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BARBADOS 2012-13 HEALTH ACCOUNTS: STATISTICAL REPORT

December 2014

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Acronyms

ARV	Anti-retroviral
BDS	Barbados Drug Service
CHE	Total Current Health Expenditure
GDP	Gross Domestic Product
HA	Health Accounts
HAPT	Health Accounts Production Tool
HC	Healthcare function
HFG	Health Finance and Governance Project
HSA	Health Satellite Accounts
ICD	International classification of disease
IP	Inpatient
LRU	Ladymeade Reference Unit
MOH	Ministry of Health
NGO	Nongovernmental organization
NHA	National Health Accounts
NHE	National Health Expenditure
OECD	Organisation of Economic Cooperation and Development
OOP	Out-of-pocket
OP	Outpatient
PLHIV	People living with HIV
QEH	Queen Elizabeth Hospital
SHA	System of Health Accounts
THE	Total Health Expenditure
USAID	United States Agency for International Development
UWI-HEU	University of the West Indies, HEU, Centre for Health Economics
VCT	Voluntary counselling and testing
WHO	World Health Organization

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1. Introduction

The lack of solid up-to-date health financing information for evidence-based planning inspired the Ministry of Health (MOH) to conduct a Health Accounts (HA) exercise. Although the Ministry completed a Health Satellite Accounts (HSA) exercise in 2013, lack of complete National Accounts data resulted in incomplete spending captured for key groups such as commercial insurance companies, private employers, and households. The Ministry of Health (MOH) therefore conducted a HA exercise complementing the evidence from the HSA to better understand health spending and to inform resource allocation decisions in order to achieve its UHC objective¹. Barbados is currently undergoing consultations for health financing reforms and the HA data will ensure that reforms are designed based on sound evidence.

As part of the exercise, the HA analysis also sought to understand the sustainability of financing for HIV/AIDS and where HIV/AIDS resources are being spent given the increasing competing priorities for resources from areas such as NCDs.

The analysis sought to answer key policy questions highlighted below.

Scope	Policy area	Policy question
Overall health system	Sustainability of health financing	Who funds health spending and how much do they contribute?
	Risk pooling	To what extent are funds for health pooled to minimize risk?
	Financial risk protection	What level of financial risk protection is available to households in Barbados when seeking care?
	Primary vs. Secondary vs. Tertiary care spending	How does health spending compare at different levels of the health system?
	Relative spending on prevention / promotion vs. curative care	How is health spending allocated among treatment, prevention and other activities?
National HIV response	Spending on NCDs	Which diseases and health conditions does Barbados spend on?
	Sustainability of health financing	Who is funding the HIV response in Barbados and how sustainable is it?
	Financial risk protection	What level of financial risk protection is available to PLHIV in Barbados when seeking care?
	Relative spending on prevention / promotion vs. curative care	How is health spending allocated among HIV treatment, prevention and other activities?

¹ Barbados is aiming to achieve Universal Health Coverage (UHC) for its population, which will require it to ensure a basic package of goods and services to its population, without impoverishing its population when they need to seek care.

This Barbados 2012-13 HA was conducted between June and December 2014. Following the launch workshop in June 2014, the HA team, with representation from the Government of Barbados and the Health Finance and Governance (HFG) Project, began primary and secondary data collection. Collected data were then compiled, cleaned, triangulated, and reviewed. Data was imported into the HA Production Tool and mapped to each of the SHA 2011 classifications. The results of the analysis were verified with MOH stakeholders in November and with a wider group of country stakeholders in December 2014. The official dissemination workshop took place December 18th, 2014. Participants who were invited to these workshops, and who are recommended for participation in future HAs, are listed in Annex A.

This report provides the detailed statistical tables depicting the magnitude and flow of the resources from the source (such as government, households, donors) to end-use (defined by type of activity and disease / health condition) as well as methodological details. The report is divided into three chapters. The first chapter provides a brief introduction of the purpose and overall approach of the health accounts exercise in Barbados. The second chapter provides an overview of the health accounts conceptual framework and a summary of the methodology namely: data sources, data collection, assumptions made as well as limitations. The third section discusses the limitations of the HA estimation. Finally, sections 4 and 5 provide a series of two dimensional tables showing the flow of health and HIV spending.

This statistical report is intended for HA practitioners and researchers who desire the detailed expenditure flow information for additional operational and scientific research as well as an understanding of how the figures are generated. This is complementary to the analytical report prepared which provides responses to key policy questions, their implications and recommendations².

2. Health Accounts Conceptual Framework and Methodology

2.1. Conceptual Framework

HA is an internationally recognized methodology used to track expenditures in a health system for a specified period of time. It follows the flow of funding for health from its origins to end use, answering questions such as: how are health care goods and services financed? Who provided the health care goods and services consumed by the population? What goods and services are financed? By breaking down health spending by different classifications, HA provide insight into issues such as whether resources are being allocated to national priorities and health spending is sufficient relative to need; the sustainability of health financing and the extent to which there is financial risk protection for households. HA is designed to be used as a policy tool to facilitate health sector performance management and to assess how well resources are targeted to health system goals and priority areas. It provides a sound evidence base for decision making and is a useful tool in informing health financing reforms.

HA is based on the System of Health Accounts (SHA) framework, which has been developed and revised by key international stakeholders over the past two decades. First published in 2000 by OECD, EUROSTAT, and WHO, the framework was updated in 2011 (OECD et al. 2011). The SHA 2011 methodology (producing “HA”) improves upon the earlier version by strengthening the classifications to

² Government of Barbados. December 2014. Barbados 2012-13 Health Accounts

support production of a more comprehensive picture of health expenditure flows. SHA 2011 is now the international standard for national-level health accounts estimations.

The SHA 2011 methodology was used to complete Barbados' first full health accounts estimation. In order to enrich results related to HIV spending, the HA team also conducted HIV specific data collection on non-health HIV spending and out-of-pocket (OOP) spending by people living with HIV (PLHIV).

2.1.1. Boundary definitions

Boundaries defining HA estimation based on SHA 2011, which articulate expenditure included and excluded, are presented below.

Health boundary: The boundary of “health” in the HA is “functional” in that it refers to activities whose primary purpose is disease prevention, health promotion, treatment, rehabilitation, and long-term care. This boundary includes services provided directly to individual persons and collective health care services covering traditional tasks of public health. Examples of personal health care services include facility-based care (curative, rehabilitative, and preventive treatments involving day time or overnight visits to health care facilities); ancillary services to health care such as laboratory tests and imaging services; and medical goods dispensed to patients. Examples of collective health care services include health promotion and disease prevention campaigns as well as government and insurance health administration that target large populations. Services that fall outside of the functional definition of health are not counted.

Health care related and capital formation spending is tracked separately in SHA 2011. Health care related activities are intended to improve the health status of the population, but their *primary purpose* lies elsewhere. Examples of health care related activities include food, hygiene, and drinking water control and the social component of long term care for the elderly or care for People Living with HIV (PLHIV). Capital formation of health care providers covers investment lasting more than a year such as infrastructure or machinery investment as well as education and training of health personnel, research and development in health. Capital formation contrasts with “current health expenditure” which is completely consumed within the annual period of analysis.

HIV Boundary: HA according to SHA 2011 methodology focuses on the HIV spending whose primary purpose is prevention, health promotion, treatment, rehabilitation, and long term care. This boundary of HIV spending does not include spending on other activities comprising the HIV response such as care for orphans and vulnerable children (e.g. education, community support and institutional care), enabling environment programs (e.g. advocacy, human rights programs, and programs focused on women and gender-based violence), and social protection and social services (e.g. monetary benefits, social services, and income-generation projects). Spending data on non-health HIV services are provided in the 2012-13 HA report³.

Time Boundary: The HA time boundary specifies that each analysis covers a one-year period and includes the value of the goods and services that were consumed during that period. HA includes expenditure according to accrual accounting, by which expenditures are classified within the year they create economic value rather than when the cash was received.

³ Ibid.

Space Boundary: HA “focuses on the consumption of health care goods and services of the resident population irrespective of where this takes place” (OECD et al. 2011). This means that goods and services consumed by residents (citizens and non-citizens) are included while non-residents in Barbados (e.g. tourists) are excluded.

Exports/ imports: The inclusion of exports and imports for health care goods and services follow the functional definition of health. All health care goods and services imported in order to serve residents of Barbados are included in the Health Accounts. In these cases, imports are included whether they relate to either the provider of service or the financier. For example, spending by a Barbados resident travelling overseas to seek care is included (import of a provider); a non-Barbados insurance company reimbursing a Barbados provider for services to a Barbados resident is equally included. Since exports relate to spending incurred by non-residents, they are excluded from the Health Accounts.

2.1.2. Definitions of the Classifications

The HA exercise involves analyzing data on health expenditure according to a set of classifications, defined below. For additional details on the SHA 2011, please refer to the SHA 2011 Brief⁴ or the SHA 2011 manual⁵.

Financing schemes (HF): the main funding mechanisms by which people obtain health services, answering the question “how are health resources managed and organized?” Financing schemes categorizes spending according to criteria such as: mode of participation in the scheme (compulsory vs. voluntary), the basis for entitlements (contributory vs. non-contributory), the method for fund-raising (taxes/ compulsory pre-payments vs. voluntary payments) and the extent of risk pooling. Examples include: government programs; voluntary private insurance; and direct (i.e. out-of-pocket (OOP)) payments by households for goods and services.

