GUYANA

2016 Guyana Health Accounts

Brief:
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1. Introduction

The health spending data is a critical input into monitoring the progress of Guyana's commitment to achieving universal health coverage and sustainability planning for the national HIV response. Recognizing the importance, the Ministry of Public Health with the support of the Ministry of Finance, the Bureau of Statistics and Georgetown Public Hospital Corporation conducted its first Health Accounts exercise covering the fiscal year 2016 (January 1-December 31,2016). This Health Accounts exercise used the System of Health Accounts 2011 (SHA 2011) framework, which captures spending from all sources within an economy: the government, nongovernmental organizations (NGOs), external donors, private employers, private 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 study in Guyana occurs at a critical time. As donor funding for health has declined, the Government of the Cooperative Republic of Guyana has steadily increased its investment in the health system. Further increases in financing from the national budget are likely to be needed for adequate and continuous funding to achieve HIV targets and objectives in the face of additional funding cuts from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the United State Government (USG), and to make good on Guyana's commitment to implement a Treat All approach. It is critical for the country to develop a credible long-term financing scenario that

includes efforts to diversify funding sources and optimize resource utilization.[1]

At the same time, demand and costs for health services are increasing due to an aging population, increasing incidence of non-communicable diseases (NCDs), and the continuous threat of communicable diseases. To increase affordable access to quality health care and prevent the loss of health improvements to date while funding shrinks and costs rise, Guyana will need to focus on equitable allocation of available resources and efficient use of those resources.

In light of these, the Ministry of Public Health and partners through the Health Accounts exercise looked at the following critical questions.

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

This brief summarizes the findings to these policy questions and also provides the process and key lessons learnt for Guyana's future Health Accounts exercises.

2. Key Results

2.1 How adequate and sustainable is Guyana's Health Financing?

Total health expenditure (THE) in Guyana in 2016 amounted to G$28,595,303,655 (US$138,476,047), of which 99 percent was current spending. current 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.

Table 1: Key Health Financing Data

Indicators	2016 (values are in GYD unless otherwise noted)
Total population	743,458
Exchange rate (G$/US$1)*	206.5
GDP**	723,581,000,000
Total Health Expenditure (THE)	28,595,303,655
Current health expenditure	28,422,162,398
Capital health expenditure	173,141,256
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 total general government expenditure	10%

* Source: 2016 Bank of Guyana Annual Report, p. 21.
** Source: Guyana Bureau of Statistics, http://www.statisticsguyana.gov.gy/nataccts.html accessed 6 July, 2018.

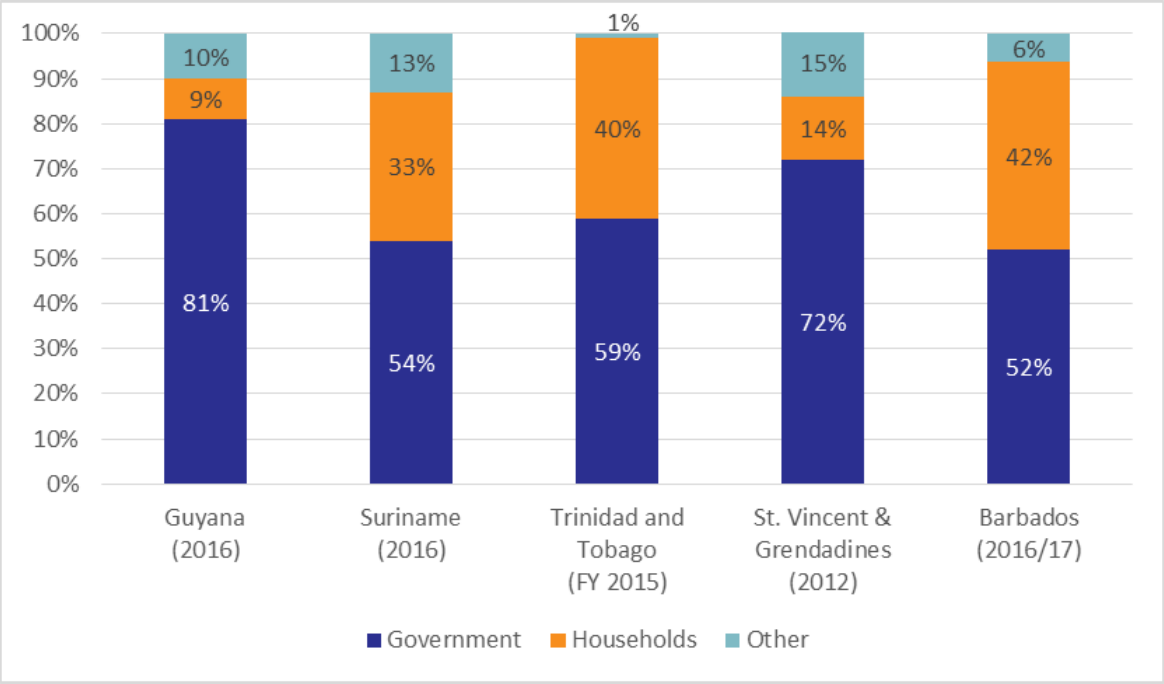
The Government of the Cooperative Republic of Guyana made the largest contribution to health spending, by contributing 81percent of the total spending. The substantial government contribution to health spending comprised 10 percent of the government's total spending in the fiscal year. The percentage contributions of households, employers and donors amounted to 9 percent, 4 percent and 6 percent, respectively.

