Barbados 2016/17 Health Spending Estimation

Final Results

September 2018

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PROCESS AND METHODOLOGY

Process for estimating 2016/17 health spending

Planning (Apr 2018) → Data collection (Jun-Aug 2018) → Data analysis (Aug 2018) → Dissemination and report writing (Aug-Sep 2018)

Method of 2016/17 health spending estimation exercise[1]

- Quick, cost-effective way to estimate health spending in between full Health Accounts exercises
- Approx. 25 days of technical experts time, with collaboration of MHW staff
- Maximized use of secondary data
- Uses same framework as Health Accounts to allow comparisons

[1] See the following document for more details on the methodology and lessons learnt - Bhuwanee, Karishmah. 2018. *Barbados 2016/17 Health Spending Estimation: Methodology Note*. Rockville, MD: Health Finance & Governance Project, Abt Associates Inc.

Data sources

Type of data	Source of data
Government Appropriation Accounts	Ministry of Finance
Clarifications on government health spending	Barbados Drugs Service, MHW
Utilization data from health facilities	QEH, Polyclinics, Bayview, LRU
2016 Living Standards Survey (household spending)	Barbados Statistical Service
NGO, Employer, Insurance spending	2012/13 Health Accounts data
Donor health spending	PEPFAR (targeted “sampling”)

Data adjustments

- Insurance
  - Data from 2012/13, weighted for non-responses from health insurance companies
  - Adjusted for inflation since 2012/13
- Employers
  - Data from 2012/13, stratified by sector and weighted to population of employers
  - Adjusted for inflation since 2012/13
- NGOs
  - Adjusted for inflation since 2012/13
  - Excluded NGOs no longer working in health e.g. Caribbean HIV/AIDS Alliance

Key assumptions

- Insurance: assume same # of policy holders as in 2012/13 → slight underestimation
- Employers : assume same # of employees as in 2012/13 and same pattern of employers health benefits → slight underestimation
- NGOs : same spending pattern as in 2012/13
- Household: spending took place at the provider during their last visit and all reported spending is out-of-pocket

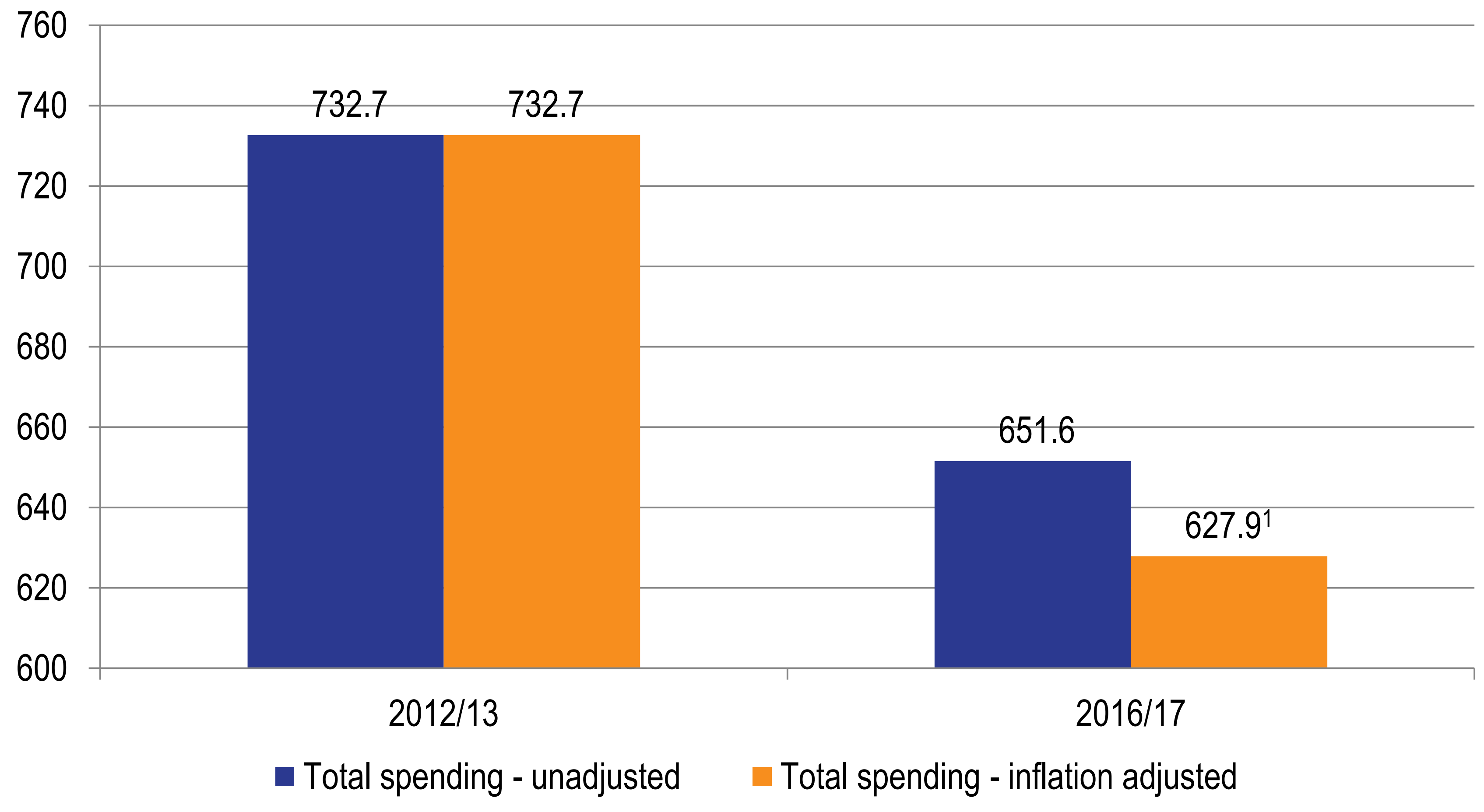
Factors affecting interpretation of 2016/17 results