Revenue of financing schemes (FS): the types of transactions through which funding schemes mobilize their income. Examples include: transfers from the ministry of finance to governmental agencies, direct foreign financial transfers (e.g. external donors providing funds to NGOs); and voluntary prepayment from employers.

Financing agents (FA): the institutional units that manage one or more health financing schemes. Examples include: Ministry of Health, commercial insurance companies, NGOs and international organizations.

Health care providers (HP): organizations and health professionals who provide medical goods and services as their main activity, as well as those for whom the provision of health care is only one activity among many others. Examples include: Hospitals, clinics, health centers, pharmacies.

Health care functions (HC): the goods and services consumed by health end-users. Examples include: Curative care, information, education, and counseling programs, medical goods such as supplies and pharmaceuticals, and governance and health system administration.

Factors of Provision (FP): the inputs to the production of health care goods and services by health care providers. Examples include: compensation of employees, health care goods and services (e.g.

⁴ Cogswell, Heather, Catherine Connor, Tesfaye Dereje, Avril Kaplan, and Sharon Nakhimovsky. September 2013. *System of Health Accounts 2011 What is SHA 2011 and How Are SHA 2011 Data Produced and Used?*. Bethesda, MD: Health Finance & Governance project, Abt Associates Inc.
⁵ OECD, European Union, and the World Health Organization. 2011. *A System of Health Accounts*. OECD Publishing

pharmaceuticals, syringes, or lab tests used up as part of a curative or preventive contact with the health system) and non-health care goods and services (e.g. electricity and training).

Beneficiary Characteristics: the groups that consume, or benefit from, the health care goods and services. Several classifications can group beneficiaries, including disease, gender and age classifications.

2.1.3. Health Accounts Aggregates and Indicators

There are two key aggregates that are generated by Health Accounts and that are used for comparisons across countries.

Total Current Health Expenditure (CHE): Total current expenditure on health quantifies the economic resources spent on health functions and represents final consumption on health goods and services by residents of the country within the year of estimation. A related indicator is CHE-HIV, which includes all current spending on HIV specifically.

Gross capital formation: Gross capital formation on health is measured as the total value of assets that providers have acquired during the estimation year (less the value of sales of similar assets) and that are used for longer than one year in the provision of health services.

Additional indicators that are usually generated by countries for policy and planning purposes include:

Total Health Expenditure (THE):⁶ The sum of current health spending and gross capital formation.

National Health Expenditure (NHE):⁷ The sum of current health spending, health care related spending, and gross capital formation.

Government spending on health as percentage of general government expenditure: health expenditure financed by government agencies as a percentage of total government expenditure. The estimate of general government expenditure for 2012-13 came from the 2013-14 Government Estimates of Revenue and Expenditure⁸.

Total current health expenditure as percentage of gross domestic product (GDP): CHE as a percentage of GDP. The estimate of GDP for 2012-13 is sourced from the World Bank's DataBank⁹.

Total Current Health Expenditure per capita (CHE per capita): CHE divided by the population. The estimation of population for 2012-13 is sourced from the World Bank's DataBank¹⁰.

⁶ This aggregate is comparable to NHA and SHA 1.0 estimations.

⁷ This aggregate is not an internationally standardized indicator as part of the SHA 2011 methodology, but can have relevance for national level policy making in Barbados.

⁸ <http://www.barbadosparliament.com/uploads/estimates/44a64e31bf71ca9b9a02346b2b1fa3a6.pdf>. Accessed November 2014.

⁹ <http://databank.worldbank.org/data/home.aspx>. Accessed November 2014.

¹⁰ Ibid.

2.2. Data Sources

2.2.1. Institutional data

The HA team conducted primary and secondary data collection from the institutions listed below. For the former, the HA team provided each institution with a HA survey instrument covering health spending and, when appropriate, non-health HIV expenditure. The Health Accounts team also conducted general household and PLHIV spending surveys, which are discussed in Sections 2.2.2 and 2.2.3.

- **Donors.** (both bilateral and multilateral donors) A list of all donors involved in the health sector was compiled through consultation with the MOH and other key stakeholders and a survey was sent to each of them. Three donors were identified; one completed the HA survey and data for one other was obtained via the Ministry of Health.
- **Nongovernmental organizations (NGOs)** A complete list of NGOs involved in the health sector was compiled through consultation with the MOH and other key stakeholders. Seventeen NGOs were identified and all were sent a survey; nine responded to the questionnaire.
- **Employers.** Using the Chamber of Commerce's Business Directory, a complete list of formal sector employers was developed. A total of 209 employers were identified and a sample of 72 was surveyed. In order to obtain the sample frame, employers were stratified into four groups based on size: large (500+ employees), medium (201-500 employees), small (51-200 employees), micro (50 employees or less). Due to the small number of medium and large employers, all were included in the sample. 75% of small and 10% of micro employers were randomly sampled and included in the list. In total, 36 employers responded to the questionnaire.
- **Private insurance companies:** A list of insurance companies providing medical coverage through health, motor and other insurance policies was compiled through consultation with the MOH and other key stakeholders. All 14 insurance companies identified were sent a survey and data was received from 7. Of those companies which responded, four incurred health expenditures through their health insurance policies and three through car insurance.

Secondary data collection comprised of information on health spending as well as service utilization and unit cost data. Service utilization and unit cost data were used in order to calculate allocation keys (see below for more detail), which seek to break down spending aggregates to the level of detail required by the SHA 2011 framework.

- **Spending data**
 - Barbados Drug Service. Barbados pharmaceutical sales by individual drug, broken down by pharmacy. April 2012 – March 2013.
 - Government Appropriation Accounts for 2012-13. This included
 - MOH spending broken down by inputs (e.g., staff costs, utilities, rent, etc.) for each of the departments: Direction & Policy Formulation Services, Primary Healthcare, Hospital Services, Care of the Disabled, Pharmaceutical Program (BDS), Care of the Elderly, HIV/AIDS Prevention & Control Unit and Environmental Health Services.

- Spending for the HIV Prevention and Control Program by all other ministries.
 - Barbados National Insurance medical spending for the period 2012-2013 (these expenses were not disaggregated by type of provider or type of service)
 - Defense Force. Medical expenses for the period 2012-2013.
- **Utilization Data**
 - Queen Elizabeth Hospital 2012-13: Inpatient utilization (e.g., number of bed-days by service); outpatient utilization (number of visits by service); and accident and emergency utilization by diagnosis.
 - Utilization data by diagnosis at the eight polyclinics.
 - Inpatient and outpatient utilization by type of clinic for 2012-13 at Bayview Hospital.
- **Unit Cost Data**
 - Stephen Musau, Josef Tayag and Abigail Vogus. May 2013. *Saint Lucia: Health Service Delivery Costing and Other Economic Analyses*. Bethesda, MD: Health Systems 20/20 Caribbean project, Abt Associates Inc: estimates of unit costs for inpatient and outpatient care were used as a proxy for inpatient and outpatient unit costs for QEHL
 - WHO CHOICE database was consulted to triangulate allocation keys between inpatient and outpatient care at hospitals. World Health Organization. http://www.who.int/choice/country/country_specific/en/. Accessed September 2014.
- **Other Secondary Sources**
 - MOH's HIV/AIDS Program provided the number of people living with HIV (PLHIV) as at March 2013, the number of PLHIV on anti-retroviral (ARV) treatment in the public and private sectors, and the total number of HIV tests conducted at polyclinics.

2.2.2. Health Expenditure Survey of Households

Data collected in the general household survey informs the estimates of household out-of-pocket spending in Barbados. The household survey covered a range of topics, including whether the respondent was sick or injured in the last four weeks and whether s/he received outpatient care in the last four weeks. Similar questions were asked about inpatient admissions occurring in the six months preceding the interview. If outpatient or inpatient care was paid for, the respondent was asked to answer additional questions that cover diagnosis, choice of provider, the amount of out of pocket spending and the type of service paid for. In order to calculate spending for 2012-13, the survey data was adjusted for the population growth and the consumer price index for medical goods between 2012 and 2014.

Field supervisors and interview teams were recruited and trained during a workshop held in Barbados in November 2014. The survey instrument was pre-tested in order to ensure quality and logical flow of questioning.

From the period of November 11th to December 5th, 2014, a total of 1,429 households were surveyed via a representative population sample survey. 972 households completed the survey and there were 317 non-responses resulting in a 68% completion rate. The HA team worked in collaboration with Barbados Statistical Services during the planning phase in order to avoid duplication of interviews with the ongoing Labour Force Survey. Using the most recent census survey data, Barbados Statistics Service

supported the team to construct the sample frame¹¹. Sampling weights were used to account for any bias that may be related to unequal probabilities of selection, non-response and unequal coverage of population groups.

