Health Financing Reform: Stakeholder Group Consultation on Financing Options

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## Contents

- Background ........................................................................................................................................... 3
- Consultation Objective (Goal 9) ......................................................................................................... 4
- Consultation Participants (Goal 9) ...................................................................................................... 4
- Consultation Dates .............................................................................................................................. 5
- Consultation Materials ....................................................................................................................... 5
- Responses Summary .......................................................................................................................... 7
- Consultation Conclusions .................................................................................................................. 10
Background

The Bermuda Health Strategy (BHS) mission is to “to provide affordable and sustainable healthcare for all Bermuda residents”. The BHS states, “The need for this strategy arose from long-term concerns about healthcare costs, weaknesses in our health system and its inability to meet the needs of contemporary Bermuda ... The Bermuda Health Strategy [aims to] prioritize actions that will result in long-term reform.”

During July 2018, a Health Financing Reform (HFR) Steering Group was put together to support the relevant reforms aligned to the BHS.

A key role of the HFR Steering Group is to identify collaborative mechanism to achieve Goal 1 of the Bermuda Health Strategy and enable Universal Health Coverage and value for money in Bermuda’s health system.

Health Financing Reform Steering Group membership is comprises of:

- Permanent Secretary (Chair)
- Bermuda Health Council Director
- Health Economist
- HID Director
- Bermuda Health Council Finance and Economics Committee Chair
- Bermuda Hospitals Board (BHB) Chief Financial Officer
- Ministry of Health Comptroller (Deputy Chair)
- Bermuda Health Council CEO

Universal Health Coverage is the overarching goal of any healthcare system. Universal Health Coverage seeks that “access to basic health insurance coverage shall be assured for all residents of Bermuda to ensure access to essential healthcare and protection from financial risk”. Specifically, for Bermuda to achieve better health outcomes, improve life expectancy, and reduce disparity, access to health insurance coverage for essential healthcare shall be the long-term goal. This shall include mechanisms to ensure that persons with chronic health conditions have access to necessary coverage and services. Eligibility for coverage access shall be determined according to residence which shall be defined in law, and the package of services covered shall be defined in law and sufficient to meet the basic needs of the population.

A number of reforms are needed to achieve Goal 1, but an essential one among them is stated as Goal 9 of the BHA: “Bermuda’s health system shall be financed through the most cost-effective means available to reduce complexity and duplication and improve efficiency”. Goal 9 states:

The World Health Organization recognizes that “timely access to health services... is critical [to promote and sustain health; and...] this cannot be achieved without a well-functioning health
financing system”. Assuring equitable access to coverage of a sound basic package requires application of health financing arrangements that provide value for money for the health system. International evidence has shown that this is best achieved by consolidating funding into large pools to ensure efficiency through strength in numbers and reduced fragmentation. Importantly, private insurance will continue to play a significant role in health financing in Bermuda; however, the scope and function will reflect the priorities and imperatives necessary to achieve equity, quality and sustainability. International experience globally provides evidence of efficiency measures available that may be applied in Bermuda. Detailed financial modelling to reform and optimise Bermuda’s financing mechanisms has been undertaken to enable evidence-based decisions on coverage and funding sources, including grants, subsidies, and private insurance.

Consultation Objective (Goal 9)

The Bermuda Health Council was asked by the Ministry of Health to facilitate consultation with a set of health system representatives. These representatives were appointed by the Minister of Health to a HFR Stakeholder Consultation Group, to discuss options related to health financing reform.

The role of the HFR Stakeholder Consultation Group was to review the financial options and analysis prepared in the 2012 Report on a Health Financing Structure in Support of Bermuda’s National Health Plan, and provide feedback to the Ministry about how the options presented may impact the people of Bermuda and more specifically your respective stakeholder group.

Consultation Participants (Goal 9)

To address the financing of the healthcare system, the Minister of Health appointed the following 15 members to serve on a HFR Stakeholder Consultation Group (see Appointment Letters):

- Dr. Amanda Marshall (Mental Health)
- Dr. Annabel Fountain (Bermuda Medical Doctors Association)
- Dr. Kyjuan Brown (Healthcare business, Northshore Medical)
- Dr. Michael Richmond (Hospital)
- Dr. Reid Robinson (Allied health representative provider)
- Mr. Anthony Santucci (Patient Representative)
- Mr. Jason Hayward (Bermuda Public Services Union)
- Mr. Jonathan Peacock (Colonial Insurance)
- Mr. Peter Lozier (Argus Insurance)
- Ms. Betsy Baillie (Health charity, Bermuda Diabetes Association)
- Ms. Ianthia Wade (Seniors advocate)
- Ms. Kathy Swan (Nursing representative)
Ms. Kendaree Burgess (Local employers, Chamber of Commerce)
Ms. Kirsten Beasley (International Business)
Ms. Michelle Jackson (Bermuda First)

