041,055,030). The substantial government contribution to health spending comprised more than 10 percent of the government's total spending in the fiscal year and reflects the government's commitment to increase spending on health to advance universal health coverage.

The contributions of employers, households, and donors to THE amounted to 4 percent, 9 percent and 6 percent respectively. Relative to other countries in the region and in its income bracket, household spending on health is low, which is a good sign that Guyana is achieving financial protection for its population. In 2016 approximately 90 percent of household spending, or 8 percent of THE, was out-of-pocket (OOP) expenditure.

Who manages health funds? Overall, the government managed 82 percent of THE, of which 58 percent was managed by the central government and 24 percent by the regional government. Households (8 percent), donors (3 percent), the National Insurance Scheme (NIS) (2 percent), and nongovernmental organizations (NGOs), insurance companies and corporations (4 percent) managed the remainder.

Where are funds spent? 40 percent of health funds was spent at public hospitals and 7 percent in private hospitals and clinics. Spending at public primary care facilities (health posts and health centers) amounted to approximately 31 percent.

On what goods and services? The majority of funds (64 percent) was spent on curative care, while 19 percent was spent on preventive care. Administration and the purchase of medicines and medical goods accounted for 9 and 5 percent of THE, respectively.

On which diseases? Non-communicable diseases (NCDs) received the highest allocation of funds, at 34 percent of THE, followed by infectious and parasitic diseases (22 percent), injuries (13 percent) and reproductive health (12 percent). Health expenditures for HIV amounted to 8 percent of THE.

Policy implications and recommendations

Based on the findings and policy implications of the 2016 Health Accounts exercise, the Health Accounts Technical Team makes the following recommendations:

- **Assess the efficiency and sustainability of domestic health financing, including by exploring the fiscal space for increasing health spending, improving allocative efficiency, increasing domestic resources for HIV and AIDs, and diversifying health financing mechanisms that pool risk across the population.** If Guyana is to achieve universal health coverage with financial risk protection and access to health care, the government will need to increase resources for health in a way that continues to minimize the financial burden households. Decisions on priority actions to improve the sustainability and availability of domestic resources for health should be supported by in-depth assessment of the efficiency of health spending, as opportunities for increased efficiency can free up resources within the health sector. A fiscal space analysis could be useful for determining how the government can create room within the national budget for additional spending on health. In the country's efforts to achieve UHC, the government should further evaluate and engage the private sector as a source of additional health financing.
- **Allocate more funding to prevention of NCDs.** Increasing preventive spending on NCDs would better support Guyana's commitment to reduce the burden of NCDs by scaling up health promotion and interventions to address modifiable risk factors. Because NCDs are the major cause of morbidity and mortality, improving the impact of prevention efforts will reduce the demand and costs of health services, in addition to improving the quality of life of the population.

- **Strengthen financial and programmatic commitment to HIV prevention services.** HIV prevention spending currently exceed UNAIDS recommendations for 25% of the HIV budget but is likely to decrease as resources are channeled to expand the treatment program. Declining donor funding also jeopardizes prevention programs provided by civil society organizations (CSOs) for key populations. Further investigation of the efficiency and impact of prevention spending is recommended to inform efforts to ensure continued availability of a range of effective prevention interventions.
- **Strengthen the Health Information Management System (HIMS).** Ensuring that the HIMS properly records health service utilization and provides financial data will facilitate improved planning and programming, including through production of HA to inform policy discussions.
- **Institutionalize Health Accounts to ensure timely and regular data for decision-making.** This requires adequate financial and technical resources for Health Accounts to facilitate the regular production of expenditure estimates to inform policy and planning.

I. INTRODUCTION

I.1 Importance of Health Accounts Data in Guyana

Health spending data is critical for informing the creation and improvement of health financing mechanisms as countries aim for universal health coverage (UHC) and to achieve the Sustainable Development Goals (SDGs). The Guyana Ministry of Public Health (MOPH) conducted a Health Accounts exercise covering the fiscal year 2016 (January 1 - December 31, 2016). This exercise used the System of Health Accounts 2011 (SHA 2011) framework,¹ which captures spending from all sources within an economy: the government, nongovernmental organizations (NGOs), external donors, private employers, commercial insurance companies, and households. The analysis presents a breakdown of spending into the standard classifications defined by the SHA 2011 framework: sources of financing, financing schemes, type of provider, type of activity, and disease/health condition. This is the first time that Guyana has completed a Health Accounts estimation, and it represents a major achievement in supporting evidence-based decision-making for allocative efficiency of health resources.

Guyana's National Health Strategy (Health Vision 2020) advances the goals of reduced health inequities and access to quality, accessible and responsive services. Achieving universal health coverage (UHC) is recognized to require a renewed focus on primary health care, increased financial risk protection, and improved access to health services. Health financing is a key element to consider in the move towards UHC and the provision of quality health services to the population at an affordable cost. Health Accounts provide crucial data to inform the creation and improvement of health financing mechanisms, providing decision-makers with a better understanding of the current health financing situation.

The 2016 Health Accounts study in Guyana occurs at a time of significant change in the health financing landscape: as donor funding rapidly declines, the Government of Guyana has dramatically increased its allocation of resources to the health system and for HIV programming in particular. As the MOPH continues to transition from donor funding to full national ownership of an expanded HIV program, it is also contending with rising demand and costs for health services due to an aging population, increasing incidence of non-communicable diseases (NCDs), and the continued threat of communicable diseases. To prevent the loss of health improvements in the face of shrinking funding and rising costs, Guyana will need to increase domestic resource mobilization and improve the efficient allocation and use of available resources. Guyana has developed a draft Sustainability Plan for the National HIV response that identifies the need to generate and utilize financial data to strengthen a budgeting process that is evidence-based and linked to programming priorities (Guyana Ministry of Public Health August 2018). The HA results provide important inputs for achieving this: by providing sound estimates of past spending, the HA findings can help determine whether health care spending is sufficient, whether allocations are efficient, effective, and equitable, and how reallocations could achieve improved value for money.

¹ First published in 2000 by the Organization for Economic Cooperation and Development (OECD), the System of Health Accounts framework was updated in 2011 by OECD, EUROSTAT, and WHO. SHA 2011 framework is now the international standard for national-level Health Accounts estimations. For additional details on SHA 2011, please refer to the 2011 Edition of the System of Health Accounts (OECD et al. 2011) and two technical briefs on the SHA 2011 (Nakhimovsky et al. 2014; Cogswell et al. 2013).



This report provides data on the sustainability of Guyana's health financing, with a focus on the financing of the HIV response; the impact of current spending on priority health conditions and diseases; and the impact of out-of-pocket expenditure on Guyana's population. This will inform strategic decision-making by helping determine where spending has been effective and where it is necessary to allocate additional resources. In light of the wealth of information the Health Accounts generate, the MOPH aims to institutionalize Health Accounts. This would create capacity within Guyana to regularly produce and use Health Accounts data.

1.2 History of Health Accounts in Guyana

This report presents the findings of Guyana's Health Accounts exercise for the 2016 fiscal year. This is Guyana's first completed round of Health Accounts.

1.3 Study Objectives

The immediate objective of the 2016 Health Accounts exercise was to track the magnitude and flow of health spending in Guyana from all sources, including government agencies, households, NGOs, employers, insurers, and donors. During the planning stages of the Health Accounts, the Ministry of Public Health and the Health Accounts Steering Committee identified policy questions that the Health Accounts should answer. In light of these, the Health Accounts exercise, aimed to explore the following critical questions:

- How sustainable are the overall resources flowing to the health sector, given the decline of donor support?
- What is the role of households in financing health care? What share of spending on health is out of pocket?
- What is the balance of spending between primary and tertiary care? What is the balance of spending between prevention and curative care?
- What is the role of civil society/non-governmental organizations in managing health care related resources?
- Where do resources for the HIV response come from and how sustainable are these?

1.4 Data Sources

Health Accounts provide a comprehensive view of total health spending in a country from all sources. To gather primary data, the Health Accounts Technical Team, led by the MOPH, surveyed a wide range of sources (Table 1). In addition to the primary data collected, the team collected secondary data to supplement the analysis. For more detailed information on the methodology Guyana used, along with a list of data sources, assumptions, and limitations, see the Guyana 2016 Health Accounts Statistical Report (Guyana Ministry of Public Health September 2018).

Table 1: Primary data sources for Health Accounts 2016

Data source	Key health spending information
Donors (bilateral and multilateral)	Level of external funding for health programs in Guyana
NGOs involved in health	Flow of resources through NGOs that manage health programs
Private employers	Health benefits that employers provide for employees, such as health insurance, health facilities, or workplace prevention programs
Insurance companies	Health benefits that are paid through insurance schemes

The technical team collected information from the following secondary data sources:

- **Government:** Data on health spending by the MOPH and regions.²
- **National Insurance Scheme (NIS):** Data on revenue sources and health benefits paid.
- **Households:** Data on OOP health expenditures, estimated using Guyana’s 2006 Household Budget Survey.
- **Various sources of health service utilization:** Data on health service utilization at public facilities from the MOPH’s 2009 Statistical Bulletin, the 2009 Guyana AIDS Response Report, and Guyana’s 2009 Demographic and Health Survey to estimate the distribution keys.
- **St. Lucia costing study:** Unit cost data for health services to estimate the distribution keys from St. Lucia were used because there was not a similar study available for Guyana.