- Source of data for household spending improved
  - Health-Accounts specific survey (2012/13) → Living Standards Survey (2016)
- Level of detail of utilization data changed (some less, some more detail) – affects breakdown of spending by
  - IP/OP/prevention
  - Disease/ health condition
- Response rate of NGOs from 2012/13 → possible underestimation of health spending
- Prevention spending underestimated at NGO and QEH

2016/17 HEALTH SPENDING RESULTS

Real health spending fell by 14% between 2012/13 and 2016/17…

- …driven by 21% fall in MHW spending



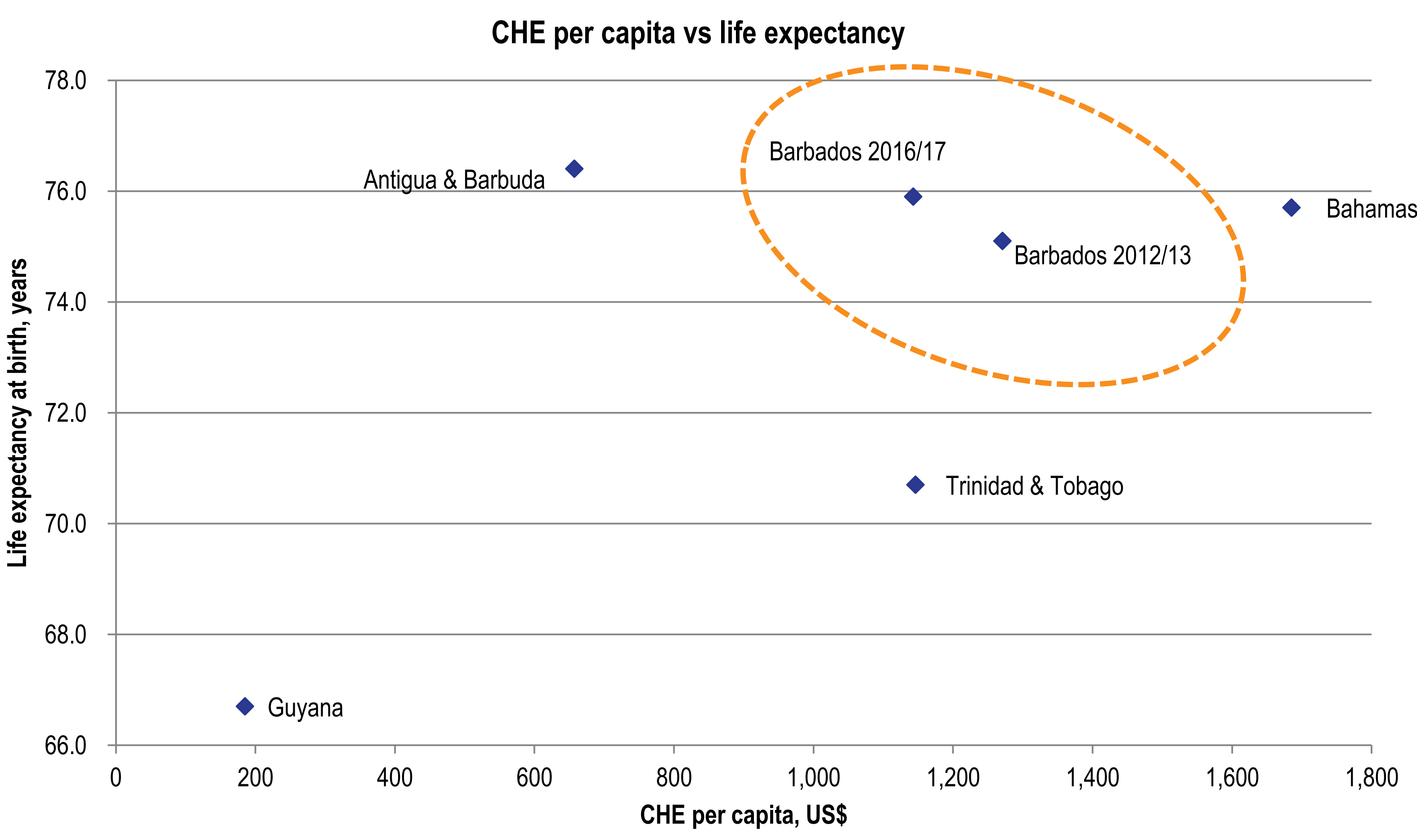
[1] Inflation adjustments using Barbados Annual Consumer Price Index, IMF International Financial Statistics