Guyana's government spending on health represents the largest share of THE (81 percent) relative to Suriname, Trindad and Tobago, St. Vincent and the Grenadines, and Barbados, according to those countries' most recent Health Accounts estimates[2].

[1] Torpey, K., Mwenda, L., Thompson, C. et al. JIAS (2010) 13: 19. https://doi.org/10.1186/1758-2652-13-19

[2] See www.hfgproject.org for these Health Accounts reports.

Figure 1. Regional comparison of source of THE



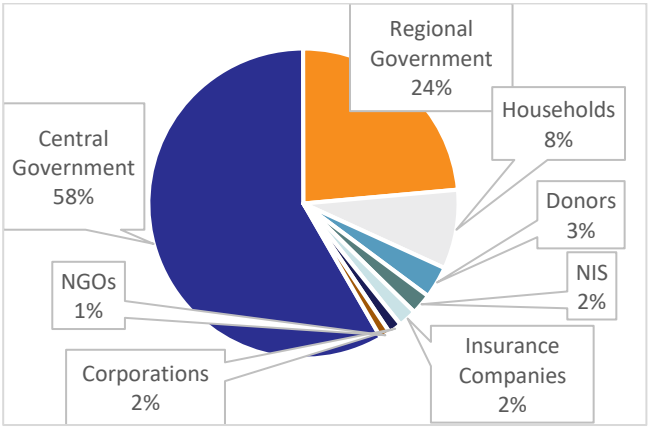
Notes: All countries' data displays the funding as a proportion of THE, with the exception of St. Vincent, which comprises current health expenditure only. The SHA 2011 FS.RI classification was used to determine the source of funding and provide data for this graph.

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 Who manages the health funds?

The Government managed 82 percent of total health spending, with the central government managing 58 percent of this while the regional governments managed 24 percent (Figure 2). Given the increasing move towards decentralization, the share of the latter is expected to progress. Households manage 8 percent of the total spending, directly paying for health services out of pocket. Development partners directly manage 3 percent of the spending while government's main insurance scheme- the National Insurance Scheme manages 2 percent. The remaining 5 percent managed by private insurance companies, NGOs and private corporations.