1.5 Health Accounts Process

The 2016 Health Accounts was the first such exercise completed by the Guyana MOPH. The study was supported by the USAID-funded HFG project, in collaboration with PAHO/WHO. The process benefited from broad stakeholder engagement and emphasized the critical objective of strengthening Guyana’s capacity to institutionalize Health Accounts and conduct future studies.

The following activities comprised the Guyana 2016 Health Accounts exercise:

- **Health Accounts Launch:** The MOPH began the HA exercise on June 5, 2017 with a launch event attended by over 30 stakeholders, including representatives from the MOPH, Ministry of Finance (MOF), Bureau of Statistics (BOS), the National Insurance Scheme (NIS), USAID, PAHO/WHO, United Nations Children’s Fund (UNICEF), and the Joint United Nations Program on HIV and AIDS (UNAIDS).
- **SHA 2011 Training:** USAID’s HFG project trained members of the HA Technical Team on the SHA 2011 framework and the Health Accounts methodology on June 5-9, 2017.

² Health spending data obtained from the Ministry of Finance, Government of the Cooperative Republic of Guyana Estimates of Revenues and Expenditures 2016 (Republic of Guyana n.d.)

- **Steering Committee Meetings:** The first HA Steering Committee meeting occurred on June 9, 2017 to identify key policy questions for the 2016 exercise. Subsequent meetings took place every 3-4 months throughout the activity.
- **Data Collection:** Five data collectors were hired to conduct primary data collection. These individuals were trained by the HFG project in July 2017 and primary data collection lasted from July to September 2017. The Technical Team conducted secondary data collection and validation from October 2017 to February 2018, with some additional data collection happening thereafter.
- **Data Analysis:** The HFG project led a data analysis workshop in February 2018, where the Technical Team was trained in the methodology for cleaning and analyzing health expenditure data. After the workshop, the Technical Team conducted and refined the HA results, collecting additional data as necessary.
- **Data Validation:** The HA results were validated through a series of conversations and meetings with the Technical Team and Steering Committee. The results were finalized in July 2018.
- **Dissemination:** The HA results were shared with Guyana’s health system stakeholders at a dissemination event on August 3, 2018.

1.6 Capacity Building

A critical objective of the technical support provided by USAID’s HFG project was to build the institutional capacity and the technical knowledge base necessary to conduct future Health Accounts studies in Guyana.

The following governing bodies were created to facilitate Health Accounts capacity building:

- **Health Accounts Technical Team:** The MOPH led the Technical Team, comprised of staff from the MOPH, MOF, Bureau of Statistics, NIS, and PAHO/WHO that was responsible for collecting data for and analyzing the results of the Health Accounts. Members received training on the SHA 2011 framework in June 2017 and technical assistance throughout the HA exercise from the USAID HFG Project. This group possesses the technical knowledge of HA and the SHA 2011 framework that will be essential in future HA studies.
- **Health Accounts Steering Committee:** The MOPH formed a Health Accounts Steering Committee with members from the BOS, MOF, NIS, the Bank of Guyana, PAHO/WHO, USAID, and CSOs. The Steering Committee met every 3-4 months and was responsible for providing strategic guidance and support to the MOPH and the Technical Team. Continued engagement with these stakeholders will improve coordination within the health system, facilitate use of the HA results for policy- and decision-making, and ensure accurate future HA estimations.

1.7 Accomplishments and Limitations³

Guyana is to be congratulated for successfully completing a Health Accounts estimation for the first time. Despite challenges in obtaining some secondary data, the Technical Team was able to produce estimates with informative detail for policy and planning purposes. A hands-on approach to technical support from the HFG project that engaged the MOPH and Technical Team in planning, managing and

³ Additional detail on data limitations and recommendations can be found in the 2016 Health Accounts Statistical Report.

implementing all aspects of the exercise has strengthened Guyana's technical knowledge of Health Accounts and ability to institutionalize and produce HA in the future.

The MOPH engaged many stakeholders in the implementation of the HA, including the Ministry of Finance, Bureau of Statistics and the National Insurance Scheme. Continued engagement by the MOPH with these stakeholders will be important for increasing the level of detail available in future HA estimations by improving survey response rates during data collection and strengthening the data validation process. An additional benefit of maintaining stakeholder engagement around Health Accounts is to improve coordination and communication within the health system and between the Ministry of Finance and MOPH.

Accomplishments of the Guyana HA process include encouraging response rates from donors, employers, NGOs and insurance companies. This is likely to be further improved in subsequent rounds, as stakeholders become more aware of the importance of monitoring health spending and the vital role that they play in providing health data for decision-making.

In addition to primary data collection, Health Accounts use secondary data on health spending to assess the government and household spending on health. Improving the quality, level of detail for non-earmarked spending, format, and completeness of secondary data from the MOPH and from Regional Health Authorities (RHAs) will significantly help to produce more accurate and timely HA in the future.

Data from Guyana's 2006 Household Budget Survey was used to estimate households' OOP health spending in 2016.⁴ To improve the availability and detail of OOP health spending data, HFG provided the Bureau of Statistics with questions that can be included in the next household survey; see the Health Accounts Statistical Report for additional detail on this.

Supplementary data on health service utilization and unit costs were used to unpack non-earmarked spending by function and disease with distribution keys. To the extent possible, HA use existing data that are collected through government systems to create distribution keys. In Guyana, a limited amount of secondary data on health service utilization and cost is available; the most accurate validated data were 2009 health information system (HIS) data⁵ and information from a 2010-2011 costing study in St. Lucia. Future HA exercises in Guyana will benefit from regular and timely production of HIS and costing data.

The Technical Team collected secondary data on revenue and health benefits paid by NIS in 2016. While this dataset provided impressive detail on the type of care that an expenditure funded, it did not specify where the care was provided (e.g. at a hospital or a clinic) because NIS claims do not include provider information. By tracking at which providers NIS pays for health benefits, Guyana can improve its understanding of the government's role in financing health services and increase the level of detail of future Health Accounts results.

HA estimations are most useful when they are sufficiently recent to inform decision-making through processes including annual planning and budgeting cycles. The 2016 Health Accounts exercise took more than a year, in part due to limited availability and high turn-over rates in the Planning Unit of the MOPH. Expenditure tracking is an important decision-making tool for the government, and it is important for the MOPH to commit team members that can allocate sufficient time to produce and analyze Health Accounts on a regular basis. Including staff from a wide range of agencies, such as the MOF, BOS, NIS,

⁴ The 2006 data was adjusted using medical inflation and population growth.

⁵ This includes data from the 2009 Statistical Bulletin, 2009 Demographic Health Survey, and the Guyana AIDS Response Report (2009 data).

GPHC and PAHO/WHO on the technical team, and engaging them in all aspects of the exercise, has ensured that national capacity to conduct HA exists within these agencies as well.

2. HEALTH ACCOUNTS KEY RESULTS

Total health expenditure (THE) reflects the sum of all recurrent and capital expenditures on health. THE in Guyana in 2016 amounted to G\$ 28,595,303,655 (US\$ 138,476,047) of which 99 percent was recurring spending.⁶ Recurring spending is the spending on health goods and services consumed within the year of the Health Accounts analysis. The remaining balance of 1 percent of spending was for capital investment, which includes goods and services that are consumed over a period longer than one year. Health care-related items such as social care for people living with HIV totaled an additional G\$ 28,772,368, and pre-service training and research and development account for an additional G\$ 580,768,200; these amounts are not included in THE.

Total health expenditure as a percentage of gross domestic product (GDP) indicates the level of health care expenditure relative to the country's economic development. In 2016, Guyana's total health expenditure was 4 percent of GDP, falling below the PAHO/WHO recommendation that governmental health spending represent at least 6 percent of GDP (PAHO/WHO 2014). The government contribution to health spending comprises 10 percent of the government's overall spending.

2.1 Summary of General Health Accounts Findings

⁶ The exchange rate of 206.5 used to convert G\$ to US\$ was obtained from page 21 of the Bank of Guyana's Annual Report for 2016.

Table 2 provides a summary of the level of health expenditure, spending actors, and main health items and services on which funds are spent.