Results summary

Indicator	Barbados 2012/13	Barbados 2016/17	2016 OECD average[1]
CHE per capita in US$	1,271	1,116	3,882[2]
CHE as % GDP	8.5%	7.0%	9%
Govt health spending as % CHE	55%	51%	73%
Govt health spending as % total govnt spending	11%	8%	n/a
OOP spending as % CHE	39%	43%	27%

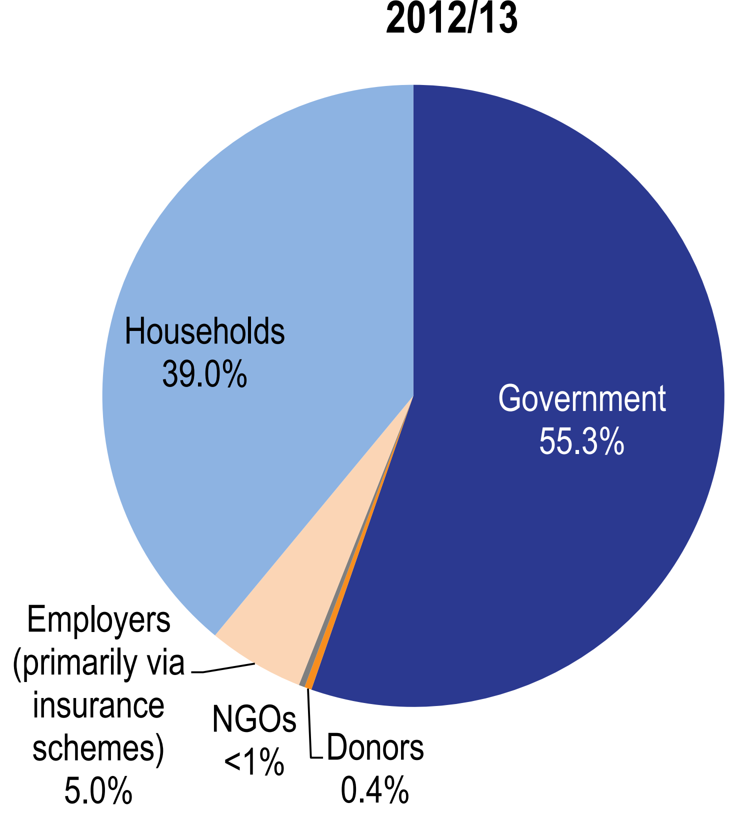
[1]OECD.Stats
[2] Per capita, current prices, current PPPs.

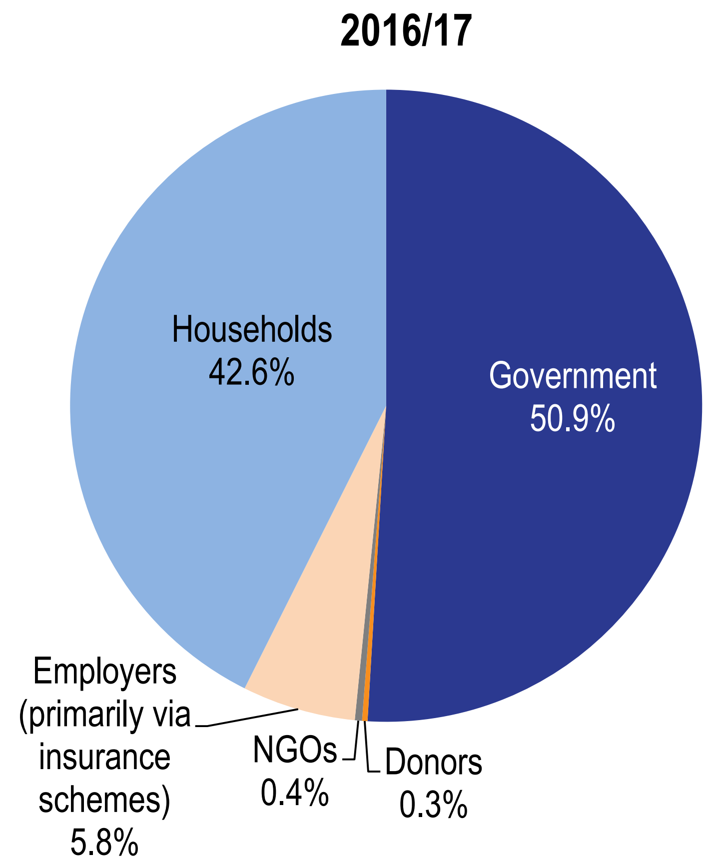
Country comparisons: CHE per capita (US$) vs. life expectancy



Who is financing health spending in Barbados?

