

ADVANCE REVIEW AND APPROVAL FRAMEWORK FOR MATERIAL CHANGES IN BERMUDA'S HEALTHCARE SYSTEM

CONSULTATION FEEDBACK AND RECOMMENDATIONS
OCTOBER 2026



Contact us

If you would like any further information about the Bermuda Health Council, or if you would like to bring a health system matter to our attention, we look forward to hearing from you.

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Published by

Bermuda Health Council
October 2026

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Executive summary

The consultation provides strong support for proceeding with an advance review framework for genuinely material healthcare changes, while also giving a clear message that the final regime must be narrower, more proportionate and more operationally precise than the consultation draft in several areas.

Headline finding	Result / interpretation
Support for advance review	Strongly support.
Power to protect the public	refusal where significant harm could not be addressed; 23 of those wanted the power confined to clearly defined circumstances.
Core caution	Respondents repeatedly warned against capturing routine decisions, organic growth, ordinary staffing or procurement, and low-risk investment by small providers.
Small-island design	limited specialist workforce or no practical alternative makes a numerically small change systemically important.
Governance	Stakeholders want early clinical input, transparent recommendations and reasons, conflict safeguards, clear timelines and practical review rights.
Regulatory coordination	already held by Government. There is less consensus on the exact final legal allocation between Health and the CRA.

Overall policy conclusion

Proceed with the framework, but revise it before drafting so that it is clearly risk-based, protects routine operations and small providers, uses existing Health-sector information and regulation, has bounded clocks and stronger due-process safeguards, and settles the Health/competition interface in statute rather than leaving duplication to operational workarounds.

Recommended decision

- Retain the core Cabinet-approved architecture: advance notification of material changes, Health Council assessment, Ministerial public-interest decision, and detailed thresholds and procedures in regulations.
- Amend the policy now to create a clearer materiality gate, negative list, small-provider and access-preserving safeguards, proportionate review levels, tighter timelines, stronger clinical participation, data reuse and clearer review rights.
- Before final legislative drafting, settle the statutory interface with the proposed Competition Act and BMA framework, with a single coordinated filing pathway and no duplicate evidence requests or conflicting decisions.

- Undertake focused technical validation with insurers, digital-health stakeholders and relevant regulators because those groups were underrepresented in the online survey.

Purpose and methodology

This report synthesises the consultation submissions received on the proposed Advance Review and Approval Framework for Material Changes in Bermuda's Healthcare System. It is intended to support final policy refinement before legislative drafting. The analysis uses three evidence streams: (1) closed-ended results from the online consultation survey; (2) thematic review of open-ended survey responses by stakeholder group; and (3) detailed review of formal written submissions. Formal submissions are summarised as stakeholder positions and are not treated as independently verified findings unless the point is also supported by the consultation record.

Evidence base and limitations

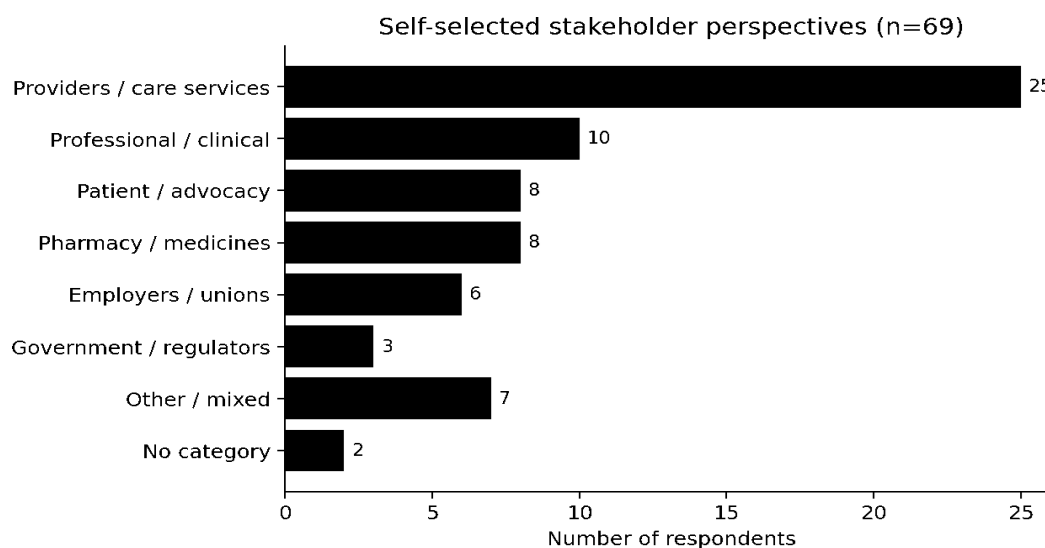
69 online consultation responses, together with four substantive formal written submission packages from Atlantic Podiatry, Dr Stanley James / Premier Health & Wellness Centre, My Pharmacy LLC, and Northshore Medical & Aesthetics Center Ltd (NMAC). Formal submissions are treated as qualitative evidence and are not added to the survey respondent count. The survey was voluntary and self-selected. Results describe the respondents who participated; they should not be read as statistically representative of Bermuda as a whole. The consultation also had limited direct participation from health insurers, digital-health organisations and regulatory bodies, which matters for technical calibration of some provisions.