Table 2: Key Health Accounts Findings

Indicator	2016 (amounts are in G\$, unless otherwise noted)
Total population*	743,458
Exchange rate (G\$/US\$)**	206.5
GDP***	723,581,000,000
GDP per capita (US\$)	4,713
Total Health Expenditure (THE)	28,595,303,655
Current health expenditure	28,422,162,398
Capital health expenditure	173,141,256
THE on HIV and AIDS	2,148,441,290
Current health spending on HIV and AIDS	2,128,128,590
Capital health spending on HIV and AIDS	20,312,700
THE per capita	38,463
THE/GDP	4%
Health care-related spending	28,772,368
Pre-service training and research and development	580,768,200
Total government health expenditure	23,041,055,030
Current government health expenditure	22,916,111,030
Capital government health expenditure	124,944,000
Government health spending as a percentage of GDP	3%
Government health spending as a percentage of total general government expenditure	10%
Who funds health? Key financing sources (% THE)	
Public	81%
Private	13%
Donors	6%
How much do households spend? Household spending (% THE)	
Total household spending (prepayments to health insurance and direct payments to providers) as a % of THE	9%
Household OOP spending (direct payments to providers only) as a % of total health spending	8%
Who manages health resources? Key financing agents (% THE)	
Central government	58%
Regional government	24%
Households	8%
Donors	3%
National Insurance Scheme (NIS)	2%
Insurance companies	2%
Corporations (other than insurance corporations)	1%
NGOs	1%
Where are health funds spent? Key health care providers (% THE)	
Public hospitals	40%
Health posts and health centers	32%

Indicator	2016 (amounts are in G\$, unless otherwise noted)
Administrators	9%
Private hospitals and clinics	7%
Pharmacies	5%
Other	3%
Providers of prevention	3%
Laboratories and diagnostic centers	2%
What types of health care are consumed? Key health functions (% THE)	
Curative care	64%
Preventive care	19%
Administration	9%
Pharmaceuticals	5%
Laboratory and diagnostic services	2%
Other	1%
Capital spending	1%

* Source of 2016 population data: Guyana Bureau of Statistics, Statistical Bulletin for January-December 2017.

** Source of 2016 exchange rate: 2016 Bank of Guyana Annual Report.

*** Source of 2016 GDP: Guyana Bureau of Statistics, Current Gross Domestic Product – Revised and Rebased Series (2006-2017).

Note: Where applicable, values are in real 2016 Guyana dollars unless otherwise noted

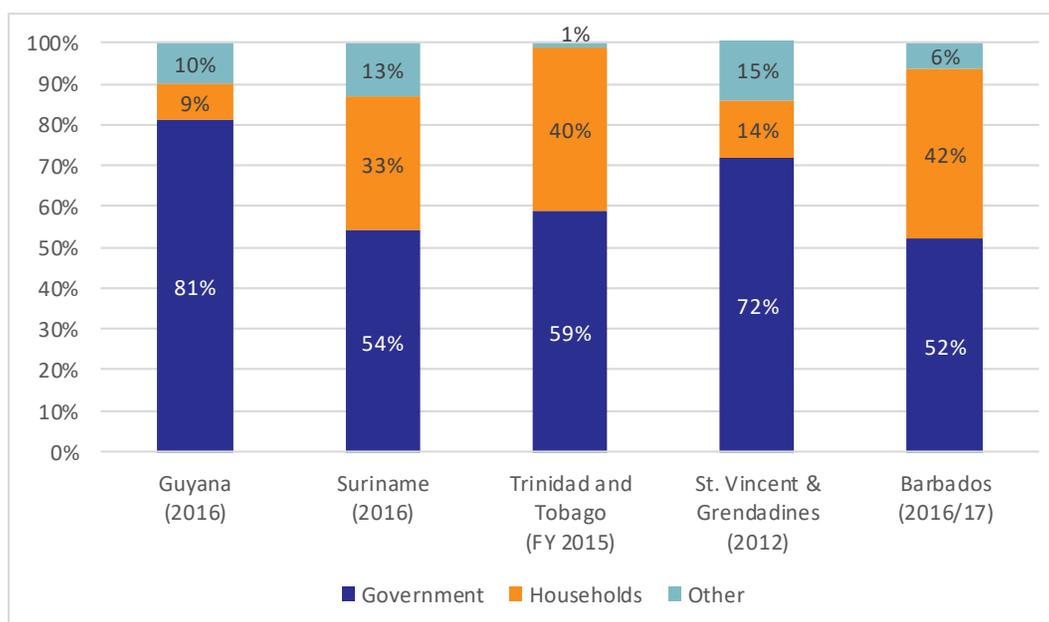
Figure 1 presents a comparative analysis of countries across the Caribbean with different levels of income, which have conducted Health Accounts estimations. While Guyana, with its per capita spending of US\$ 186, spends less than half the Caribbean average of US\$ 551 on health, the commitment of the government to directing resources towards health is high in comparison to the relatively low share of spending on health services from international development partners: the government contributes 81 percent of THE, while donor spending represents 6 percent. Compared to the most recent HA estimates for Suriname, Trinidad and Tobago, St. Vincent and the Grenadines,⁷ and Barbados, Guyana's government spending on health represents the largest share of THE (

⁷ Note that the calculations for St. Vincent and the Grenadines only consider current health expenditure, and not THE, as is the case for the other countries included in the comparison.



Figure 1).

Figure I: Regional Comparison of Source of Total Health Expenditure (THE)



Notes: All countries' data displays the funding as a proportion of THE, with the exception of St. Vincent, which comprises current health expenditure only. The SHA 2011 FS.RI classification was used to determine the source of funding and provide data for this graph.

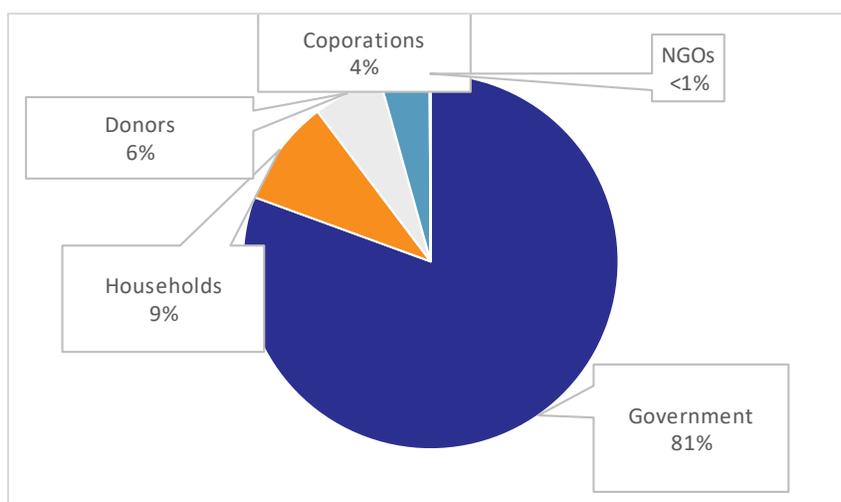
Sources: Data for Suriname were obtained from Suriname's 2016 HA study; data for Trinidad and Tobago data were obtained from the HA for FY 2015; St. Vincent were obtained from Annex A of Barbados's Health Accounts Report (2012 - 2013); the Barbados data for 2016/17 were obtained from the 2016/17 Health Spending Estimation. Also note that all of the countries' data displays the funding as a proportion of THE, with the exception of St. Vincent, which comprises CHE only. The FS.RI classification was used to determine the source of funding.

2.2 General Health Accounts Findings

2.2.1 Who pays for health care?

Financing sources include all entities and institutions that contribute funds to the health system. During the 2016 fiscal year, the Government of Guyana made the largest contribution to health spending, contributing more than four-fifths (81 percent) of health spending, which is financed predominantly via the tax-based system used to generate general revenue for the government. The second largest share of health spending comes from households which provide 9 percent, while donors, employers and NGOs contribute 6 percent, 4 percent and less than 1 percent, respectively.

Figure 2: THE by Source of Financing

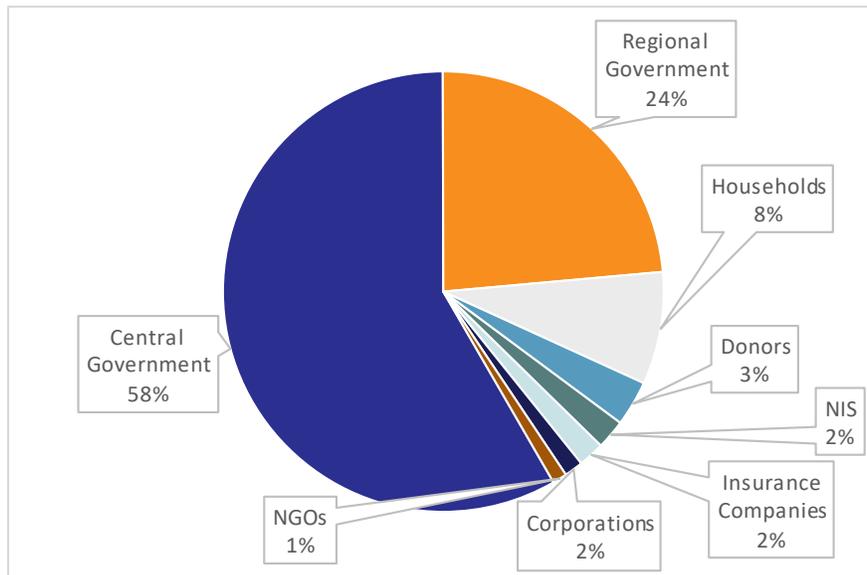


2.2.2 Who manages health funds?

The Government manages 82 percent of total health spending, with the central government managing 58 percent of this and the regional governments manage 24 percent (Figure 3). Households manage 8 percent of the total health spending, directly paying for health services out-of-pocket. Donors directly manage 3 percent of the spending while the National Insurance Scheme (NIS) manages 2 percent. The remaining 5 percent is managed by private insurance companies, NGOs and private corporations.