2.2.3. Health Expenditure Survey of People Living with HIV

In order to estimate OOP spending on HIV, the HA team conducted a health expenditure survey of people living with HIV (PLHIV). The data collection instrument used in this health expenditure survey covered a range of issues including whether the PLHIV was sick or injured in the last four weeks and whether s/he received outpatient care in the last four weeks. Similar questions were asked about inpatient admissions occurring in the six months preceding the interview. In order to reduce some of the bias caused by the location of the interview, PLHIV were asked about their last visit other than that at LRU. If outpatient or inpatient care was paid for, the respondent was asked to answer additional questions that cover diagnosis, choice of provider, the amount of out of pocket spending and the type of service paid for. In order to calculate spending for 2012-13, the survey data was adjusted for the population growth and the consumer price index for medical goods between 2012 and 2014.

The PLHIV survey was implemented by the MOH and the University of the West Indies, HEU, Centre for Health Economics (UWI-HEU), in conjunction with the Barbados Statistical Service. Field supervisors and interviewers were recruited and trained in November 2014. The PLHIV survey was pre-tested and data collection took place over a three week period from November 17th to December 5th, 2014. A purposive sample of the PLHIV population was chosen from patients visiting the Ladymeade Reference Unit (LRU), based on recommendations of local health officials. The sample size was 135 out of an estimated population of 1,595 PLHIVs.

2.3. Data Analysis

2.3.1. Weighting

Weights are used in the HA to inflate the survey responses to account for entities that were either not surveyed or did not return a survey. In the absence of a 100% response rate, weighting expenditure gathered through institutional surveys can minimize underestimation of health expenditure.

In this exercise, all employers were first categorized by the sector of operation, using the Barbados Business Directory as a reference. Within each sector, health spending by organizations was weighted based on the number of full time employees in each company. This method of weighting is in line with SHA 2011 recommendations and has been used by many countries conducting HAs: it assumes that, within a particular sector, health spending of organizations is proportional to their number of employees. This weighting allowed for the estimation of health spending from employers who did not respond to the survey.

For insurance spending, an average spending amount was calculated per health insurance policy holder. Average spending was multiplied by the number of policy holders in Barbados who were not part of the

¹¹ Survey sample selection involved a two-step process. First, all districts in Barbados were listed with their corresponding number of households. This process ensured that the sample selected was representative of the entire population. The second step involved the selection of households within districts to be sampled, using a systematic random selection process.

insurance surveys received. The latter figure was calculated from the total number of policy holders in Barbados (sourced from the household survey) subtracted by the number of policy holders covered by HA surveys received from 4 health insurance companies.

The HA team however did not apply any weights to NGO. Given the variability in NGO spending and the limited knowledge about health and HIV related NGOs in Barbados, the HA team decided to err on the side of underestimating NGO spending rather than introduce baseless assumptions about the spending of the eight NGOs which did not respond.

2.3.2. Double counting

HA analysis includes careful compilation from all data sources, and identification and management of instances when two data sources cover the same spending. For example, spending on donor-funded health and HIV programs administered by NGOs were reported both in donor surveys as well as NGO surveys. In these cases, the HA team selected the spending as reported by NGOs, as they were closer to the actual consumption of health care services than donors. Since they are closer to the spending, they are therefore likely to have more precise information about real spending, not planned spending or disbursements.

Similarly, double-counting exists at the employer and insurance level since employers reporting spending for health insurance is equally reported as revenue used by insurance companies to pay claims. As with the previous example, the data of the organization closest to the spending, in this case the insurance companies, took precedence and employer spending on health insurance was excluded.

While donor and employer data were excluded, this does not preclude the importance of collecting their spending information as a useful source of triangulation.

2.3.3. Estimation and application of allocation splits

In some cases, health and HIV spending as reported in secondary sources or in surveys required additional breakdowns in order to allocate spending to classifications of the SHA framework. Part of the HA therefore involved estimating “allocation keys” to break down spending for the provider, functional and disease classifications. This section lists the allocations keys developed for this HA along with the data sources and assumptions made for each one.

TABLE I. FUNCTIONAL ALLOCATION KEYS

Allocation Key	Methodological Approach and Assumptions
Inpatient vs. outpatient care at QEH	<p>This split was used to disaggregate total QEH spending by inpatient and outpatient care. Expenditures on accident and emergencies were included as part of outpatient care.</p> <p>Data used: 2012-13 patient days from inpatient wards and number of visits in outpatient clinics (from QEH Medical Records).</p> <p>Approach: Inpatient days combines the number of admissions with the average length of</p>

Allocation Key	Methodological Approach and Assumptions
	<p>stay. The average length of stay is a reflection of the intensity of resource use. In the absence of unit cost data, the number of bed days has shown to be a good proxy of health expenditure. For outpatient visits, the total number of visits was utilized. This also allowed for inpatient and outpatient visits to be represented in comparable units. The proportion of spending for inpatient care was calculated using the formula below. Spending for outpatient care was calculated in a similar way.</p> <div style="background-color: #e0e0e0; padding: 10px; margin: 10px 0;"> $\text{Inpatient Expenditure} = \frac{(\#IP \text{ bed days})}{(\#IP \text{ bed days}) + \#OP \text{ visits}}$ </div> <p>Assumptions: In the absence of unit cost data, this method assumes that</p> <ul style="list-style-type: none"> • average unit costs of OP visits, regardless of diagnosis, have, on average, equal average unit cost (not including pharmaceuticals); • IP bed days, regardless of diagnosis, have, on average, equal average unit costs (not including pharmaceuticals).
<p>Polyclinics split by function</p>	<p>This split was used to disaggregate prevention spending from curative care spending at the polyclinics.</p> <p>Data & Approach: 2012-13 Appropriation Accounts for polyclinics provided information on the number of health nurses employed at each polyclinic, the total expenditure for health nurse salaries, and the total polyclinic budget. Following interviews with key experts from the polyclinics and the MOH, it was suggested that health nurses in the Family and Child Health unit of the polyclinics spend the majority of their time on health prevention and promotion: therefore, all human-resources related spending in the Family and Child Health unit of the polyclinics were allocated to the “prevention” category. The remainder of the total polyclinic budget (i.e. the General Practice) was classified as HC.1.3.1- general outpatient curative care.</p> <p>Since family planning (FP) has a specific prevention code, the spending allocated to FP was calculated on the assumption of each visit lasting one hour. Salary-related costs associated with FP were allocated to HC 6.nec –other prevention. The remainder of prevention spending in the Family and Child Health unit was allocated equally between HC.6.1 (Information, education, and counselling programs) and HC.6.3 (early disease detection programs).</p> <p>Assumptions: All health nurses in the Family and Child Health unit spend 100 percent time of prevention and promotion work. Excluding family planning consultations, we assumed that a health nurse’s time is divided equally among HC.6.1 (Information, education, and counselling programs) and HC.6.3 (early disease detection programs).</p>
<p>Inpatient vs. outpatient care at Bayview Hospital</p>	<p>This split was used to disaggregate inpatient from outpatient spending when the amount of money going to Bayview was known, but how it was spent was unknown.</p> <p>Data used: 2012-13 number of hospital admissions, total number of outpatient visits and average length of stay (from QEH data).</p>

Allocation Key	Methodological Approach and Assumptions
	<p>Approach: The team converted all IP data into “hospitalization bed days” by multiplying the number of inpatient admissions by the average length of stay of those admissions from QEH (average length of stay was calculated by dividing the number of discharge days by the number of admissions at QEH). The average length of stay is a reflection of the intensity of resource use. In the absence of unit cost data, the number of bed days has shown to be a good proxy of health expenditure. This conversion allowed for inpatient and outpatient visits to be represented in comparable units. The proportion of spending for inpatient care was calculated using the formula below. Spending for outpatient care was calculated in a similar way.</p> <p>Assumptions: In the absence of unit cost data, this method assumes that</p> $Inpatient\ Expenditure = \frac{(\#IP\ bed\ days)}{(\#IP\ bed\ days) + \#OP\ visits}$ <ul style="list-style-type: none"> • average unit costs of OP visits, regardless of diagnosis, have, on average, equal average unit cost (not including pharmaceuticals); • IP bed days, regardless of disease, have, on average, equal average unit costs (not including pharmaceuticals); • The average length of stay at Bayview hospital is similar to that of QEH.
Curative vs. prevention spending at Ladymeade Reference Unit (LRU)	<p>This split was used to disaggregate curative and prevention spending at LRU.</p> <p>Approach: LRU provides outpatient curative care services as well as prevention services including Voluntary Counselling and Testing and the distribution of condoms. In the absence of disaggregated data an equal split of spending between curative outpatient care and prevention care was assumed. Prevention spending was further broken down equally between HC.6.1- Information, education, and counselling programs and HC.6.3 – Early disease detection programs (which includes testing). For this purpose the provision of ARVs was considered under outpatient curative care services.</p>

TABLE 2. DISEASE ALLOCATION KEYS

Allocation Key	Methodological Approach and Assumptions
Inpatient care at QEH split by disease	<p>This split was used to disaggregate inpatient spending at QEH by disease area.</p> <p>Data used & approach: Discharge days by Service from QEH records. Where possible, a disease/ health condition category was allocated to each Service based on the primary purpose of that Service e.g. Radiotherapy service was assigned to DIS 4.1 – Neoplasms or Psychiatry service was assigned to DIS 4.4 – Mental disorders. The breakdown of IP spending by disease / health condition was calculated on the basis of bed days within each Service.</p>