Participation and quantitative findings

Respondent profile

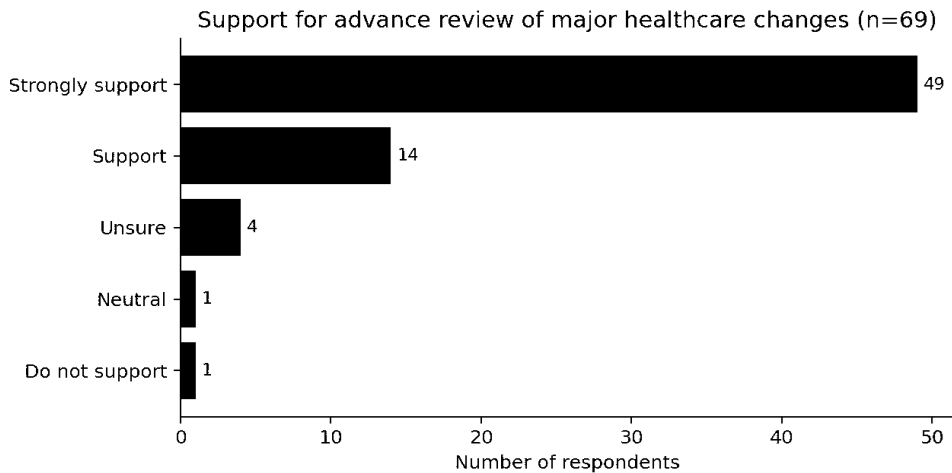
Self-selected perspective	Responses	Share
BHB, community healthcare provider or care service	25	36.2%
Professional body, professional council or clinical regulator	10	14.5%
Patient, senior, disability, charity or advocacy organisation	8	11.6%
Pharmacy, medicine importer, wholesaler, distributor or prescriber	8	11.6%
Employer or union	6	8.7%
Government department, public body or regulator	3	4.3%
Other / mixed self-described perspective	7	10.1%
No stakeholder category recorded	2	2.9%

No respondent self-selected the dedicated health insurer or digital-health/data/technology branch. Only two respondents completed the Government/regulator branch questions. These are material gaps for the calibration of premium, benefit, digital and inter-regulator provisions.



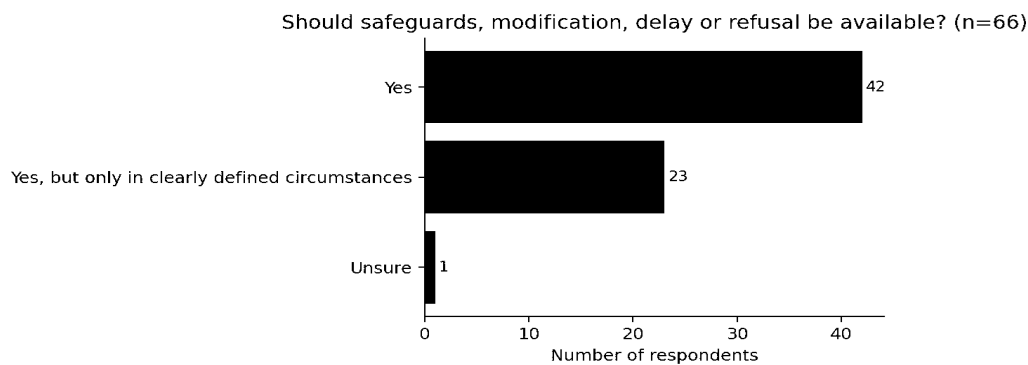
Support for the framework

Response	Number	Percent
Strongly support	49	71.0%
Support	14	20.3%
Unsure	4	5.8%
Neutral	1	1.4%
Do not support	1	1.4%



Power to impose safeguards, modify, delay or refuse

Of the 66 respondents who answered this question, 42 selected Yes, 23 selected Yes but only in clearly defined circumstances, and 1 was unsure. The result supports meaningful intervention powers, but also reinforces the need for precise statutory tests, proportionality and procedural safeguards.