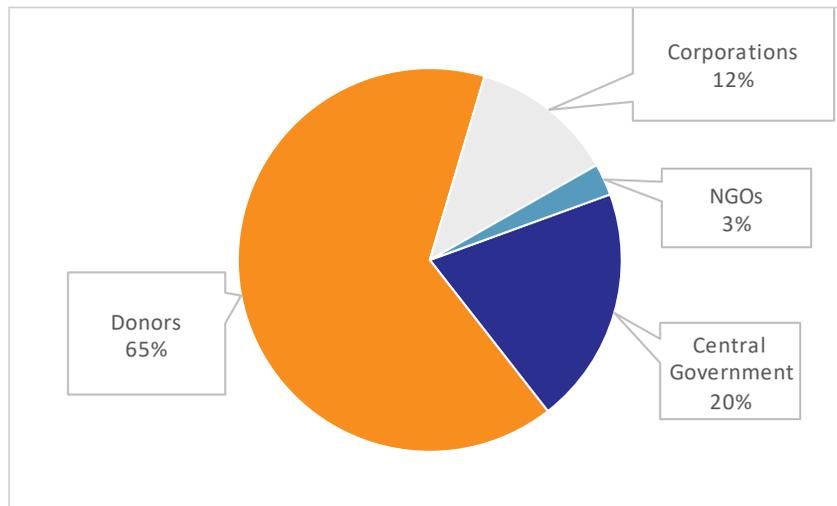
Risk pooling in health spending is one indication of the level of equity in health financing, given that it highlights the extent to which individuals are financially burdened when they require health care. Pooling resources across a large group of individuals based on ability to pay, in order to provide health services on the basis of need, is important for spreading risk evenly across a population. In Guyana, all of the resources not directly managed by households are pooled resources with risks distributed across the population. Government schemes account for 82 percent of current health spending, while 5 percent is pooled via insurance schemes and NGO schemes, 8 percent is managed by households, 25 by donors and 3% is unspecified. Household OOP payments do not provide risk pooling across individuals, given that households bear the full cost of health services at the time of need. According to the WHO, countries with OOP spending less than 20 percent of total health spending reduce the likeliness of having significant catastrophic spending (Xu et al. 2010). While Guyana falls well within this limit, OOP spending by households should be actively managed with a view to continuing to increase risk pooling.

Figure 3: THE by Manager



Health care-related expenditures such as social care for people living with HIV are not included in THE, and totaled an additional GY\$ 28,772,368 in 2016. Donors managed the majority (65 percent) of this amount, followed by the government (20 percent), corporations (12 percent) and NGOs (3 percent) (Figure 4). Conversely, health care-related capital spending totaled G\$ 580,768,200; 99 percent of these funds were managed by the central government. Health care-related capital spending includes funding for research and development and pre-service training of health personnel.

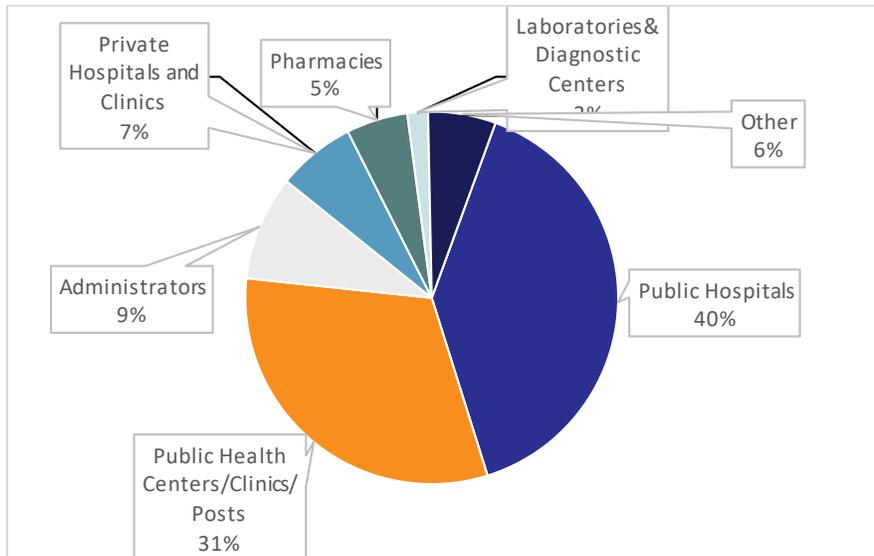
Figure 4: Managers of Health-Related Resources



2.2.3 Which providers receive funds to deliver care?

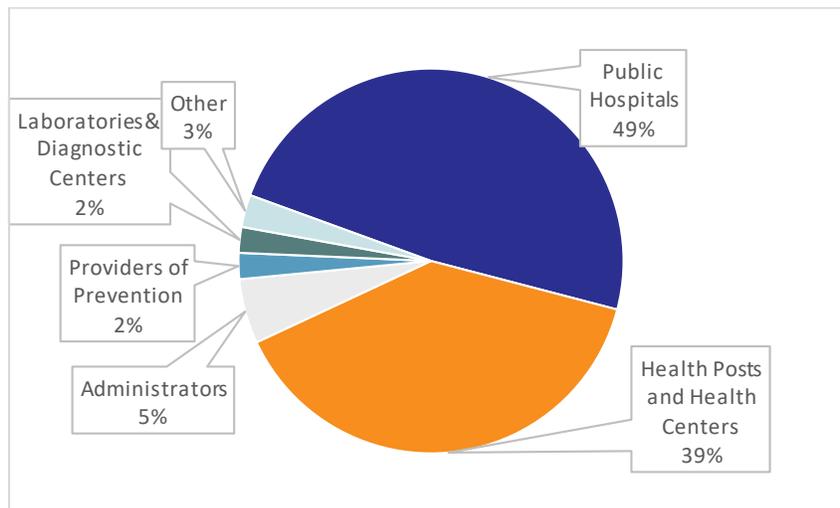
Government hospitals and primary level public facilities (which include health centers and health posts) receive the greatest portion of health spending to deliver care, with public hospitals accounting for 40 percent and health centers and health posts accounting for 31 percent of THE (Figure 5). Public health centers and clinics are the entry point into the public health care system and the main providers of primary health care. Private hospitals and clinics account for another 7 percent of THE; however, the Health Accounts analysis was unable to disaggregate spending at private hospitals from spending at private primary level facilities.

Figure 5: THE by Provider



The health funds that the government contributes are mostly spent at public hospitals, with almost half (49 percent) of government spending being spent at public hospitals (Figure 6). Consistent with the overall health spending by provider, 39 percent of government expenditure is at public health centers and health posts, and only 2 percent on providers of preventive care. Health system administration received 5 percent of the government health spending.