Consultation Dates

To ensure that the context for consultation was provide as well as clarifications to the objectives, meetings were held individually and in group with the appointed stakeholders. The meetings provided an overview as well as opportunity for discussion on the general progression of Bermuda’s healthcare system towards Universal Health Coverage and the key challenges thereto. These individual and group meetings took place on the following dates in 2018:

- **6th September** – Full Stakeholder Consultation Group
- **18th September** – Overview meetings with individual stakeholders who could not make initial overview meeting
- **20th September** - Overview meetings with individual stakeholders who could not make initial overview meeting
- **26th September** - Overview meetings with individual stakeholders who could not make initial overview meeting
- **3rd October** (2 meetings) - Overview meetings with individual stakeholders who could not make initial overview meeting
- **4th October** - Full Stakeholder Consultation Group
- **17th October** - Full Stakeholder Consultation Group
- **31st October** - Full Stakeholder Consultation Group

Consultation Materials

In addition to consultation meetings, each stakeholder representative was provided with a set of instructions and consultation questions (see Consultation Document), and a package of materials for review as relevant questions may arise. Categories for these materials include:

- Report on a Health Financing Structure in Support of Bermuda’s National Health Plan and Bermuda Health Strategy
- Bermuda Health and System Reform Overview
- Single Payer Review Papers
- Risk Pooling Review Papers
- Implementing Health Financing Reform Review Papers
- Guarantee Access
Mandatory Health Insurance

Over an 8 week period (ending with a 12th November deadline\textsuperscript{1}) each participant was asked to meet with their respective stakeholder groups to review the consultation questions and their related documentation. Meetings with members was left up to each representative as to which format they believed best captured the group input on the included questions (e.g., large forum, electronic survey, emailed responses). The goal of the process was to then obtain a summary of each stakeholder group’s robust perspective about the financing structures (8 questions) that could enhance the delivery of care in Bermuda and funding available for the health system.

Stakeholder Feedback

Written feedback was received from 14 of the 15 representatives on the Stakeholder Consultation Group (Bermuda First, Complementary and Alternative Medicine Providers, Employee Unions, Health Insurers, Health Related Charities, Hospital, International Business, Nursing, Patients/Patient Advocates, Physicians, Psychologists, Seniors, and the healthcare business representatives) – (Feedback was not received from the local employers)

<table>
<thead>
<tr>
<th>The following questions were asked of each stakeholder group:</th>
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<tbody>
<tr>
<td>a. Does the Report on a Health Financing Structure (See Primary Background Documents) capture the health system concerns related to your members, and if not, what financing concerns is it missing?</td>
</tr>
<tr>
<td>b. Which financial structure (Dual or Unified) indicated in the report makes our healthcare system stronger? And why?</td>
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<td>c. What level of involvement should the government, associated organizations (e.g., QUANGOs), or the private sector have in the management of a Dual or Unified financial structure?</td>
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<td>d. What are some key attributes that a new financial structure should accommodate when it comes to enhancing patient care and outcomes? (e.g., case management, efficiency in administration, good customer service, governance)</td>
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<td>e. What risks and/or benefits would guaranteed access create for your stakeholder group?</td>
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<tr>
<td>f. What is your view on mandating health insurance coverage, regardless of employment status?</td>
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<td>g. For health insurance, what should be the conditions of patient subsidy for SHB coverage? Who should be priority groups that are subsidized partially or fully? Current subsidization is based primarily on age and to a lesser degree on income.</td>
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<td>h. Any other concerns?</td>
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\textsuperscript{1} The original deadline had been XX October 2018 but following feedback the Minister extended the deadline by one month to 12th November 2018.
Responses Summary

A. Does the Report on a Health Financing Structure capture the health system concerns related to your members, and if not, what financing concerns is it missing?

Stakeholders noted that the system did require significant changes to improve health outcomes and reduce costs. However, the primary financing options report was seen as very high level from a financing perspective and not directly addressing how population health would change with a new financing model. In addition a number of participants felt that the report did not quantify the expected total costs to be saved through the implementation of a new financing structure, or address the fundamental levers for controlling healthcare inflation.

B. Which financial structure (Dual or Unified) indicated in the report makes our healthcare system stronger? And why?

The quantitative feedback on the two options presented can be summarized as follows:

<table>
<thead>
<tr>
<th>Stakeholder Group</th>
<th>Dual</th>
<th>Unified</th>
<th>No Stated Preference</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Bermuda First</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Allied Health</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Employee Unions</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Health Insurer: Argus</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Health Insurer: Colonial</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Health Related Charities</td>
<td>●</td>
<td></td>
<td></td>
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<tr>
<td>7. Hospital</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. International Business</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Nursing</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Patients/Patient Advocates</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Physicians*</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Psychologists</td>
<td></td>
<td></td>
<td>●</td>
</tr>
<tr>
<td>13. Seniors</td>
<td>●</td>
<td></td>
<td></td>
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<tr>
<td>14. Healthcare Business</td>
<td>●</td>
<td></td>
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</tr>
</tbody>
</table>

● - Preference stated in submitted feedback
□ - Preference also implied in feedback, contradicting stated the preference
* - Physician feedback based on survey results (limited)

Note: Feedback was not submitted by local employers
Respondents indicated that there are conceptual savings that can come from administrative efficiency through unifying the SHB pools. However there is need to validate and to accurately assess what the financial impact would be based on actual revenue numbers. Of the 14 responses, 4 stated a preference for the dual option, 4 for unified, and 6 did not state a preference for either. However, there were contradictory statements in 3 of the 14 responses: 2 of the ‘dual’ responses also indicated a preference for single payer systems (i.e. unified models); and 1 of the ‘no preference’ responses indicated a preference for unified models.