Cross-cutting themes from the consultation

Strong support for prospective review

Respondents generally accepted the central policy problem: in a small health system, a major change can become difficult to reverse before Government has had an opportunity to understand its effects. Support was strongest for review of insurer-provider integration, exclusive or preferred networks, essential-service closure or reduction, major reimbursement changes, pharmaceutical supply concentration and other system-shaping changes.

Proportionality and protection of routine operations

The dominant caution was that a framework designed for major system change must not become a general approval regime for ordinary healthcare operations. Small practices and independent providers were particularly concerned about routine hiring, equipment purchases, fee changes, supplier changes, modest changes in operating hours, organic growth and other low-risk decisions becoming subject to filing, delay or information requests. Formal submissions from Atlantic Podiatry, My Pharmacy and NMAC all reinforced the need for proportionality, clearer safe harbours or more targeted treatment of small-provider and low-risk changes.

Materiality must reflect Bermuda's small-island reality

Respondents broadly supported review below numerical thresholds where the real-world effect could be material because there is only one provider, limited specialist capacity, a sole supplier, no practical alternative or an essential service at risk. At the same time, stakeholders warned that “limited capacity” describes much of Bermuda and cannot by itself trigger full review. The framework therefore needs a qualitative risk test that is specific, documented and capable of distinguishing system risk from ordinary scarcity.

Clear definitions, examples and bounded timelines

A recurring concern was uncertainty about what “material” means, who decides, what must be filed and how long the process can take. Stakeholders asked for published examples, objective criteria, a closed completeness checklist, binding or reliable pre-filing advice, differentiated review levels and consequences when decision deadlines are missed. NMAC also asked for explicit clarification of whether presumptively complex changes proceed directly to Level 2 or first pass through Level 1 screening. Several respondents described the policy paper as too complex for general audiences.

Clinical and frontline expertise must be built into review

Providers and professional bodies repeatedly asked for meaningful clinical participation early in the process rather than consultation after a direction has effectively been chosen. For service changes, staffing changes, clinical pathways and essential services, the relevant specialty or professional expertise should inform the Health Council assessment. A minority of respondents also expressed concern about concentrating final authority in one Minister, which can be addressed through published independent recommendations, written reasons and review safeguards while preserving the Cabinet-approved Ministerial decision role.

Workforce fragility is itself a system-risk issue

Responses highlighted dependence on small numbers of specialists, recruitment difficulty, immigration and work-permit processes, locum reliance, succession risk and the time required to replace specialised staff. Premier Health & Wellness Centres' written submissions also asked that cumulative physician-employment concentration, Bermudian workforce development and independent clinical capacity be monitored as part of system resilience.

Overseas care is not a simple substitute for local care

Respondents consistently identified the consequences of increased overseas referral: travel and accommodation, delays, family and caregiver burden, insurance and public cost, disruption to continuity and the loss of local follow-up capacity. The framework should therefore assess whether a proposed change increases avoidable dependence on overseas care, while recognising that overseas treatment remains necessary for services Bermuda cannot sustainably provide locally.

Patient choice must be practical, not only theoretical

Patient and provider submissions raised concerns about insurer-provider integration, network design, co-payment differentials, referral pathways and pharmacy channelling. Premier Health & Wellness Centre urged the framework to distinguish nominal provider choice from meaningful choice and to consider continuity, trust and clinical independence. This suggests that network and vertical-integration reviews should assess practical access and steering effects, not simply the number of providers listed as available.

Reuse existing Health-sector data and regulation

Stakeholders asked Government to avoid duplicate reporting and to use information already collected through Health Council licensing and regulatory processes, insurer and BMA returns, claims data, professional registers, HRHT registration, the Drug Formulary, provider registers and other lawful sources. This theme is particularly important given that healthcare already has a sector-specific statutory architecture. Competition oversight should add expertise where needed rather than recreate provider, insurance, medicines or health-data regulation.

Transparency, confidentiality and procedural fairness

Respondents supported transparency but also emphasised commercial confidentiality, patient information protection and clear conflict rules. My Pharmacy in particular requested stronger controls around supplier-specific information and adverse evidence. Across the consultation, there was support for written reasons, disclosure of the case to be answered, conflict and recusal safeguards, practical review rights and a public performance register.