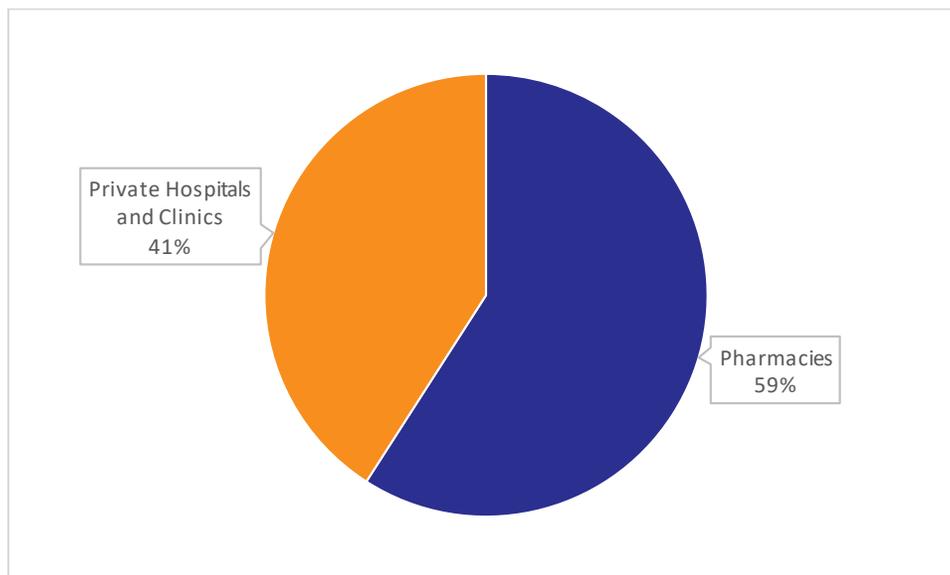
Figure 6: Government THE by Provider



2.2.4 On what health services do households spend?

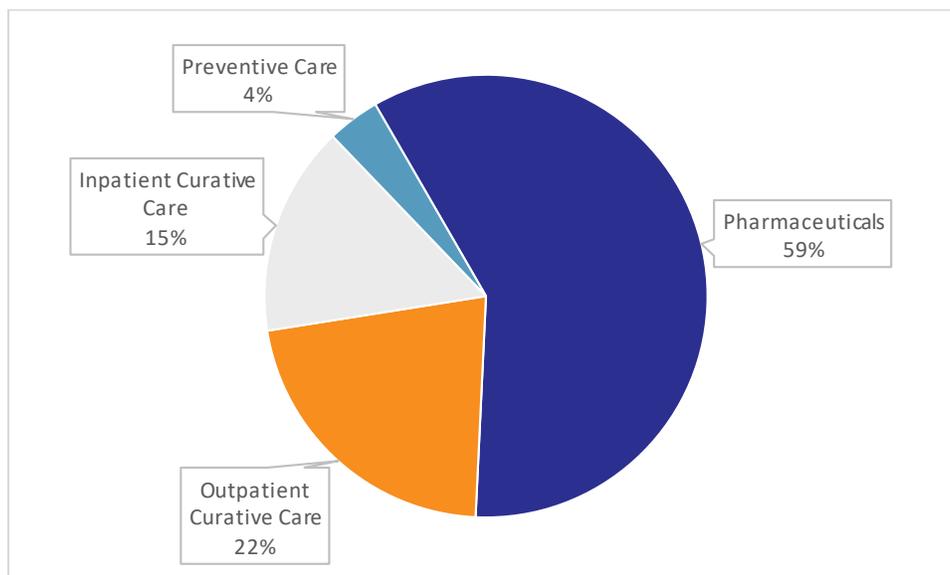
Given the implications of OOP spending for the population's risk of catastrophic financial burden, it is important to understand how households spend their money on health. Household OOP spending is divided between spending at pharmacies, which accounts for the majority of the expenditure (59 percent), and spending at private providers which accounts for 41 percent (Figure 7).

Figure 7: Household OOP Spending by Type of Provider



An overwhelming majority of household OOP spending goes to pharmaceuticals (59 percent), followed by curative care (37 percent), and only 4 percent spent on prevention (Figure 8).

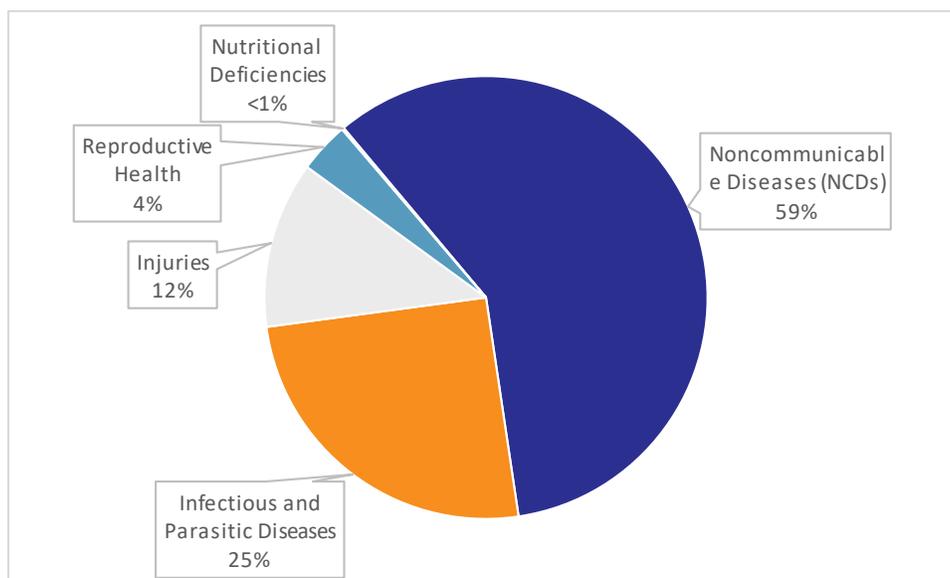
Figure 8: Household OOP Health Spending by Function



With regard to health conditions, 59 percent of household OOP payments go towards NCDs, while one-quarter of OOP spending is for infectious and parasitic diseases (this includes HIV and AIDS).

Injuries (12 percent) and reproductive health (4 percent) receive the next highest shares of household spending (Figure 9).

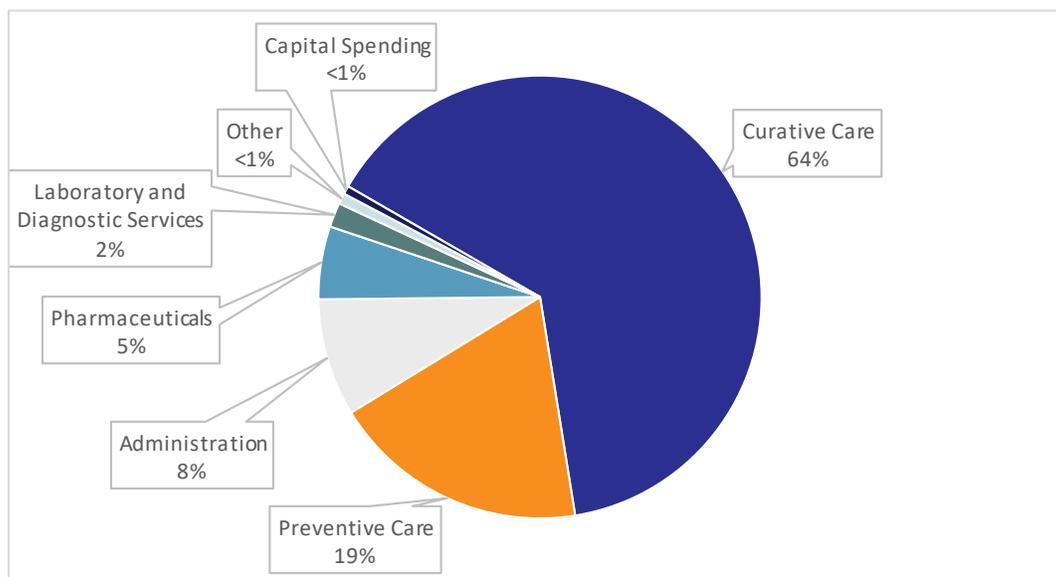
Figure 9: Household OOP Health Spending by Health Condition/Disease



2.2.5 On what types of goods and services are health funds spent?

The majority of funds (64 percent) were spent on curative care, while only 19 percent was spent on preventive care. Administration accounted for 8 percent of health spending, while the purchase of pharmaceuticals and laboratory and diagnostic services consumed 5 and 2 percent, respectively, of total health spending.

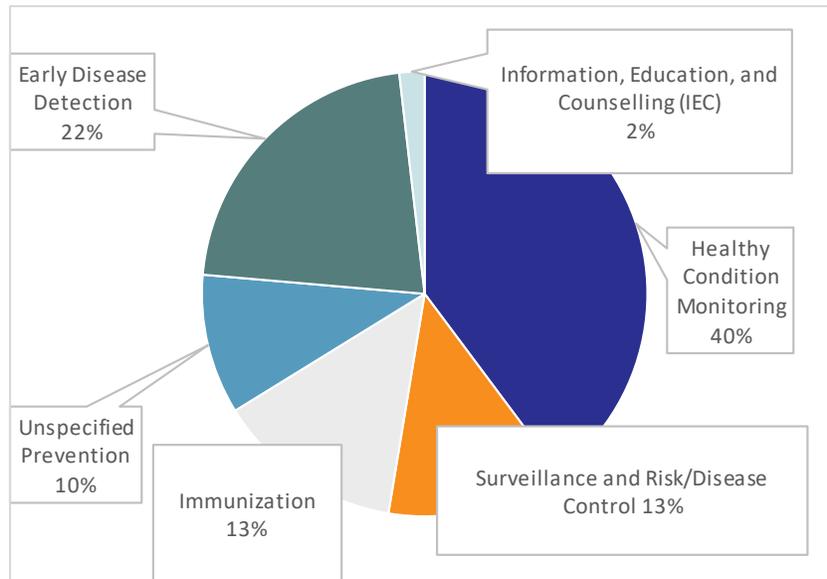
Figure 10: THE by Function



Prevention is defined as the spending used to prevent and detect diseases in their early stages. Of the 19 percent of THE that is spent on prevention, the majority (40 percent) is spent on healthy condition

monitoring, with 22 percent going to early disease detection and 13 percent to surveillance and risk/disease control as well as immunization programs.⁸