Allocation Key	Methodological Approach and Assumptions
	<p>Assumptions: average unit costs of IP visits, regardless of diagnosis, have, on average, equal average unit cost (not including pharmaceuticals)</p> <p>For future exercises, discharge data would be more accurate for the disease classification as QEH categorizes bed days by ICD-10 classifications upon discharge.</p>
<p>Outpatient care at QEH split by disease</p>	<p>This split was used to disaggregate outpatient spending at QEH by disease area.</p> <p>Data used & approach: Number of visits by Clinic from QEH records. Where possible, each Clinic was assigned a Health Accounts disease / health condition category, based on the primary purpose of that Clinic e.g. Obstetrics was assigned to DIS 2.1 – Maternal Conditions or Gynecology was assigned to DIS 2.nec – Other reproductive Health Conditions. However, in some cases this was not possible e.g. Renal, Neurology, Rheumatology Clinics. The breakdown of OP spending by disease / health condition was calculated on the basis of number of visits within each Clinic.</p> <p>Assumptions: average unit costs of OP visits, regardless of diagnosis, have, on average, equal average unit cost (not including pharmaceuticals)</p>
<p>Polyclinic spending split by disease</p>	<p>This split was used to disaggregate curative care at the Barbados polyclinics by disease / health condition.</p> <p>Data used & approach: Number of visits by symptom from polyclinic records. Where possible, a disease/ health condition category was allocated to each symptom. However, it is challenging to assign diseases to symptoms and in many cases this was not possible given the lack of diagnosis data. The breakdown of OP spending by disease / health condition was calculated on the basis of number of visits by symptom.</p> <p>To determine spending for HIV activities, VCT visits at the polyclinics were used. It was assumed that an average HIV VCT visit lasts 30 minutes. The total number of VCT visits per polyclinic was collected from the polyclinic utilization data. This provided us with the total time worked by health nurses on VCT visits. Assuming a health nurse has 22 working days in a month we were able to calculate the proportion of salary spending for HIV prevention activities. This approach excludes laboratory costs and test kits, which have been included in the non-HIV spending at polyclinics due to lack of disaggregated data.</p> <p>Assumptions: average unit costs of OP visits, regardless of diagnosis, have, on average, equal average unit cost (not including pharmaceuticals received)</p>

Allocation Key	Methodological Approach and Assumptions
Government pharmaceutical program (BDS)	<p>This split was used to disaggregate pharmaceutical spending by disease area.</p> <p>Data used and approach: The Barbados Drug Service provided a list of drug expenditures for the year 2012-13 broken down by public and private providers and by individual drug. Using medical experts, drugs were assigned to one of 19 possible disease classifications using the “main condition method” i.e. where possible, drug spending was assigned to the primary disease/ condition that the drug is used to treat. The ratio of spending was applied to total drug spending by BDS.</p> <p>For some drugs, it was not possible to assign a disease code; spending on these drugs were classified as “Non disease specific”.</p>
Inpatient and outpatient care at Bayview Hospital split by disease	<p>This split was used to disaggregate inpatient and outpatient spending at Bayview Hospital by disease area.</p> <p>Data used & approach:</p> <p>IP split by disease: Data on the 2012-13 IP admissions (from Bayview records) by clinic area were obtained. Expert opinion was used to classify the clinic areas by disease categories, to the extent possible. A ratio of IP admissions per disease category versus total IP admissions for the year was used to split expenditures by disease.</p> <p>OP split by disease: Data on the 2012-13 OP visits (from Bayview records) by clinic area were obtained. Expert opinion was used to classify the clinic areas by disease categories, to the extent possible. A ratio of OP visits per disease category versus total OP visits for the year was used to split expenditures by disease.</p> <p>Assumptions: The IP and OP allocation keys for disease at QEH was considered for Bayview but was rejected since QEH treats a wider range of diseases than Bayview hospital. The approach above assumes that OP visits and IP admissions across all diagnoses have, on average, equal average unit cost.</p>

In addition to the allocation splits provided above, a split was also used to disaggregate insurance spending by provider. In its survey, one insurance company specified the providers to which it paid medical expenses. In cases where other insurance companies did not specify the providers through which they incurred health spending, the provider breakdown from the complete survey was used. This approach assumes that insurance companies use similar providers in similar proportions.

2.4. Use of HA Production Tool

Throughout the HA process, the technical team utilized the HA Production Tool (HAPT), a software developed by WHO. The HAPT is a tool that facilitates the planning and production of Health Accounts. It automates several previously time-consuming procedures e.g. repeat mapping, and incorporates automatic quality checks. Its advantage also lies in providing a repository for HA data and HA tables

which can be easily accessed by team members years after the production of Health Accounts. In addition, allocation keys and mapping decisions from previous years can be used to facilitate data analysis in subsequent years.

A list of all institutions to be surveyed was entered into the HAPT. All data collected was imported into the HAPT and was mapped to the SHA 2011's key classifications. The team utilized the Data Validation module in the Tool to verify the final data and check for any errors, before automatically generating the HA tables.

3. Limitations

A significant challenge encountered by the Health Accounts team is the lack of disaggregated government data e.g. by type of activity or disease/ health condition. Government data is largely tracked through inputs and not by outputs or results. This led to several consequences. Spending for prevention activities was not complete at the polyclinic level. Given information provided by interviews with several health experts, all spending in the Family and Child Health clinics of the polyclinics were considered health prevention work. It is acknowledged that much prevention work also takes place at the General Practice of the polyclinics. However, due to lack of detailed data, it was not possible to break down spending at General Practice between prevention and curative care.

Response rate from NGOs was lower than expected which led to an underestimation of health spending. Several NGOs expressed not having the time or human resources to provide data in the format required and within the deadline set. A significant amount of NGO funding is sourced from corporate and individual donations; the contributions made by corporations and households to NGOs were not captured by the employer or household surveys and therefore could not be used as a proxy for NGO spending. However, absolute response rates do not give an indication as to the percentage of total health expenditure which has been captured. The majority of large NGOs operating in Barbados did respond to the survey and therefore most of NGO spending has been captured. Many NGOs conduct important work in health prevention and promotion. Again, this spending was underestimated at the NGO level due to response rates.

Breakdown of health spending by disease was only possible for 48% of health spending (excluding general management costs). Lack of data led the HA team to estimate “distribution keys” which were used to break down spending by disease and by type of activity. These distribution keys were calculated using SHA 2011 recommendations and were triangulated with other sources, such as WHO CHOICE, wherever possible. Details of the distribution keys used can be found in the Statistical Report¹².

The Health Accounts provide the first ever breakdown of out-of-pocket spending by households on health. The data collected by the Health Accounts team enables the government to understand where households are spending out-of-pocket and for what types of services. However, due to time constraints and the ongoing Labor Force Survey, the sample size and the response rate of the general household survey was not as large as anticipated. Confidence intervals for the health expenditure estimates are provided in the table below. Working with the Barbados Statistical Service, the Health Accounts team did however ensure that the household survey was nationally representative.

	Health Accounts estimation (BBD)	90% confidence interval (BBD) - minimum	90% confidence interval (BBD) - maximum
Total outpatient spending (excluding medications)	195,911,224	120,288,323	279,419,751
Total inpatient spending (excluding medications)	23, 547,709	1,246,456	29,159,512

Please note that a 90% confidence interval would be considered ambitious for a survey of this sample size.

¹² Ibid.

The sample for HIV survey is similarly low. Despite the low sample sizes, we believe that the approach used for recruiting interviewees and the structure of the survey instrument minimized any significant bias associated with conducting the survey at the LRU. According to the MOH's HIV/AIDS Program, the vast majority of the PLHIV population receives care at LRU. Those consulting private health providers also utilize LRU for their ARVs. In addition, the survey instrument was designed to capture spending during the respondent's last two visits with the aim of capturing any visits at providers other than LRU. Therefore, the sole potential bias introduced by the above approach is that PLHIV who have never utilized LRU would have been excluded from the survey. We were informed by the HIV/AIDS Program that this is extremely unlikely.

4. General Health Accounts Statistical Tables

The statistical tables provided in this section summarize the HA data through a series of two dimensional tables. Each table cross-tabulates spending for two HA classifications. Unless otherwise specified, these tables summarize recurring health spending only.