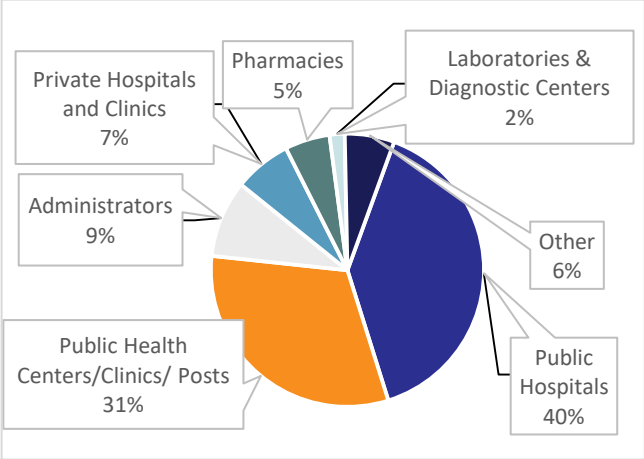
Figure 2. Managers of THE



2.3 Where are the funds spent?

Seventy-one percent of health funds were spent on public facilities (levels 1, 2, 3, and 4), while private facilities 7 percent of THE was spent at private facilities. Furthermore, the Government of Guyana spent 49 percent of its THE at public hospitals, and 39 percent of government THE was spent at the primary and secondary facility level (health centers and health posts).

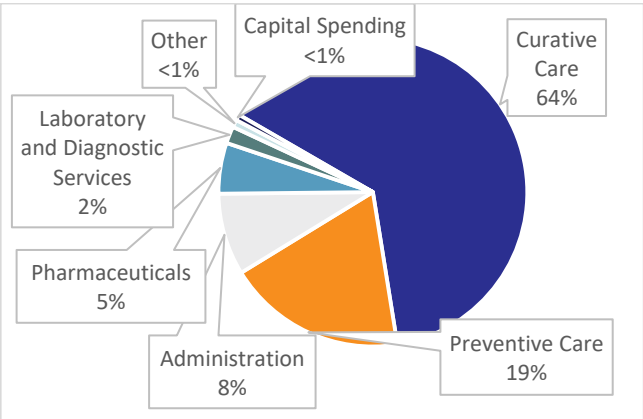
Figure 3. THE by provider



2.4 On what goods and services?

The majority of funds (64 percent) was spent on curative care, while 19 percent of funds were spent on preventive care. Administration consumed 8 percent of THE, and the purchase of pharmaceuticals accounted for 5 percent of THE.

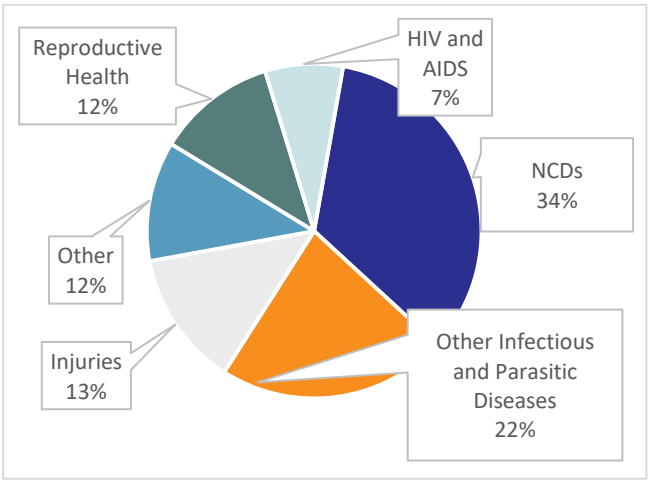
Figure 4. THE by function



2.5 On which diseases?

Non-communicable diseases received the highest allocation of funds, at 34 percent of THE, followed closely by infectious and parasitic diseases, at 29 percent (including HIV and AIDS); within this, spending on HIV and AIDS represented 7 percent of THE.

Figure 5. THE by Disease/Health Condition



2.6 Detail on HIV and AIDS funding

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. The majority of HIV and AIDS current spending goes towards prevention, which includes activities such as voluntary counseling and testing (52 percent of THE). Curative care for HIV and AIDS represents 21 percent of THE, which includes antiretroviral therapy.