C. What level of involvement should the government, associated organizations (e.g., QUANGOs), or the private sector have in the management of a Dual or Unified financial structure?

Preference was for an outsourced management model with government oversight. Oversight should be critical and aimed at ensuring that the management ultimately leads to achieving equity, quality and sustainability. Consider the Bermuda Monetary Authority model and ensure that there are checks and balances and clear legislative authority.

D. What are some key attributes that a new financial structure should accommodate when it comes to enhancing patient care and outcomes? (e.g., case management, efficiency in administration, good customer service, governance)

There was universal agreement that the focus of the health system, regardless of financing structure, needs to move from sick care to a wellness (prevention) model. This change in focus should also look to incentivize outcomes and not volume. Success should be measured by achieving the classic definition of Universal Health Coverage. Other aspects that are critical to a new financial structure to enhance outcomes must be a reform of the included benefits, greater transparency, and flexibility to meet the actual health related demands of the local population.

E. What risks and/or benefits would guaranteed access create for your stakeholder group? Guaranteed access means that all residents would be able to purchase at least the minimum insurance with no conditions attached to it.

Overall, the feedback indicated that guaranteed access to health insurance is critical to allow for higher levels of prevention and earlier presentation of disease. However, the risks to guaranteed access are moral hazard, higher utilization, and a pressure to reduce compensation for services due to a larger number of system users. If guaranteed access is to be implemented, there must be an accompanying policy that all individuals on island are mandated to have health insurance. Mandated health insurance must however be affordable as the current costs of healthcare creates a barrier for individuals to purchase.

F. What is your view on mandating health insurance coverage, regardless of employment status?
Mandating health insurance coverage is important but its purpose is not achieved when the coverage is primarily geared towards sick care. Such a mandate that incentivizes the provision of treatment instead of prevention and wellness is not sustainable. The select groups where mandates would be more complex are for those that may suffer from severe mental illness or those with limited incomes.

G. For health insurance, what should be the conditions of patient subsidy for SHB coverage? Who should be priority groups that are subsidized partially or fully? Current subsidization is based primarily on age and to a lesser degree on income.

There is strong support that patient subsidies need to be reformed to ensure coverage to the most vulnerable (needs based) through some mechanism of means testing based on assessed incomes.

H. Any other concerns?

Along with the submission of answers to questions, additionally the following concepts were stated as absolutely needing to be addressed in the context of the conversations about financing reform holistically:

i. Development of alternate payment models/standard pricing and deductibles
ii. Behaviour and lifestyle changes
iii. Diversification of our overseas clinical partners (not just US)
iv. Adoption of electronic health records or Personal health records
v. Enhanced case management
vi. Better financing of the hospital
vii. General system affordability
viii. Guaranteed access to healthcare coverage
ix. Management of health insurer profits
x. Improved data mining and data collection
xi. Integration within healthcare and care coordination
xii. Creation of long-term care insurance
xiii. Management of utilization/physician gatekeeping
xiv. Increased market transparency
xv. Measurement of quality/outcomes
xvi. More focus on mental healthcare
xvii. Greater emphasis on primary care and a feasible island strategy
xviii. Price controls for medications
xix. Private sector innovation in healthcare/National Health Information Technology strategy
xx. Reduction of reliance on hospital care
xxi. Change in the relationship between employment and insurance/mandatory coverage
xxii. Removal of perverse financial incentives
xxiii. Compliance with standards of care
xxiv. Reduction of uninsured and underinsured/create coverage for all
Consultation Conclusions

The Stakeholder Consultation Group members’ feedback was provided to the Minister of Health and the HFR Steering Committee. The feedback provides some of the fundamental concerns within the system amongst stakeholder groups. This will assist in developing policy considerations to ensure reforms achieve meaningful improvements.

It was also noted that many of the concerns of stakeholders cannot be significantly changed without a more flexible and coordinated healthcare system. Within the vein of creating policies to reform the healthcare system, a major emphasis must be placed on fixing the current system fragmentation, avoiding short term solutions that have unintended long term consequences, and considering carefully the changing population demographics.

Publication of stakeholder feedback was not requested as an initial condition of appointment. As such it resulted in a more open discussion on the challenges of the healthcare system by the stakeholder groups. Subsequent to the discussions, it was requested that the feedback be formally published for public consumption, however a majority of members preferred that the published report focused on the pooled feedback of the Consultation Stakeholder Group.