4.1. Financing scheme (HF) x Revenues of health care financing schemes (FS)

Revenues of health care financing schemes		FS.1		FS.2		FS.3		FS.5		FS.6		FS.7		All FS									
		FS.1.1	FS.1.3	FS.1.4	FS.3.2	FS.5.1	FS.5.2	FS.6.1	FS.6.2	FS.6.3	FS.7.1	FS.7.2											
Barbados Dollars (BBD), Million		Internal transfers and grants		Transfers distributed by government from foreign origin		Social insurance contributions		Voluntary prepayment		Other domestic revenues		Direct foreign transfers											
Transfers from government domestic revenue (allocated to health purposes)		Subsidies		Other transfers from government domestic		Social insurance contributions from employers		Voluntary prepayment from individuals/households		Other domestic revenues n.e.c.		Direct foreign financial transfers											
												FS.7.1.1											
												FS.7.2											
												FS.7.2.1											
												FS.7.2.1.2											
												FS.7.2.1.3											
Financing schemes																							
HF.1	Government schemes and compulsory contributory health care financing schemes	390.47	389.14	1.34	1.86	0.48	0.48			0.08				392.90									
	HF.1.1 Government schemes	390.47	389.14	1.34	1.86					0.08				392.42									
	HF.1.2 Compulsory contributory health insurance schemes					0.48	0.48							0.48									
HF.2	Voluntary health care payment schemes	5.87	5.25	0.61				37.21	3.18	34.04	3.50	1.38	2.12	0.80	0.76	0.76	0.05	0.05	0.01	0.03	47.38		
	HF.2.1 Voluntary health insurance schemes	5.25	5.25					37.21	3.18	34.04											42.47		
	HF.2.1.1 Primary/substitutory health insurance schemes	5.25	5.25					37.21	3.18	34.04											42.47		
	HF.2.1.1.1 Employer-based insurance (other than enterprises schemes)	5.25	5.25					34.87	0.84	34.04											40.13		
	HF.2.1.1.3 Other primary coverage schemes							2.34	2.34												2.34		
	HF.2.2 NPISH financing schemes (including development agencies)	0.61		0.61							2.12		2.12	0.80	0.76	0.76	0.05	0.05	0.01	0.03	3.53		
	HF.2.3 Enterprise financing schemes									1.38		1.38									1.38		
HF.3	Household out-of-pocket payment										276.87	276.87									276.87		
	HF.3.1 Out-of-pocket excluding cost-sharing										276.87	276.87									276.87		
All HF		396.34	389.14	5.25	1.95	1.86	0.48	0.48	37.21	3.18	34.04	280.45	276.87	1.38	2.20	0.80	0.76	0.76	0.05	0.05	0.01	0.03	717.14

4.2. Financing scheme (HF) x Institutional Units providing revenues to financing schemes (FS RI)

Revenues of health care financing schemes			Memorandum items						
			FS.RI.1	FS.RI.1.1	FS.RI.1.2	FS.RI.1.3	FS.RI.1.4	FS.RI.1.5	
Barbados Dollars (BBD), Million			Revenues by institutional units	Institutional units providing revenues to financing schemes	Government	Corporations	Households	NPISH	Rest of the world
Financing schemes									
HF.1	Government schemes and compulsory contributory health care financing schemes		392.90	390.47	0.48			0.08	1.86
	HF.1.1	Government schemes	392.42	390.47				0.08	1.86
	HF.1.2	Compulsory contributory health insurance schemes	0.48		0.48				
HF.2	Voluntary health care payment schemes		47.38	5.87	35.42	3.18	2.12	0.80	
	HF.2.1	Voluntary health insurance schemes	42.47	5.25	34.04	3.18			
	HF.2.1.1	Primary/substitutory health insurance schemes	42.47	5.25	34.04	3.18			
	HF.2.1.1.1	Employer-based insurance (other than enterprises schemes)	40.13	5.25	34.04	0.84			
	HF.2.1.1.3	Other primary coverage schemes	2.34			2.34			
	HF.2.2	NPISH financing schemes (including development agencies)	3.53	0.61				2.12	0.80
	HF.2.3	Enterprise financing schemes	1.38		1.38				
HF.3	Household out-of-pocket payment		276.87			276.87			
	HF.3.1	Out-of-pocket excluding cost-sharing	276.87			276.87			
All HF			717.14	396.34	35.89	280.04	2.20	2.67	

4.3. Institutional Units providing revenues to financing schemes (FS RI) x Financing agent (FA)

Institutional units providing revenues to financing schemes	Financing agents (used for HF.RI.1) <i>Barbados Dollars (BBD), Million</i>	FA.1	FA.1.1				FA.1.3	FA.2	FA.3	FA.4	FA.5	All FA
		General government	Central government	FA.1.1.1	FA.1.1.2	FA.1.3.1	Insurance corporations	Corporations (other than insurance corporations) (part of HF.RI.1.2)	Non-profit institutions serving households (NPISH)	Households		
FS.RI.1.1	Government	177.88	177.88	176.81	1.07		5.25		213.20			396.34
FS.RI.1.2	Corporations	0.48				0.48	0.48	34.15	1.27			35.89
FS.RI.1.3	Households							3.18			276.87	280.04
FS.RI.1.4	NPISH									2.20		2.20
FS.RI.1.5	Rest of the world	1.86	1.86	1.86						0.80		2.67
All FS RI		180.22	179.74	178.67	1.07	0.48	0.48	42.58	1.27	216.21	276.87	717.14

4.4. Institutional Units providing revenues to financing schemes (FS RI) x Function (HC)

Institutional units providing revenues to financing schemes	Health care functions <i>Barbados Dollars (BBD), Million</i>	HC.1		HC.2	HC.3	HC.4	HC.4			HC.5	HC.5		HC.6	HC.6						HC.7	All HC
		Curative care	HC.1.1 Inpatient curative care	HC.1.3 Outpatient curative care	Rehabilitative care	Long-term care (health)	Ancillary services (non-specified by function)	HC.4.1 Laboratory services	HC.4.3 Patient transportation	HC.4.nec Other ancillary services (n.e.c.)	Medical goods (non-specified by function)	HC.5.1 Pharmaceuticals and other medical non-durable goods	HC.5.2 Therapeutic appliances and other medical goods	Preventive care	HC.6.1 Information, education and counseling programmes	HC.6.3 Early disease detection programmes	HC.6.4 Healthy condition monitoring programmes	HC.6.5 Epidemiological surveillance and risk and disease control programmes	HC.6.nec Other preventive care (n.e.c.)	Governance, and health system and financing administration	
FS.RI.1.1	Government	267.08	138.48	128.60	2.10	74.48	0.35	0.06	0.29	13.76	13.70	0.06	16.28	7.54	4.21		4.53	0.01	22.30	396.34	
FS.RI.1.2	Corporations	31.83	12.46	19.38	0.29		1.45		1.45	0.91	0.91		1.41	0.09	0.05	1.27				35.89	
FS.RI.1.3	Households	218.97	29.74	189.23	0.02		0.09		0.09	60.96	60.96		0.01	0.00	0.00					280.04	
FS.RI.1.4	NPISH	0.15	0.08	0.07	1.70	0.05	0.04		0.04	0.04	0.03	0.01	0.24	0.22	0.02					2.20	
FS.RI.1.5	Rest of the world	0.68	0.20	0.48									1.83	0.58	0.59		0.20	0.46	0.16	2.67	
	All FS RI	518.71	180.96	337.75	4.11	74.53	1.92	0.06	0.04	1.83	75.66	75.59	0.07	19.76	8.43	4.87	1.27	4.73	0.47	22.46	717.14

4.5. Health care provider (HP) x Financing scheme (HF)

Financing schemes	HF.1		HF.2	HF.2.1			HF.2.2	HF.2.3	HF.3	All HF		
	Government schemes and compulsory contributory health care financing schemes	Government schemes		Compulsory contributory health insurance schemes	Voluntary health care payment schemes	Voluntary health insurance schemes	Primary/substitutory health insurance schemes	Employer-based insurance (other than enterprises schemes)			Other primary coverage schemes	NPISH financing schemes (including development agencies)
<i>Barbados Dollars (BBD), Million</i>												
Health care providers												
HP.1 Hospitals	275.15	275.06	0.09	8.45	8.40	8.40	7.94	0.46		0.05	77.48	360.68
HP.1.1 General hospitals	240.52	240.43	0.09	8.45	8.40	8.40	7.94	0.46		0.05	77.48	326.06
HP.1.1.1 General Public Hospital	240.44	240.43	0.01	2.84	2.84	2.84	2.69	0.15		0.00	19.63	262.91
HP.1.1.1.1 Private Wing (QEH)	0.01		0.01	2.84	2.84	2.84	2.69	0.15		0.00	17.38	20.23
HP.1.1.1.nec Other General Public Hospital (QEH)	240.43	240.43									2.25	242.68
HP.1.1.2 Private Hospital	0.08		0.08	5.62	5.56	5.56	5.26	0.31		0.05	57.04	62.73
HP.1.1.n Other General hospitals											0.02	0.02
HP.1.2 Mental health hospitals	34.63	34.63										34.63
HP.2 Residential long-term care facilities	19.88	19.88		2.26					2.26			22.14
HP.3 Providers of ambulatory health care	52.71	52.37	0.34	23.44	23.22	23.22	21.91	1.31	0.15	0.06	154.10	230.24
HP.3.1 Medical practices	0.45	0.16	0.29	22.19	22.13	22.13	20.89	1.24		0.06	153.87	176.51
HP.3.2 Dental practice	0.05		0.05	1.09	1.09	1.09	1.02	0.07		0.00		1.15
HP.3.4 Ambulatory health care centres	52.21	52.21		0.10					0.10		0.23	52.54
HP.3.4.6 Polyclinics	42.27	42.27		0.00					0.00		0.23	42.50
HP.3.4.7 Ladymeade Reference Unit	7.61	7.61										7.61
HP.3.4.9 All other ambulatory centres	2.33	2.33		0.10					0.10			2.43
HP.3.5 Providers of home health care services				0.05					0.05			0.05
HP.4 Providers of ancillary services	0.06	0.06		1.87	1.83	1.83	1.74	0.09	0.04			1.92
HP.5 Retailers and other providers of medical goods	13.61	13.59	0.01	1.19	1.16	1.16	1.08	0.07	0.04	0.00	45.07	59.87
HP.5.1 Pharmacies	13.55	13.53	0.01	1.19	1.16	1.16	1.08	0.07	0.03	0.00	45.07	59.80
HP.5.2 Retail sellers and other suppliers of durable	0.06	0.06		0.01					0.01			0.07
HP.6 Providers of preventive care	0.87	0.87		2.44	0.13	0.13	0.12	0.01	1.03	1.26		3.30
HP.7 Providers of health care system administration and	30.59	30.59										30.59
HP.9 Rest of the world	0.04		0.04	7.74	7.73	7.73	7.32	0.40	0.01	0.00	0.62	8.40
All HP	392.90	392.42	0.48	47.39	42.47	42.47	40.13	2.34	3.53	1.38	276.87	717.14