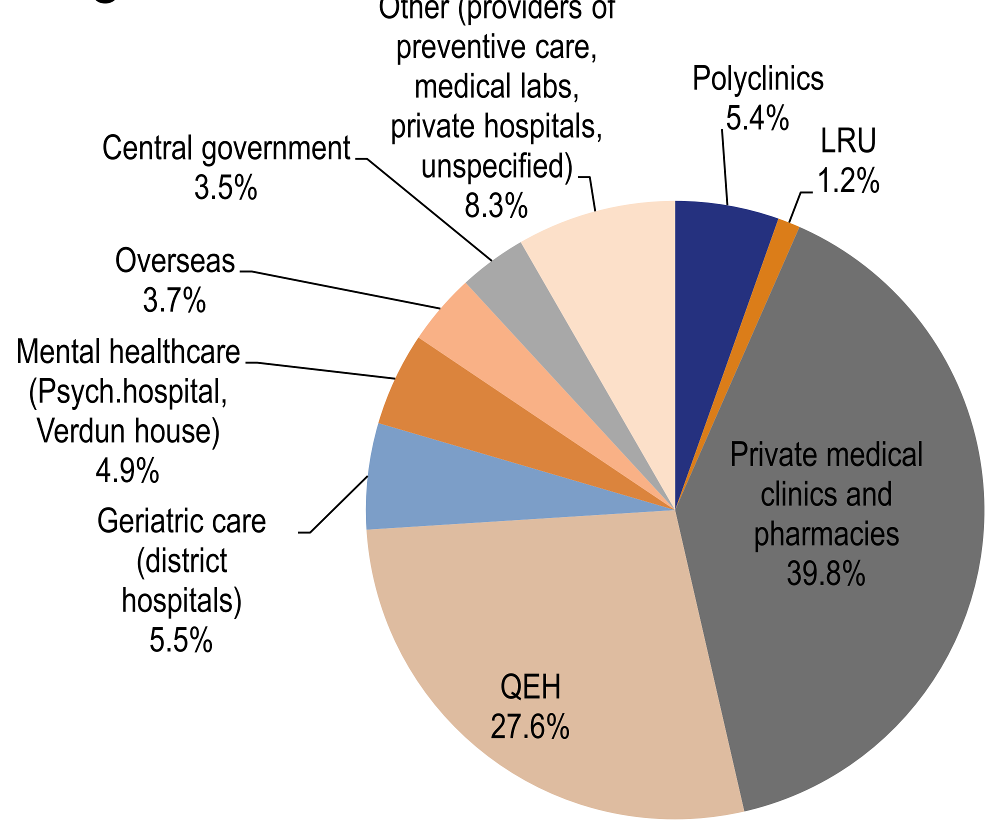
- Government and households are still the two biggest spenders for health





Which providers spend to provide health care goods and services?

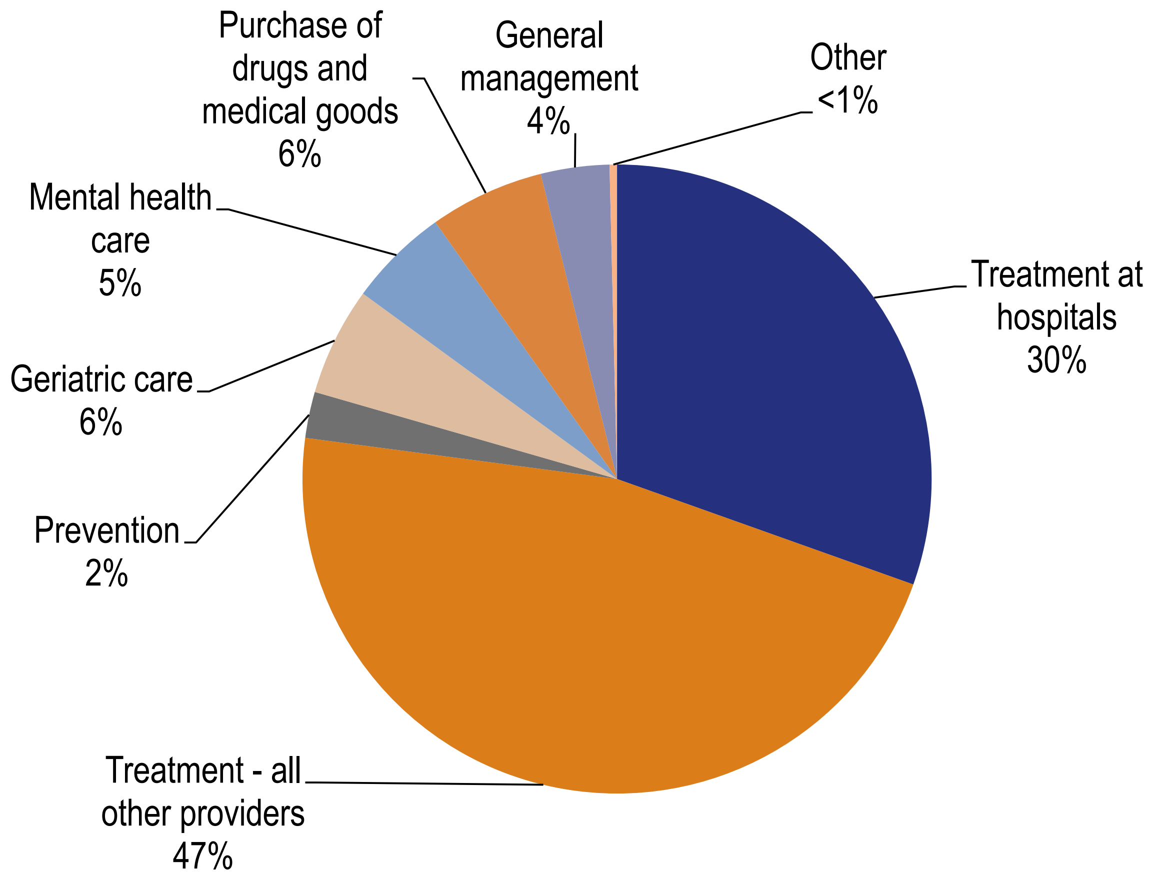
- Private medical clinics, paid for out-of-pocket, dominate health spending