Figure 6. HIV and AIDS current health spending by source

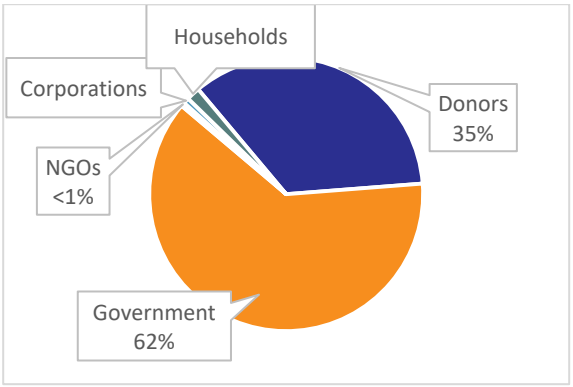
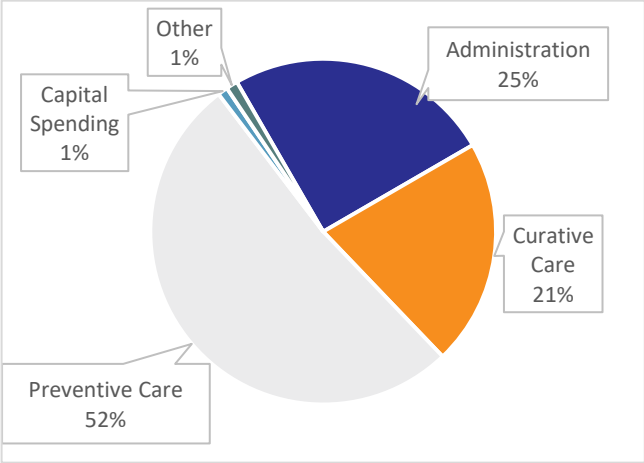


Figure 7. HIV and AIDS current spending by type of service



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:

1. **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.
2. **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.
3. **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.
4. **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 though production of HA to inform policy discussions.
5. **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.

4. Methods of the Health Accounts Exercise

4.1 Data Sources

Health Accounts provides a comprehensive view of total health spending in a country – covering public, private and donor sources of funds. To gather primary data, the MOPH led a technical team that surveyed a wide range of sources (Table 2). In addition to the primary data collected, the team collected secondary data to supplement the analysis.

Table 2: Primary Data Sources for Health Accounts 2016

Data Source	Key Health Spending Information
Donors (both bilateral and multilateral donors)	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 medical insurance, health facilities, or workplace prevention programs
Insurance companies	Health benefits that are paid through insurance schemes

The team collected information from the following secondary data sources:

- **Government:** Data on health spending by the MOPH and regions[3]
- **National Insurance Scheme (NIS):** Data on revenue sources and health benefits paid
- **Households:** Data on OOP health expenditures estimated using Guyana's Household Budgetary 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.

[3] 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.)

4.2 Health Accounts Process and Capacity Building

The 2016 Health Accounts was the first exercise completed by the Guyana MOPH. The study was supported by the United States Agency for International Development's (USAID) Health Finance and Governance (HFG) project and the Pan American Health Organization (PAHO)/World Health Organization (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.

Health Accounts Process

The following activities comprised the Health Accounts exercise:

- **Health Accounts Launch:** The MOPH began the Health Accounts 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.
- **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.

Health Accounts Capacity Building

A critical objective of the technical support provided by USAID's HFG project was building the institutional capacity and the technical knowledge base necessary to conduct future Health Accounts studies. The following governing bodies were created to facilitate Health Accounts capacity building in Guyana:

- **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.

The Health Accounts Technical Team

4.3 Accomplishments and Limitations

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 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. Additionally, the MOPH engaged many stakeholders in the implementation of the HA, including the Ministry of Finance, Bureau of Statistics and the National Insurance Scheme.

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. The following improvements would also increase the deail for future Health Accounts exercises:

- Increasing the level of detail of the health expenditure data obtained from the MOPH and the regions.
- Increasing the detail of NIS claims data
- Conducting a new household survey on health spending
- Improving the health information system to produce standardized and frequent health service utilization data
- Conducting a costing study

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, 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.

The Health Finance and Governance (HFG) project works with partner countries to increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. Designed to fundamentally strengthen health systems, the HFG project improves health outcomes in partner countries by expanding people's access to health care, especially priority health services. The HFG project is a five-year (2012-2017), $209 million global project funded by the U.S. Agency for International Development under Cooperative Agreement No: AID-OAA-A-12-00080. The HFG project is led by Abt Associates in collaboration with Avenir Health, Broad Branch Associates, Development Alternatives Inc., Johns Hopkins Bloomberg School of Public Health, Results for Development Institute, RTI International, and Training Resources Group, Inc.

For more information visit www.hfgproject.org/.

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