4.6. Health care function (HC) x Financing Scheme (HF)

Financing schemes			HF.1		HF.2		HF.2.1			HF.2.2		HF.2.3		HF.3		All HF
			Government schemes and compulsory contributory health care financing schemes	Government schemes	Compulsory contributory health insurance schemes	Voluntary health care payment schemes	Voluntary health insurance schemes	Primary/substitutory health insurance schemes	Employer-based insurance (other than enterprises schemes)	Other primary coverage schemes	NPISH financing schemes (including development agencies)	Enterprise financing schemes	Household out-of-pocket payment	Out-of-pocket excluding cost-sharing		
Barbados Dollars (BBD), Million																
Health care functions																
HC.1	Curative care		263.59	263.12	0.46	39.11	38.98	38.98	36.83	2.15	0.06	0.07	216.01	216.01	518.71	
	HC.1.1	Inpatient curative care	136.78	136.66	0.12	15.46	15.46	15.46	14.64	0.82		0.00	28.72	28.72	180.96	
	HC.1.3	Outpatient curative care	126.81	126.46	0.35	23.65	23.52	23.52	22.19	1.33	0.06	0.07	187.29	187.29	337.75	
HC.2	Rehabilitative care		1.43	1.43	2.68	0.37	0.37	0.35	0.02	2.31					4.11	
HC.3	Long-term care (health)		74.48	74.48	0.05					0.05					74.53	
HC.4	Ancillary services (non-specified by function)		0.06	0.06	1.87	1.83	1.83	1.74	0.09	0.04					1.92	
HC.5	Medical goods (non-specified by function)		13.61	13.59	0.01	1.19	1.16	1.16	1.08	0.07	0.04	0.00	60.86	60.86	75.66	
	HC.5.1	Pharmaceuticals and other medical non-durable goods	13.55	13.53	0.01	1.19	1.16	1.16	1.08	0.07	0.03	0.00	60.86	60.86	75.59	
	HC.5.2	Therapeutic appliances and other medical goods	0.06	0.06	0.01						0.01				0.07	
HC.6	Preventive care		17.29	17.29	2.48	0.13	0.13	0.12	0.01	1.04	1.31				19.76	
	HC.6.1	Information, education and counseling programmes	7.86	7.86	0.57	0.07	0.07	0.06	0.00	0.47	0.04				8.43	
	HC.6.3	Early disease detection programmes	4.53	4.53	0.34	0.07	0.07	0.06	0.00	0.27					4.87	
	HC.6.4	Healthy condition monitoring programmes			1.27						1.27				1.27	
	HC.6.5	Epidemiological surveillance and risk and disease control programmes	4.73	4.73											4.73	
	HC.6.5.nec	Other epidemiological surveillance and risk and disease control programmes	4.73	4.73											4.73	
	HC.6.nec	Other preventive care (n.e.c.)	0.17	0.17	0.30					0.30					0.47	
HC.7	Governance, and health system and		22.46	22.46											22.46	
All HC			392.90	392.42	0.48	47.38	42.47	42.47	40.13	2.34	3.53	1.38	276.87	276.87	717.14	

4.7. Health care function (HC) x Health care provider (HP)

Health care providers	HP.1	HP.1.1						HP.1.2	HP.2	HP.3	HP.3.1									HP.3.2	HP.3.4	HP.3.5	HP.4	HP.5	HP.6	HP.7	HP.9	All HP
		General hospitals	General Public Hospital	Private Wing (QEH)	Other, General Public Hospital (QEH)	Private Hospital	Other, General hospitals				Mental health hospitals	Residential long-term care facilities	Providers of ambulatory health care	Medical practices	Offices of general medical practitioners	Offices of mental medical specialists	Dental practice	Ambulatory health care centres	Polyclinics									
Health care functions	Hospitals	General hospitals	General Public Hospital	Private Wing (QEH)	Other, General Public Hospital (QEH)	Private Hospital	Other, General hospitals	Mental health hospitals	Residential long-term care facilities	Providers of ambulatory health care	Medical practices	Offices of general medical practitioners	Offices of mental medical specialists	Dental practice	Ambulatory health care centres	Polyclinics	Lady Meade Reference Unit	All other ambulatory centres	Providers of home health care services	Providers of ancillary services	Retailers and other providers of medical goods	Providers of preventive care	Providers of health care system administration and financing	Rest of the world	All HP			
HC.1 Curative care	290.46	290.46	239.39	19.11	220.28	51.06				219.99	176.12	175.48	0.64	1.15	42.73	35.31	6.47	0.96						8.26	518.71			
HC.1.1 Inpatient curative care	173.10	173.10	155.69	19.11	136.57	17.42				0.09					0.09	0.09								7.77	180.96			
HC.1.3 Outpatient curative care	117.35	117.35	83.71		83.71	33.65				219.91	176.12	175.48	0.64	1.15	42.64	35.22	6.47	0.96						0.49	337.75			
HC.2 Rehabilitative care								2.26		1.84	0.37	0.37			1.48		1.48								4.11			
HC.2.1 Inpatient rehabilitative care								2.26																	2.26			
HC.2.3 Outpatient rehabilitative care									1.84	0.37	0.37				1.48		1.48								1.84			
HC.3 Long-term care (health)	54.60	19.97	19.97		19.97		34.63	19.88		0.05									0.05						74.53			
HC.4 Ancillary services (non-specified by function)																				1.92					1.92			
HC.5 Medical goods (non-specified by function)	15.42	15.42	3.76	1.51	2.25	11.64	0.02			0.23					0.23	0.23				59.87				0.14	75.66			
HC.5.1 Pharmaceuticals and other medical non-durable goods	15.42	15.42	3.76	1.51	2.25	11.64	0.02			0.23					0.23	0.23				59.80				0.14	75.59			
HC.5.2 Therapeutic appliances and other medical goods																				0.07					0.07			
HC.6 Preventive care	0.20	0.20	0.18		0.18	0.02		0.00	8.13	0.02	0.02				8.10	6.96	1.14							3.30	8.13	19.76		
HC.6.1 Information, education and counseling programmes	0.07	0.07	0.07		0.07			0.00	3.88						3.88	3.45	0.43							1.00	3.47	8.43		
HC.6.3 Early disease detection programmes	0.07	0.07	0.07		0.07				3.88						3.88	3.45	0.43							0.77	0.14	4.87		
HC.6.4 Healthy condition monitoring programmes	0.02	0.02				0.02			0.02	0.02														1.23	1.27			
HC.6.5 Epidemiological surveillance and risk and disease control programmes									0.20						0.20		0.20								4.53	4.73		
HC.6 Other epidemiological surveillance and risk and disease control programmes (n.e.c.)									0.20						0.20		0.20								4.53	4.73		
HC.6.nec Other preventive care (n.e.c.)	0.03	0.03	0.03		0.03				0.14						0.14	0.06	0.08							0.30	0.47			
HC.7 Governance, and health system and financing administration																									22.46	22.46		
All HC	360.68	326.06	263.30	20.62	242.68	62.73	0.02	34.63	22.14	230.24	176.51	175.87	0.64	1.15	52.54	42.50	7.61	2.43	0.05	1.92	59.87	3.30	30.59	8.40	717.14			

4.8. Financing scheme (HF) x Financing agent (FA)

Financing agents (used for HF.RI.1)		FA.1	FA.1.1				FA.2	FA.3	FA.4	FA.5	All FA
			Central government	Ministry of Health	Other ministries and public units (belonging to central government)	Social security agency					
Barbados Dollars (BBD), Million		General government					Insurance corporations	Corporations (other than insurance corporations) (part of HF.RI.1.2)	Non-profit institutions serving households (NPISH)	Households	
Financing schemes											
HF.1	Government schemes and compulsory contributory health care financing schemes	180.22	179.74	178.67	1.07	0.48			212.68		392.90
	HF.1.1 Government schemes	179.74	179.74	178.67	1.07				212.68		392.42
	HF.1.2 Compulsory contributory health	0.48				0.48					0.48
HF.2	Voluntary health care payment schemes						42.58	1.27	3.55		47.39
	HF.2.1 Voluntary health insurance schemes						42.47				42.47
	HF.2.1.1 Primary/substitutory health						42.47				42.47
	HF.2.1.1.1 Employer-based insurance (other than enterprises schemes)						40.13				40.13
	HF.2.1.1.3 Other primary coverage schemes						2.34				2.34
	HF.2.2 NPISH financing schemes (including								3.53		3.53
	HF.2.3 Enterprise financing schemes						0.11	1.27			1.38
HF.3	Household out-of-pocket payment									276.87	276.87
All HF		180.22	179.74	178.67	1.07	0.48	42.58	1.27	216.21	276.87	717.14