** Household spending is based on household's last visit. Since private clinics often have their own pharmacy, these two categories were combined.*

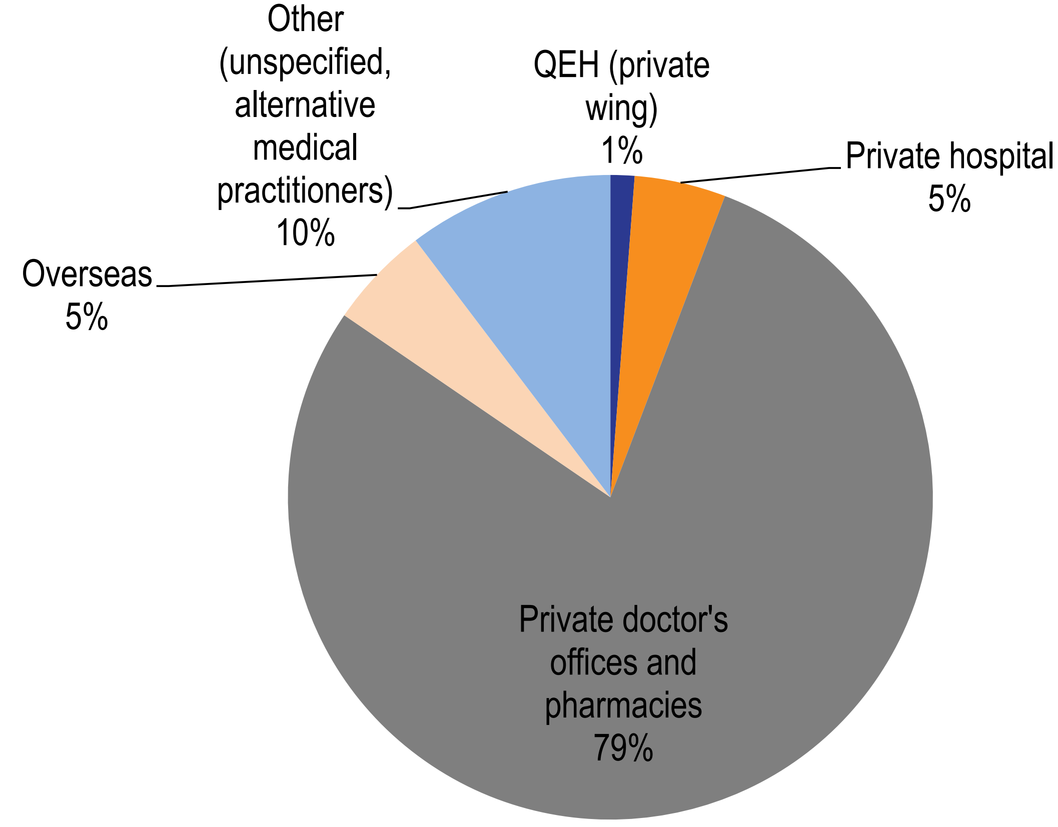
How is health spending allocated among treatment, prevention and other activities?

- Over 75% of health spending is on curative care



Where are households spending out-of-pocket?