Figure 11: Health Spending on Prevention, by Type

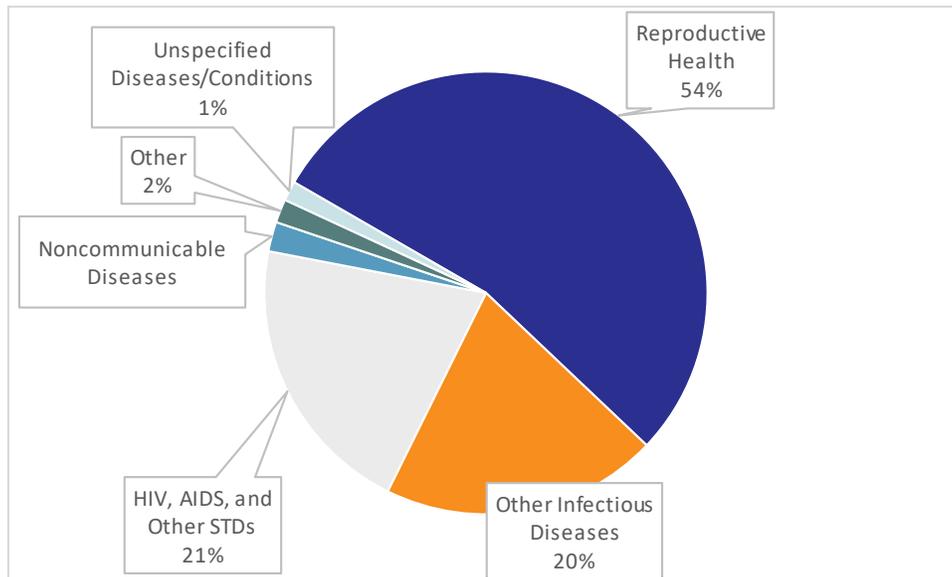


Note: Figure 11 only includes spending that comprises the 19 percent of THE spent on prevention.

Of the health spending on prevention, the largest proportion (54 percent) goes to reproductive health which received more than twice the next highest allocation, to HIV and AIDS (21 percent). Non communicable diseases receives only 2 percent of prevention spending.

⁸ The distinction between healthy condition monitoring programs and early disease detection programs is determined by the type of monitoring or screening. Early disease detection includes screening and diagnostic tests for a disease or health condition before symptoms appear, such as breast cancer screening. Healthy condition monitoring activities target specific conditions or age groups, such as antenatal care.

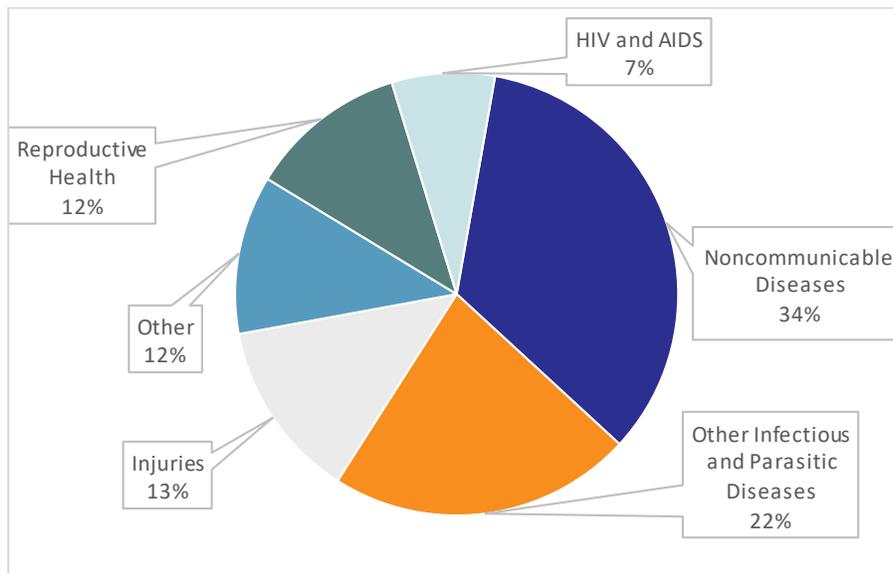
Figure 12: Prevention Spending, by Disease/Health Condition



2.2.6 On which diseases and health conditions does Guyana spend?

Non-communicable diseases received the highest allocation of funds, at 34 percent of total health spending, followed by infectious and parasitic diseases (other than HIV), at 22 percent; spending on HIV/AIDS and other sexually transmitted diseases (STDs) represented 8 percent of health spending. These allocations show the commitment the government of Guyana has made to prioritizing communicable diseases. Figure 13 shows that 82 percent of spending on NCDs comes from government sources.

Figure 13: THE by Disease/Health Condition



Addressing the incidence of non-communicable diseases through prevention and control is a priority for Guyana, as is outlined in its National Health Strategy. Recent analysis by the Institute for Health Metrics and Evaluation (IHME) shows that NCDs are the top causes of combined death and disability in Guyana

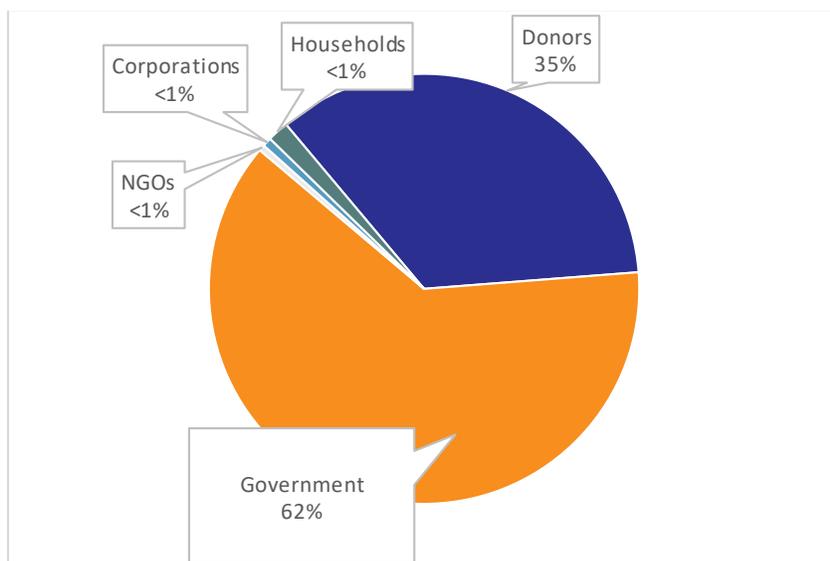
2.3 Analysis of HIV and AIDS spending

This section discusses the subset of health spending that goes to HIV and AIDS health goods and services only. Total spending for HIV in 2016 was G\$ 2,148,441,290.

2.3.1 Who is funding HIV and AIDS health goods and services?

The government provides the majority of current health spending on HIV and AIDS, followed by donors (62 and 35 percent, respectively); NGOs, corporations, and households comprise the remaining sources, each contributing less than 1 percent of HIV spending.

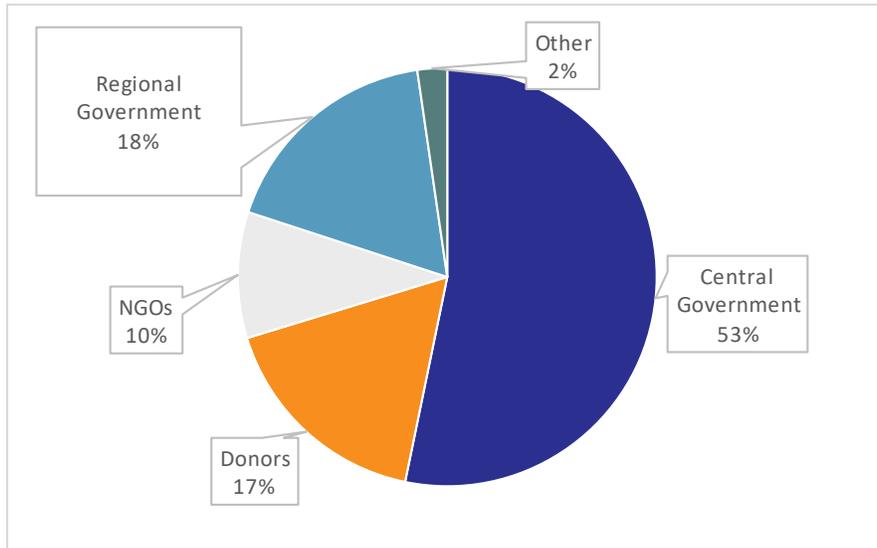
Figure 15: HIV and AIDS Current Health Spending by Source of Financing



2.3.2 Who is managing funding for HIV and AIDS?

The central government manages more than half of HIV and AIDS spending (53 percent), with regional government and donors managing similar shares (18 percent and 17 percent, respectively). NGOs manage 10 percent of current health spending on HIV and AIDS. Of note is that the government and NGOs manage larger proportions of HIV and AIDS current health spending than they contribute, while donors manage a smaller proportion than they contribute; this suggests that more than half of HIV and AIDS current health spending that comes from donors is managed by NGOs or the government.