4.9. Health care function (HC) x Classification of diseases / conditions (DIS)

Classification of diseases / conditions	DIS.1	DIS.1.1 DIS.1.3 DIS.1.4 DIS.1.5 DIS.1.6 DIS.1.7 DIS.1.nec							DIS.2	DIS.3	DIS.4	DIS.4.1 DIS.4.2 DIS.4.3 DIS.4.4 DIS.4.5 DIS.4.6 DIS.4.8 DIS.4.9													DIS.5	DIS.6	DIS.nec	All DIS		
		Infectious and parasitic diseases	HIV/AIDS	Malaria	Respiratory infections	Diarrheal diseases	Neglected tropical diseases	Vaccine preventable diseases				Other infectious and parasitic diseases (n.e.c.)	Reproductive health	Nutritional deficiencies	Noncommunicable diseases	Neoplasms	Other Neoplasms	Endocrine disorders	Cardiovascular diseases	Mental disorders	Diabetes Mellitus	Hypertension	Asthma	Other noncommunicable diseases (n.e.c.)					Injuries	Non-disease specific
Health care functions																														
HC.1 Curative care	21.44	12.12	0.00	3.26	0.69	0.32	0.02	5.02	54.69	0.29	170.06	74.66	74.66	0.30	16.71	7.12	18.04	9.70	9.65	33.88	13.52	119.76	138.95	518.71						
HC.1.1 Inpatient curative care	4.31	3.29		0.64	0.07	0.06		0.24	36.70	0.05	19.00	5.86	5.86		5.62	2.76	1.34	0.83	0.14	2.43	0.21	88.17	32.53	180.96						
HC.1.3 Outpatient curative care	17.13	8.83	0.00	2.62	0.63	0.25	0.02	4.77	18.00	0.24	151.07	68.80	68.80	0.30	11.09	4.36	16.70	8.87	9.50	31.45	13.31	31.59	106.42	337.75						
HC.2 Rehabilitative care									1.43		2.31	0.05	0.05		2.26						0.37			4.11						
HC.3 Long-term care (health)											34.68	0.05	0.05		34.63							39.85		74.53						
HC.4 Ancillary services (non-specified by function)											0.04	0.04	0.04									1.89		1.92						
HC.5 Medical goods (non-specified by function)	2.12	0.45		1.17	0.24		0.01	0.26	0.08	0.02	30.67	15.54	15.54	0.28	1.54	0.75	5.90	3.01	3.14	0.51	1.61	4.35	36.79	75.66						
HC.5.1 Pharmaceuticals and other medical non-durable goods	2.12	0.45		1.17	0.24		0.01	0.26	0.08	0.02	30.66	15.53	15.53	0.28	1.54	0.75	5.90	3.01	3.14	0.51	1.61	4.29	36.79	75.59						
HC.5.2 Therapeutic appliances and other medical goods											0.01	0.01	0.01									0.06		0.07						
HC.6 Preventive care	9.21	4.68						4.53	0.05	1.14	0.37	0.05	0.05		0.12	0.03		0.01	0.15		8.99		19.76							
HC.6.1 Information, education and counseling programmes	3.20	3.20								0.57	0.28	0.03	0.03		0.12	0.03		0.01	0.09			4.38		8.43						
HC.6.3 Early disease detection programmes	0.87	0.87								0.57	0.08	0.01	0.01				0.01		0.07			3.34		4.87						
HC.6.4 Healthy condition monitoring programmes																						1.27		1.27						
HC.6.5 Epidemiological surveillance and risk and disease control programmes	4.73	0.20						4.53																4.73						
HC.6.5.nec Other epidemiological surveillance and risk and disease control programmes	4.73	0.20						4.53																4.73						
HC.6.nec Other preventive care (n.e.c.)	0.42	0.42							0.05															0.47						
HC.7 Governance, and health system and financing administration	3.80	3.80								1.34										1.34		17.32		22.46						
All HC	36.57	21.05	0.00	4.43	0.94	0.32	0.03	9.80	56.25	1.46	239.46	90.38	90.38	0.58	18.25	44.88	23.97	12.71	12.80	35.88	15.50	192.16	175.74	717.14						

4.10. Gross fixed capital formation (HK) x Institutional unit providing revenues to financing scheme (FS RI)

Institutional units providing revenues to financing			FS.RI.1.1	FS.RI.1.4	All FS.RI
<i>Barbados Dollars (BBD), Million</i>			Government	NPISH	
Gross fixed capital formation					
HK.1	Gross capital formation		15.25	0.04	15.29
HK.1.1	Gross fixed capital formation		15.16	0.04	15.20
	HK.1.1.1	Infrastructure	12.13	0.01	12.14
		HK.1.1.1.1 Residential and non-residential buildings	12.13	0.01	12.14
	HK.1.1.2	Machinery and equipment	2.66	0.03	2.68
		HK.1.1.2.1 Medical equipment	0.07		0.07
		HK.1.1.2.2 Transport equipment	0.66		0.66
		HK.1.1.2.4 Machinery and equipment n.e.c.	1.93	0.03	1.96
	HK.1.1.3	Intellectual property products	0.38	0.00	0.38
		HK.1.1.3.1 Computer software and databases	0.38		0.38
		HK.1.1.3.2 Intellectual property products n.e.c.	0.00	0.00	0.00
	HK.1.nec	Other gross capital formation (n.e.c.)	0.09		0.09
HK.2	Non-produced non-financial assets		0.07	0.19	0.25
	HK.2.1	Land	0.07	0.19	0.25
All HK			15.32	0.22	15.55

4.11. Gross fixed capital formation (HK) x Health care provider (HP)

<i>Barbados Dollars (BBD), Million</i>		Hospitals	Residential long-term care facilities	Providers of ambulatory health care	Providers of health care system administration and financing	
Gross fixed capital formation						
HK.1	Gross capital formation	1.52	0.21	0.45	13.11	15.29
HK.1.1	Gross fixed capital formation	1.52	0.21	0.36	13.11	15.20
HK.1.1.1	Infrastructure	1.00	0.11	0.24	10.79	12.14
	HK.1.1.1.1 Residential and non-residential buildings	1.00	0.11	0.24	10.79	12.14
HK.1.1.2	Machinery and equipment	0.52	0.10	0.12	1.94	2.68
	HK.1.1.2.1 Medical equipment			0.07		0.07
	HK.1.1.2.2 Transport equipment	0.28	0.07	0.05	0.26	0.66
	HK.1.1.2.4 Machinery and equipment n.e.c.	0.24	0.04		1.68	1.96
HK.1.1.3	Intellectual property products		0.00		0.38	0.38
	HK.1.1.3.1 Computer software and databases				0.38	0.38
	HK.1.1.3.2 Intellectual property products n.e.c.		0.00			0.00
HK.1.nec	Other gross capital formation (n.e.c.)			0.09		0.09
HK.2	Non-produced non-financial assets		0.25			0.25
HK.2.1	Land		0.25			0.25
All HK		1.52	0.47	0.45	13.11	15.55

5. HIV Statistical Tables

5.1. Revenues of health care financing schemes (FS) x Financing scheme (HF)

Financing schemes		HF.1		HF.2			HF.3		All HF
		Government schemes and compulsory contributory health care financing schemes	HF.1.1 Government schemes	HF.1.2 Compulsory contributory health insurance schemes	Voluntary health care payment schemes	HF.2.1 Voluntary health insurance schemes	HF.2.2 NPISH financing schemes (including development agencies)	HF.2.3 Enterprise financing schemes	
Barbados Dollars (BBD), Million									
Revenues of health care financing schemes									
FS.1	Transfers from government domestic revenue (allocated to health purposes)	18.33	18.33	0.01	0.01				18.34
	FS.1.1 Internal transfers and grants	18.33	18.33						18.33
	FS.1.3 Subsidies			0.01	0.01				0.01
FS.2	Transfers distributed by government from foreign origin	1.86	1.86						1.86
FS.3	Social insurance contributions	0.00	0.00						0.00
FS.5	Voluntary prepayment			0.04	0.04				0.04
	FS.5.1 Voluntary prepayment from individuals/households			0.00	0.00				0.00
	FS.5.2 Voluntary prepayment from employers			0.04	0.04				0.04
FS.6	Other domestic revenues n.e.c.			0.00		0.00	0.06	0.06	0.06
	FS.6.1 Other revenues from households n.e.c.						0.06	0.06	0.06
	FS.6.2 Other revenues from corporations n.e.c.			0.00		0.00			0.00
FS.7	Direct foreign transfers			0.76	0.76				0.76
All FS		20.19	20.19 0.00	0.80	0.05 0.76	0.00	0.06	0.06	21.05