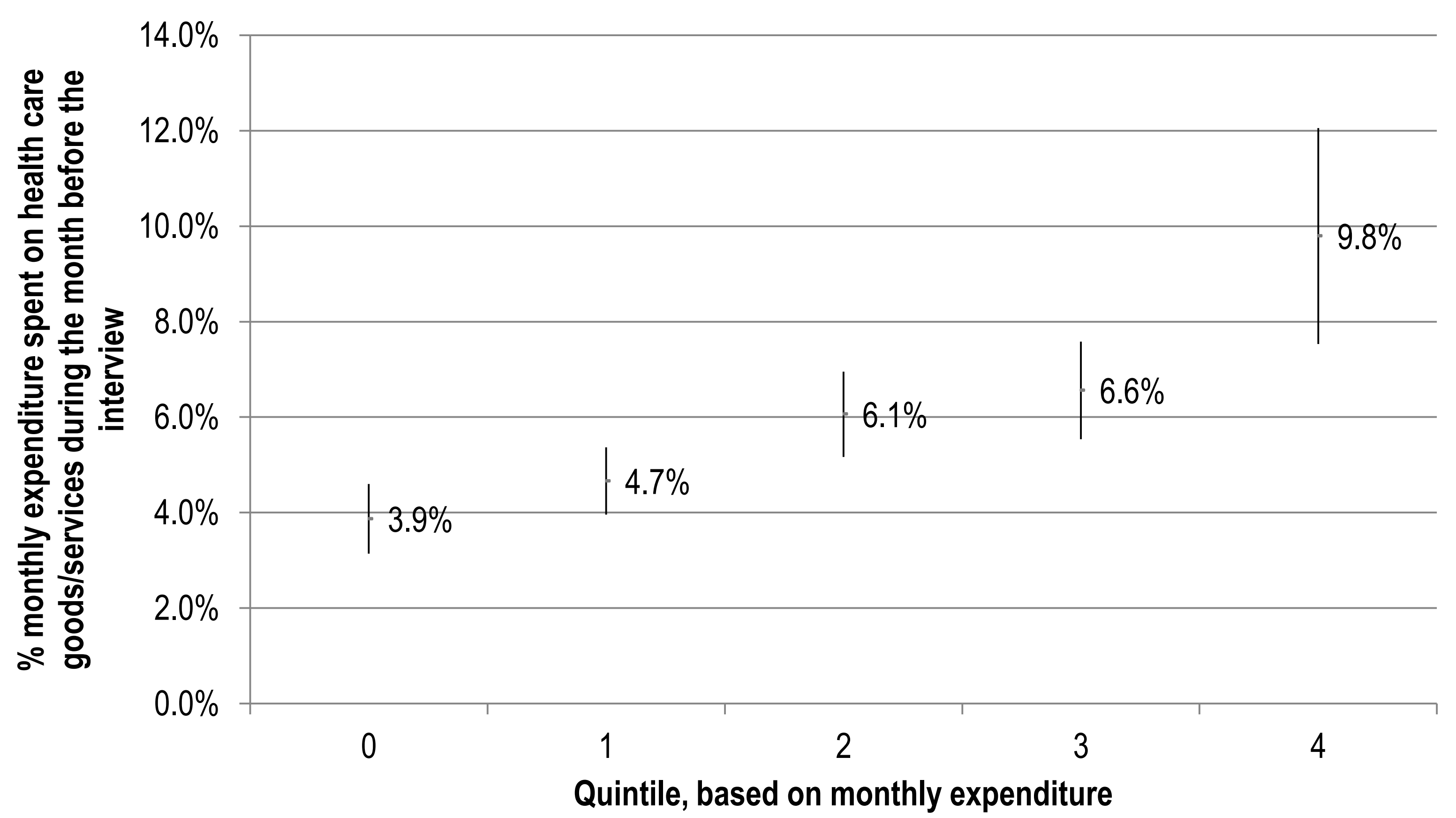
- Private doctor's offices are the main provider for households paying out-of-pocket



Household spending is based on household's last visit. Since private clinics are often tied to a pharmacy, these two categories were combined.

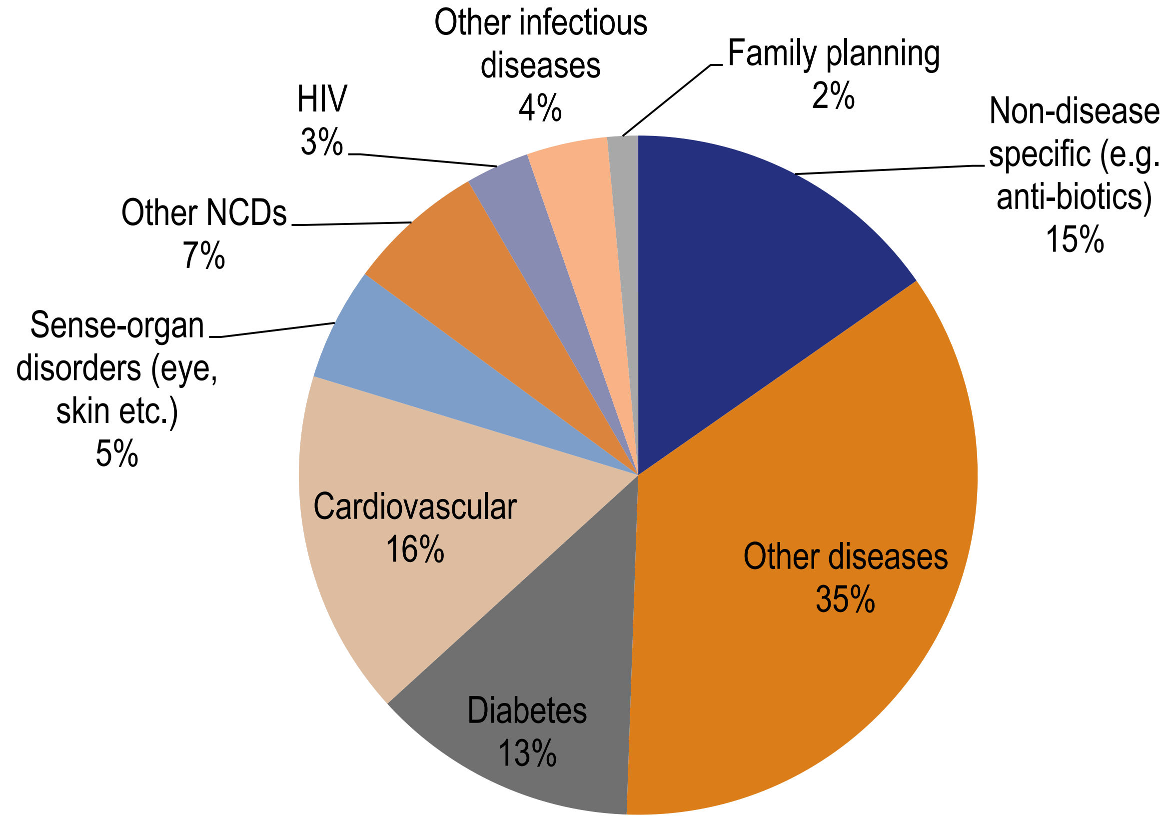
How much of household expenditure is spent on health care?