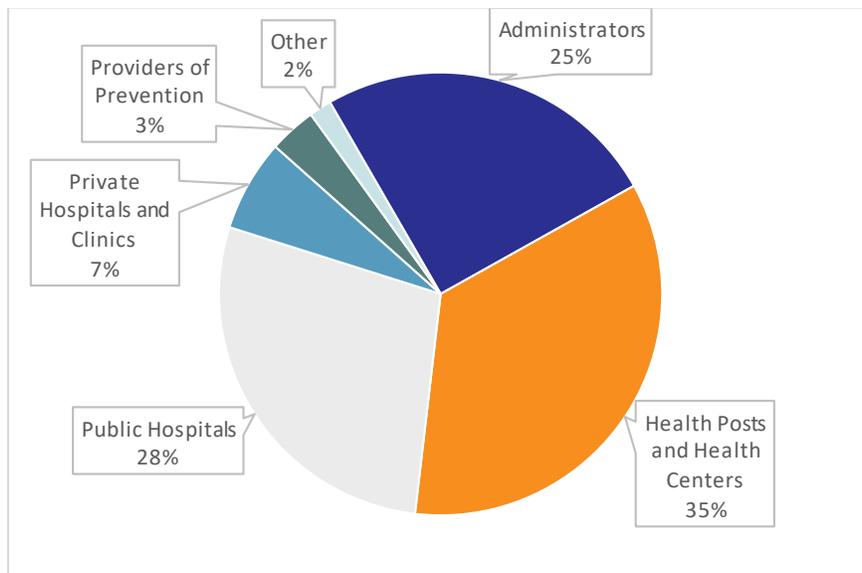
Figure 16: HIV and AIDS Current Health Spending by Manager



2.3.3 Who uses health funds to deliver HIV and AIDS services?

28 percent of HIV and AIDS current health spending was incurred at public hospitals, while 25 percent was spent at public primary level facilities (health centers and clinics). 7 percent of HIV and AIDS current health spending happened at private hospitals and clinics; the Health Accounts analysis was not able to disaggregate the distribution between private hospitals and private primary level facilities (Figure 17). Administration consumed 25 percent of HIV health spending, an amount much higher than the proportion of THE spent on administration (8 percent, Figure 10), suggesting that there may efficiencies to be gained by streamlining administration and management of HIV-related services. Only 3 percent was spent on providers of prevention services.

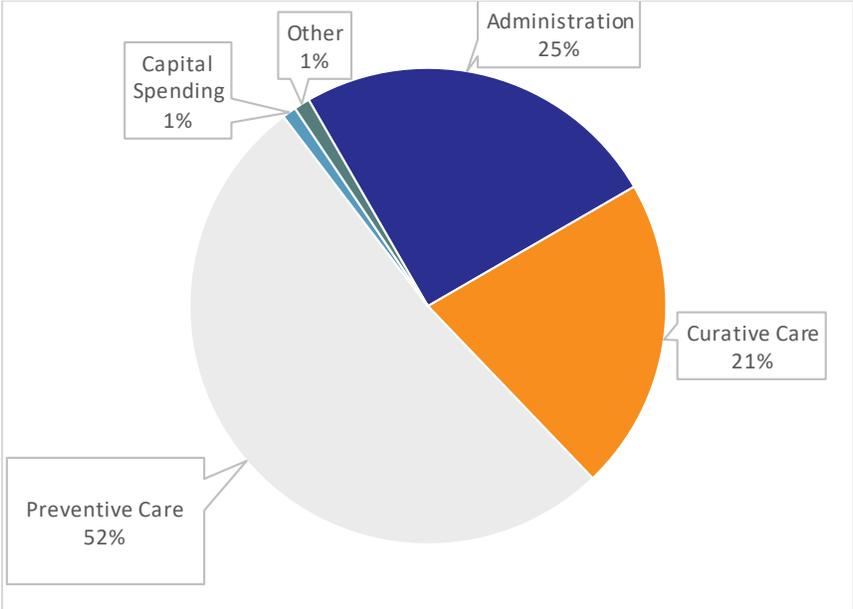
Figure 17: HIV and AIDS Current Health Spending by Provider



2.3.4 What types of HIV and AIDS health goods and services are purchased?

The majority of HIV and AIDS current health spending goes towards prevention, which includes activities such as voluntary counseling and testing, distribution of condoms, and information, education and communication (52 percent, Figure 18). Spending for the prevention of HIV and AIDS remains higher than the overall spending on prevention for all diseases combined. Curative care for HIV and AIDS, which includes antiretroviral therapy (ART), accounts for 21 percent. Administration represents 25 percent of HIV and AIDS spending. Compared with general health spending, where the share of THE spent on administration is 8 percent, the proportion of HIV spending spent on administration is high.

Figure 18: HIV and AIDS Current Health Spending by Type of Service



3. POLICY IMPLICATIONS AND RECOMMENDATIONS

Based on the findings and policy implications of the 2016 Health Accounts exercise, the Health Accounts technical team makes the following recommendations:

3.1 Assess the efficiency and sustainability of domestic health financing

3.1.1 Explore the fiscal space for increasing health spending

Of countries in the Caribbean region that have conducted HA studies since 2011, Guyana has the largest government contribution to health spending.⁹ With the government providing 81 percent of THE, household OOP household OOP spending is relatively low (8 percent), as is underscored by regional comparisons that show show household spending in Guyana to be lower than that of neighboring countries (

⁹ See Annex A of this report for data on government contribution to THE in Suriname, Trinidad and Tobago, Barbados, and St. Vincent and the Grenadines.

Figure 1). Guyana's OOP spending falls well within the WHO-recommended threshold of 20 percent of health expenditure for achieving UHC and the SDGs, including financial risk protection (Xu, Ke et al. 2010).

In addition to these positive findings regarding government spending on health, the HA results also suggest that there might be room to further increase government health spending in Guyana: THE as a percentage of GDP (4 percent) is the lowest among comparator countries, and the government contributes the second-lowest proportion of its overall budget to health (9 percent); see Annex A for additional details. Government health spending as a percentage of GDP (4 percent) also lags behind the PAHO/WHO recommendation of 6 percent (Xu, Ke et al. 2010). Furthermore, Guyana's THE per capita (US\$ 186) is the lowest of the comparator countries in Annex A.

These findings highlight the need for a fiscal space analysis to investigate the possibility of increasing overall health spending. In particular, a fiscal space analysis could suggest ways the government can create room within the national budget for additional spending on health. International evidence suggests that increasing the government health budget through reallocation of domestic resources has the best potential to increase health expenditure, and that achieving this goal requires robust evidence for budget negotiations, including from HAs and fiscal space analysis (Gheorghe 2016).

3.1.2 Increase access to care by improving allocative efficiency

A comprehensive assessment of the allocative efficiency of health spending could inform decisions about prioritization of health programs and domestic resource mobilization. This requires the MOPH to understand whether its health spending is sufficient and equitable across the population, including the extent of unmet health needs, where and how health services are being utilized, and the nature of any barriers to accessing and paying for health services.

The Health Accounts results provide a potential entry point for an assessment of allocative efficiency by providing data on the level of care and the type of health services provided. For example, the Health Accounts found that at least 40 percent of THE funds care at hospitals, while at least 31 percent funds care at primary level facilities (Figure 5).¹⁰ The Health Accounts data on the type of care provided similarly suggests that Guyana could improve the allocative efficiency of health services by re-distributing resources from curative care to prevention: in 2016 64 percent of THE funded curative care compared to 19 percent that funded preventive care (Figure 10).

Health services offered at primary level facilities are generally more accessible to the Guyanese population than services offered at hospitals. Therefore, future studies should investigate the equity, accessibility, and efficiency of health service provision and maximize the impact of health spending. These future studies may identify potential efficiency gains for the allocation of resources that fund health care goods and services.

This recommendation is consistent with the goal of the National Health Strategy (Health Vision 2020) to reduce health inequities through a renewed focus on primary health care delivered through integrated health service delivery networks. The national strategy further recognizes the need to mobilize and reorient resources to address the needs of the most populations in rural and interior locations, whose health outcomes may lag behind national levels. To improve the quality and accessibility of services in remote areas, the MOPH should consider allocating a greater portion of its resources to the primary

¹⁰ The Health accounts could not disaggregate an additional 7 percent of THE, which was spent at private facilities and includes hospitals and primary level facilities.

health care level. By increasing spending on health services at primary level facilities, Guyana may also be able to reduce the burden of NCDs, and thereby improve the quality of life of the population while reducing the overall cost of care.