5.2. Institutional Units providing revenues to financing schemes (F S RI) x Financing scheme (HF)

Financing schemes		HF.1	HF.1.1	HF.1.2	HF.2	HF.2.1	HF.2.2	HF.2.3	HF.3	HF.3.1	All HF
Barbados Dollars (BBD), Million		Government schemes and compulsory contributory health care financing schemes	Government schemes	Compulsory contributory health insurance schemes	Voluntary health care payment schemes	Voluntary health insurance schemes	NPISH financing schemes (including development agencies)	Enterprise financing schemes	Household out-of-pocket payment	Out-of-pocket excluding cost-sharing	
Revenues of health care financing schemes											
Memorandum items											
Revenues by institutional units											
FS.RI.1	Institutional units providing revenues to financing schemes	20.19	20.19	0.00	0.80	0.05	0.76	0.00	0.06	0.06	21.05
	FS.RI.1.1 Government	18.33	18.33		0.01	0.01					18.34
	FS.RI.1.2 Corporations	0.00		0.00	0.04	0.04		0.00			0.04
	FS.RI.1.3 Households				0.00	0.00			0.06	0.06	0.06
	FS.RI.1.5 Rest of the world	1.86	1.86		0.76		0.76				2.62

5.3. Institutional Units providing revenues to financing schemes (FS RI) x Health care function (HC)

Institutional units providing revenues to financing schemes	Health care functions <i>Barbados Dollars (BBD), Million</i>	HC.1	HC.1		HC.5	HC.5.1	HC.6	HC.6.1	HC.6.3	HC.6.5	HC.6.nec		HC.7	All HC
		Curative care	Inpatient curative care	Outpatient curative care	Medical goods (non-specified by function)	Pharmaceuticals and other medical non-durable goods	Preventive care	Information, education and counseling programmes	Early disease detection programmes	Epidemiological surveillance and risk and disease control programmes	Other epidemiological surveillance and risk and disease control programmes (n.e.c.)	Other preventive care (n.e.c.)	Governance, and health system and financing administration	
FS.RI.1.1	Government	11.41	3.05	8.35	0.39	0.39	2.90	2.62	0.28			0.00	3.64	18.34
FS.RI.1.2	Corporations	0.04	0.04											0.04
FS.RI.1.3	Households	0.00	0.00		0.06	0.06								0.06
FS.RI.1.5	Rest of the world	0.68	0.20	0.48			1.78	0.58	0.59	0.20	0.20	0.42	0.16	2.62
All FS.RI		12.12	3.29	8.83	0.45	0.45	4.68	3.20	0.87	0.20	0.20	0.42	3.80	21.05

5.4. Financing scheme (HF) x Health care provider (HP)

Health care providers	HP.1	HP.1.1				HP.3	HP.3.4				HP.5	HP.6	HP.7	HP.9	All HP
	Hospitals	General hospitals	General Public Hospital	Private Wing (QEH)	Other General Public Hospital (QEH)	Providers of ambulatory health care	Ambulatory health care centres	Polyclinics	Ladymeade Reference Unit	All other ambulatory centres	Retailers and other providers of medical goods	Providers of preventive care	Providers of health care system administration and financing	Rest of the world	
Financing schemes															
<i>Barbados Dollars (BBD), Million</i>															
HF.1 Government schemes and compulsory contributory health care financing schemes	4.78	4.78	4.78	0.00	4.78	8.89	8.89	1.25	7.61	0.03	0.39		6.14	0.00	20.19
HF.1.1 Government schemes	4.78	4.78	4.78		4.78	8.89	8.89	1.25	7.61	0.03	0.39		6.14		20.19
HF.1.2 Compulsory contributory health insurance schemes	0.00	0.00	0.00	0.00										0.00	0.00
HF.2 Voluntary health care payment schemes	0.05	0.05	0.05	0.05								0.76		0.00	0.80
HF.2.1 Voluntary health insurance schemes	0.05	0.05	0.05	0.05										0.00	0.05
HF.2.2 NPISH financing schemes (including development agencies)												0.76			0.76
HF.2.3 Enterprise financing schemes	0.00	0.00	0.00	0.00										0.00	0.00
HF.3 Household out-of-pocket payment											0.06				0.06
All HF	4.83	4.83	4.83	0.05	4.78	8.89	8.89	1.25	7.61	0.03	0.45	0.76	6.14	0.00	21.05

5.5. Health care function (HC) x Financing scheme (HF)

Health care functions	HC.1			HC.5	HC.5.1	HC.6	HC.6			HC.6.nec	HC.7	HC.7.1	All HC	
	Curative care	Inpatient curative care	Outpatient curative care				Information, education and counseling programmes	Early disease detection programmes	Epidemiological surveillance and risk and disease control programmes					Other epidemiological surveillance and risk and disease control programmes (n.e.c.)
<i>Barbados Dollars (BBD), Million</i>														
Financing schemes														
HF.1 Government schemes and compulsory	12.08	3.24	8.83	0.39	0.39	3.93	2.95	0.62	0.20	0.20	0.17	3.80	3.80	20.19
HF.1.1 Government schemes	12.08	3.24	8.83	0.39	0.39	3.93	2.95	0.62	0.20	0.20	0.17	3.80	3.80	20.19
HF.1.2 Compulsory contributory health insurance	0.00	0.00												0.00
HF.2 Voluntary health care payment schemes	0.05	0.05				0.76	0.25	0.26			0.25			0.80
HF.2.1 Voluntary health insurance schemes	0.05	0.05												0.05
HF.2.1.1 Primary/substitutory health	0.05	0.05												0.05
HF.2.1.1.1 Employer-based insurance (other than enterprises schemes)	0.05	0.05												0.05
HF.2.1.1.3 Other primary coverage schemes	0.00	0.00												0.00
HF.2.2 NPISH financing schemes (including						0.76	0.25	0.26			0.25			0.76
HF.2.3 Enterprise financing schemes	0.00	0.00												0.00
HF.3 Household out-of-pocket payment				0.06	0.06									0.06
All HF	12.12	3.29	8.83	0.45	0.45	4.68	3.20	0.87	0.20	0.20	0.42	3.80	3.80	21.05

5.6. Function (HC) x Health care provider (HP)

Health care functions		HC.1	HC.1.1	HC.1.3	HC.5	HC.5.1	HC.6	HC.6.1	HC.6.3	HC.6.5	HC.6.nec	HC.7	All HC
		Curative care	Inpatient curative care	Outpatient curative care	Medical goods (non-specified by function)	Pharmaceuticals and other medical non-durable goods	Preventive care	Information, education and counseling programmes	Early disease detection programmes	Epidemiological surveillance and risk and disease control programmes	Other epidemiological surveillance and risk and disease control programmes (n.e.c.)	Other preventive care (n.e.c.)	
<i>Barbados Dollars (BBD), Million</i>													
Health care providers													
HP.1	Hospitals	4.65	3.20	1.45			0.18	0.07	0.07		0.03		4.83
	HP.1.1	4.65	3.20	1.45			0.18	0.07	0.07		0.03		4.83
	HP.1.1.1	4.65	3.20	1.45			0.18	0.07	0.07		0.03		4.83
	HP.1.1.1.1	0.05	0.05										0.05
	HP.1.1.1.nec	4.60	3.16	1.45			0.18	0.07	0.07		0.03		4.78
	HP.1.1.1.nec												
HP.3	Providers of ambulatory health care	7.47	0.09	7.39			1.41	0.54	0.54	0.20	0.20	0.13	8.89
	HP.3.4	7.47	0.09	7.39			1.41	0.54	0.54	0.20	0.20	0.13	8.89
	HP.3.4.6	0.98	0.09	0.89			0.27	0.11	0.11		0.05		1.25
	HP.3.4.7	6.47		6.47			1.14	0.43	0.43	0.20	0.20	0.08	7.61
	HP.3.4.9	0.03		0.03									0.03
HP.5	Retailers and other providers of medical goods				0.45	0.45							0.45
HP.6	Providers of preventive care						0.76	0.25	0.26		0.25		0.76
HP.7	Providers of health care system administration and financing						2.34	2.34				3.80	6.14
HP.9	Rest of the world	0.00	0.00										0.00
All HP		12.12	3.29	8.83	0.45	0.45	4.68	3.20	0.87	0.20	0.20	0.42	21.05

Annex A: Recommended Workshop Participants

These representatives were invited to the launch and dissemination of the HA estimation. At the launch, these representatives participated in discussion about the key questions of the analysis as well as the scope and process. At the dissemination event, these representatives responded to the findings and discussed their policy implications. These stakeholders are recommended as minimum participants for the launch and dissemination of HA results.

- Ministry of Health: Permanent Secretary; Chief Medical Officer; Health Planning Unit; HIV/AIDS Program and other relevant staff as appropriate
- Barbados Statistical Services
- Ministry of Finance representatives
- Representatives from other ministries active in the HIV response and health programs
- Representatives of HIV/AIDS Commission
- Barbados National Insurance Scheme
- Representatives of Queen Elizabeth Hospital
- Representatives of Ladymeade Reference Unit (particularly staff involved in any PLHIV surveys)
- Representatives from other key facilities
- Barbados Association of Medical Practitioners, or other private provider representatives
- PAHO Country Program Specialist
- PEPFAR, UNAIDS, USAID, and other donor representatives
- Representative from the Financial Services Commission
- Representatives from the Insurance Association of the Caribbean and from private insurance companies on island
- Large non-governmental organizations active in health e.g. Diabetes Foundation, Cancer Society, Planned Parenthood, Red Cross
- Barbados Chamber of Commerce
- Representatives of several large employers that provide health care benefits to employees