- Poor households rely on public services more, which is driving their lower proportion of health spending



Which diseases/ conditions consume the most drugs spending?

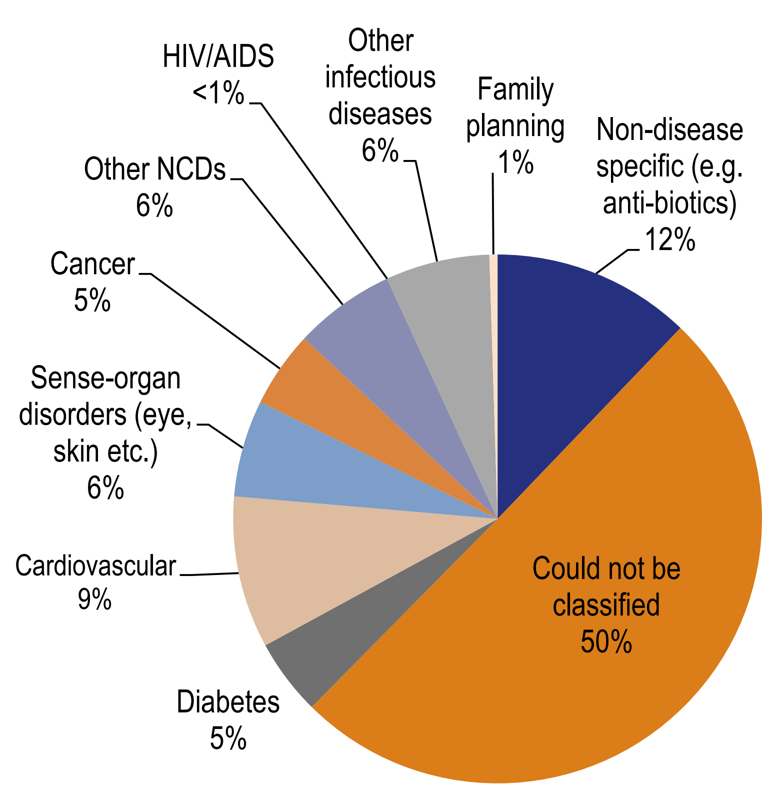
- 81% of LRU drugs spending is for HIV
- 28% and 27% of polyclinics drugs spending is for diabetes and hypertension



Comprises of spending by Drugs Service for pharmacies, LRU, QEH, specialized hospitals and polyclinics

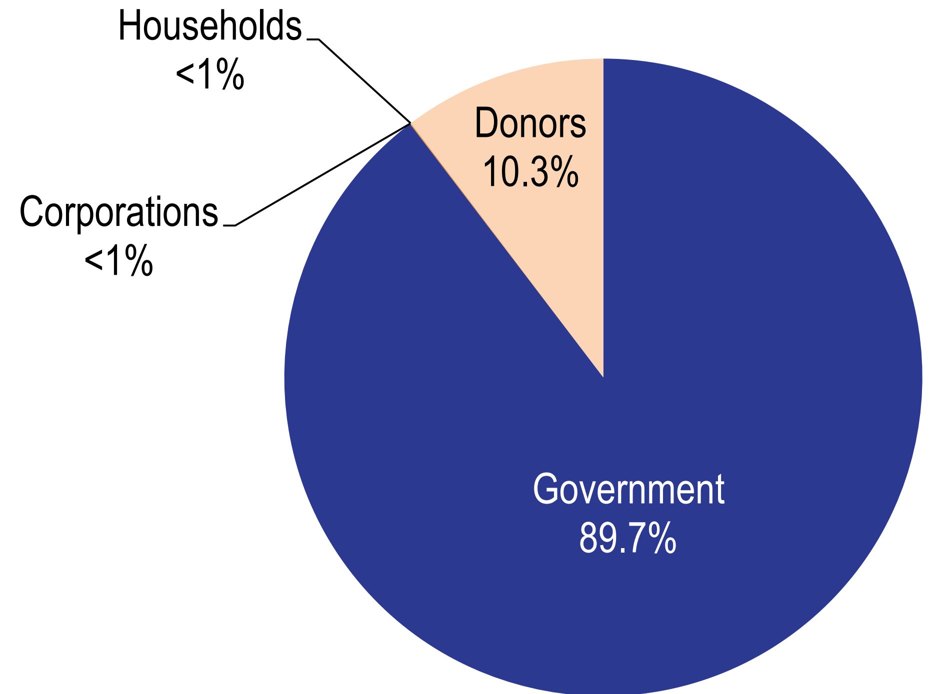
Summary spending results of QEH

- Total health expenditure at QEH: BBD 175.5m
  - Recurrent spending, except for BBD 161k for Ambulance Service
- 96% of spending is from government, remainder through private insurance and out-of-pocket
- Insufficient data for breakdown of spending by service areas (clinical, diagnostic and support services)