3.1.3 Increase domestic resources for HIV and AIDS

The Government of Guyana has been working to ensure the sustainability of the national HIV response, including increasing financing for HIV from the national budget. It is expected that Guyana will have to further increase domestic spending to offset an additional imminent decreases in funding from Global Fund to fight AIDS, TB and Malaria (GFATM) and the United States Government President's Emergency Plan for AIDS Relief (PEPFAR). This is supported by the Health Accounts data, which demonstrate that donors contribute 35 percent of health funding for HIV and AIDS, compared to the 6 percent of THE contributed by donors; meanwhile, the government contributes 81 percent of THE, compared to 62 percent of health spending on HIV and AIDS (Figure 2 and Figure 15).

Achieving HIV targets will require further increases in domestic financing alongside efforts to optimize resource use through continuation of donor-funded programming and expansion of treatment services for a Treat All approach. Guyana's commitment to Treat All, even in the context of declining external financing, recognizes that increased financial investment in the short-term will yield long-term economic benefits from reductions in transmission. In order to achieve expansion of the treatment program with domestic resource mobilization, the government may consider diversifying domestic revenue sources for HIV, such as dedicated taxes, revenue from specific selected activities or leveraging private sector resources.

3.1.4 Diversify health financing mechanisms that pool risk across the population

As the government seeks to increase the fiscal space for domestic funding for health, it is important to ensure that OOP spending does not increase because when households bear the full cost of health goods and services at the time of care, there is potential for the financial burden to become catastrophic.¹¹ In Guyana, insurance companies and NIS manage only 4 percent of THE combined, with the remaining THE managed either by the government, households, donors, corporations, or NGOs (Figure 3). Therefore, while the risk pooling in Guyana is high due to the low OOP spending and high proportion of funds managed by the government relative to other Caribbean countries (Annex A), Guyana may be able to increase financial risk protection by diversifying financing mechanisms. Mechanisms that pool risk across a large group of individuals can ensure that those who cannot afford health care and are most sick receive support from those who are wealthier and less sick. Risk pooling reduces the risk of individuals incurring catastrophic health expenditure as a result of seeking health care and ensures equity in paying for health care, as it determines the extent to which individuals will bear financial burdens when they require health care.

Increasing the role that companies play in financing health and managing resources would increase the diversity of risk pooling mechanisms. In Guyana, private corporations contribute only 4 percent and manage 1 percent of THE (Figure 2 and Figure 3). The current low level of contributions from private corporations to health represents an opportunity to diversify the source and management of health

¹¹ Catastrophic health expenditure occurs when OOP spending for health exceeds 40 percent of a household's non-subsistence spending.

funding and strengthen companies' involvement. In the country's efforts to achieve UHC, the government should further evaluate and engage the private sector as a source of additional health financing. The Guyana National Health Strategy reports that over the period 2008-2012, private sector spending was notable for being the only source that showed consistent real growth. This suggests that opportunities may exist for more strategic engagement of the sector.

3.2 Allocate more funding to prevention of NCDs

The vast majority of health spending is on curative care (64 percent of THE), and only 19 percent on prevention. While the HA results show a high level of spending on NCDs relative to other health issues, NCDs only receive 2% of the spending dedicated to prevention (Figure 12). There is therefore room to align curative and preventive spending on NCDs to better support Guyana's commitment to reduce the burden of NCDs by scaling up health promotion and interventions to address modifiable risk factors (Guyana Ministry of Public Health 2013). Because NCDs are a major cause of morbidity and mortality in Guyana, improving the impact of prevention efforts will also reduce the demand and costs of health services, in addition to improving the quality of life of the population.

3.3 Strengthen financial and programmatic commitment to HIV prevention services

HIV prevention spending currently exceed UNAIDS recommendations for 25% of the HIV budget (UNAIDS 2016). It is important to note that the HA considers the provision of antiretroviral therapy to be curative care, and the 2016 findings do not yet reflect the impact of Guyana's commitment to Treat All. The share of prevention spending is, therefore, likely to decrease as resources are channeled to expand the treatment program. Further, declining donor funding jeopardizes CSO-implemented prevention programs for key populations, as the national budget does not include funding for CSOs (Cenac et al. 2017; Health Policy Project 2016). Shifting resources away from prevention is likely to have a detrimental impact on the HIV program. Ensuring a high-impact prevention approach that reaches key populations at higher risk of HIV transmission, even while the country expands treatment, is critical for controlling the HIV epidemic. Further investigation of the efficiency and impact of prevention spending is therefore recommended to inform efforts to ensure continued availability of a range of effective prevention interventions. As a start, there is a need to better understand the distribution of HIV prevention spending by type of service. An assessment of the potential impact of introducing innovative approaches such as pre-exposure prophylaxis (PrEP), as part of robust program of combination prevention, as well as an investment case to demonstrate the value of the work of CSOs, should also be considered (Via Libre 2017).

3.4 Strengthen the Health Information Management System (HIMS)

Guyana's commitment to achieving the SDGs and UHC requires the capacity to monitor progress towards these goals. This HA exercise has demonstrated that tracking detailed spending is feasible. However, if spending is to be tracked in a regular, accurate, and timely manner, it is important for the

government to provide better documentation and availability of utilization and expenditure data. The HIMS can be improved and updated with the development of standardized reporting requirements for health utilization data that enable it to be collected and stored centrally. This should include reporting from the private sector and NGOs, to ensure that interventions are coordinated. Strengthening a standardized and consolidated approach is critical for a comprehensive picture of use of health services in Guyana. Ensuring that the HIMS properly records health service utilization and provides financial data will facilitate improved planning and programming, including through production of HA to inform policy discussions. The ultimate goal is that data for policy analysis purposes can generate the evidence required, linking expenditure with utilization and health outcomes throughout the health system.

3.5 Institutionalize Health Accounts to ensure timely and regular data for decision-making

Ensuring adequate financial and technical resources for Health Accounts can facilitate the regular production of expenditure estimates to inform policy and planning. A Ministry of Public Health budget line item for Health Accounts can ensure the financial resources needed for the exercise. Data collection in particular is time consuming and requires adequate resources that are allocated in a timely manner.

The current exercise included strengthening the capacity of the Technical Team to understand and implement the SHA 2011 framework. In the next round of Health Accounts, increased involvement of the team in the final stages of analysis and report writing will prepare them for future exercises.

The Technical Team convened on a regular basis to advance the Health Accounts exercise. It was difficult for the members to dedicate time for these meetings given their busy work schedules. For future exercises, the MOPH, with an eye on institutionalizing Health Accounts, would benefit from creating an official mandate that commits personnel and funding to produce and analyze Health Accounts on a regular basis.

Early and strong engagement of key stakeholders from both the public and private sector is critical for Health Accounts exercises. Getting stakeholders involved through the Steering Committee from the beginning and defining their roles and responsibilities can augment the HA production process.

Attendance at the launch event of key stakeholders from the private sector including NGOs, employers, and insurance companies, could help participants understand the importance and utility of data generated by a Health Accounts exercise and thereby improve survey completion rates. National umbrella organizations such as those for private employers and insurance companies should be encouraged to be accountable and play an active role in promoting and facilitating the HA data collection in their respective sectors.

Regular meetings of the Health Accounts Steering Committee can improve political will, ownership over the Health Accounts results, and engagement of stakeholders in the country. Ensuring that the Steering Committee is comprised of members that can facilitate data collection (for example from employers, insurance companies, the Ministry of Finance, and other government agencies or ministries) can also be helpful, especially when the Technical Team faces challenges in obtaining data in a timely manner.

Stakeholder engagement also includes inviting all key stakeholders to participate in the HA dissemination event, and sharing the results of the HA exercise with these entities so that they can see how the data are presented and used.

ANNEX A: KEY HEALTH INDICATORS FOR GUYANA AND COMPARATOR COUNTRIES

	Guyana (2016)	Suriname (2016)	Barbados (2016/17)	Trinidad and Tobago (FY 2015)	St. Vincent and the Grenadines (2012)
THE per capita (US\$)	US\$ 186	US\$ 362	US\$ 1,143	US\$ 1,167	US\$ 991
THE as % GDP	4%	6%	7%	7%	5%
Government health spending as % THE	81%	54%	52%	59%	72%
Government health spending as % total government spending	10%	13%	8%	9%	15%
OOP spending as % THE	8%	22%	42%	40%	14%

Sources: The Suriname data were obtained from the 2016 Health Accounts Report; the Trinidad and Tobago data were obtained from the FY 2015 Health Accounts Report; the Barbados data were obtained from the 2016/17 Health Spending Estimation; and St. the Vincent & the Grenadines data were obtained from Annex A of the Barbados 2012-13 Health Accounts Report.

Note: The health expenditure figures for St. Vincent comprise CHE only.

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