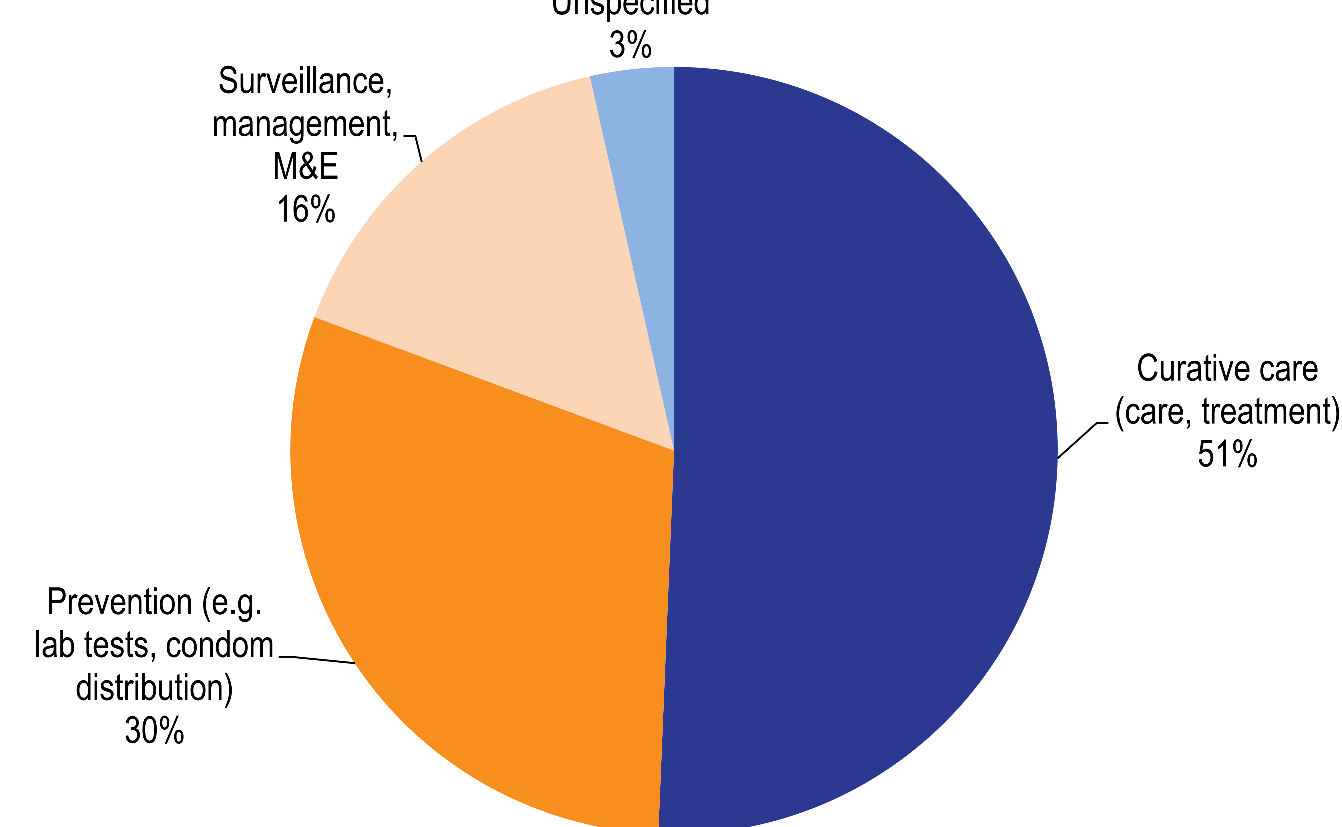
How sustainable is HIV spending?

- Total HIV spending fell by 22% in real terms from 2012/13, to BBD 17.1m
- HIV spending represents 2.6% of total current health spending
- Government still commits to the majority of HIV spending



To what goods / services does HIV spending go?

- Role of prevention spending increased from 24% of recurrent spending in 2012/13; majority of spending on treatment



Key observations

- Health spending is strongly supported by government, representing over half of recurrent spending
  - However, 43% of recurrent spending is by households paying for health care with no financial risk protection (WHO recommendation: 15-20%)
- Significant spending on curative care (vs. preventive care)
  - Planned A&E investment at QEH may increase curative care further
  - There are expectations of increased prevention/promotion spending with new Ministry of Health *and Wellness*
- HIV services are primarily funded and managed by the government, with strong focus on prevention (relative to prevention for other health spending)

Lessons learnt for future health spending exercises

- Strengthen existing data systems to facilitate analysis
  - Coordinate with Barbados Statistical Service to refine questions on Living Standards Survey
  - Work with Financial Services Commission/ Chamber of Commerce to integrate health expenditure questions for insurance companies / employers
- More consistent utilization data for polyclinics and QEH to allow comparisons over time
- Data collection system allows for limited breakdown of spending for curative vs. prevention services (e.g. government data)

Thank you

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Final Results

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