Public and private providers should be treated consistently

Respondents recognised BHB's unique role as Bermuda's hospital provider and system anchor, especially for acute and essential services. At the same time, several asked that public and private providers be subject to consistent standards where they provide comparable services, and that BHB expansion into community services be assessed for system effects rather than assumed to be preferable merely because it is public.

Equity and distributional effects need a clearer method

The consultation draft includes equity within the public-interest assessment, but Premier Health & Wellness Centres' supplemental submission asked how race or ethnicity, provider representation, Bermudian participation, independent capacity and missing data would be handled. The final methodology should define relevant equity characteristics, record important data gaps and assess who receives benefits and who bears costs, rather than relying only on aggregate effects.

Findings by stakeholder group

Providers and care services

- Strong support for protecting genuinely essential services, but concern that small independent practices could face disproportionate review burden.
- BHB is recognised as uniquely important for acute and hospital-dependent services, but respondents want community providers treated as system partners and comparable services subject to consistent standards.
- Material service reductions should be assessed using capacity, wait time, workforce, emergency coverage, patient pathways and likely overseas referral effects.
- Routine or temporary operational changes should be distinguished by duration, scale, reversibility, patient impact and availability of practical alternatives.

Professional bodies and clinical stakeholders

- Clinical or professional input should be automatic where standards of care, specialist capacity, patient safety, scope of practice or major service delivery are affected.
- Loss of one practitioner can be systemically important in a small specialty, but personal retirement or relocation should not be treated as something Government can prevent; the relevant issue is whether an organisation or service is undergoing a material capacity change.
- Workforce review should consider succession, vacancies, training pipelines, locum dependence, recruitment lead times and the availability of Bermudian and overseas professionals.

Patients, caregivers and advocacy organisations

- The eight respondents in this branch most often selected cost to patients (8), access to medicines (7), waiting times (6), provider choice (6) and need to travel overseas (6) as impacts requiring attention.
- Respondents want plain-language information before implementation, opportunities to comment on significant changes and clear explanations of decisions and safeguards.
- Trust depends on transparency, independence, accessibility and evidence that consultation changes outcomes rather than simply documenting views.

Pharmacy and medicines stakeholders

- Support for review of sole suppliers, essential medicines, restricted networks and material supply disruption, but strong concern that routine procurement, supplier substitution, freight-route changes and emergency sourcing could be slowed unnecessarily.
- Expedited pathways are needed for shortages and urgent patient needs. Routine lawful sourcing that maintains access should normally remain outside formal review unless there is evidence of material island-wide risk.
- Commercially sensitive supplier, price and route information requires strong confidentiality safeguards.

Employers and unions

- Premium, co-payment, benefit and access changes were viewed as relevant because they affect employment cost, absenteeism, productivity, recruitment and retention.
- Employers want adequate notice of material insurance changes, but the review process should not unnecessarily disrupt annual renewal cycles or normal employment arrangements.
- Several responses linked health workforce access to immigration and labour-market realities.

Government and regulators

- Participation was limited. Responses supported simplicity, reuse of information and avoiding duplicate processes, but there is insufficient survey evidence to treat the detailed inter-regulator architecture as settled.
- The Competition Act interface, BMA role, information-sharing gateways and final decision boundaries therefore require direct technical settlement among the relevant Ministries, regulators and Attorney-General's Chambers.

Consultation gaps

- No respondent completed the insurer-specific branch and none completed the digital-health/data/technology branch.
- Before thresholds and regulations are finalised, targeted technical validation should be

undertaken with licensed insurers/approved schemes, BMA and digital-health/data partners. This should be focused calibration rather than a reopening of the entire public consultation.

Formal written submissions

Three substantive written submission packages were reviewed. They add detail beyond the routed survey questions and, in some areas, present different institutional preferences. These differences are useful and should be reflected rather than collapsed into an artificial consensus.

Atlantic Podiatry

- Supports the framework in principle, conditioned on proportionality, predictability and workability for independent community providers.
- Recommends explicit coverage of material claims-administration/payer-process changes and workforce-capacity changes.
- Supports hybrid quantitative and qualitative thresholds, with streamlined treatment for passive investment and low-risk SME changes.
- Supports one health-sector filing, a mandatory CRA competition opinion and no duplicate ex ante competition approval for the same healthcare transaction.
- Recommends administrative filings with no standstill, approximately 30-day notice for Level 1, 90/120 days for Level 2, binding pre-filing advice, scaled fees and a “tell Government once” data principle.

Premier Health & Wellness Centre

- Focuses on payer-provider integration, meaningful patient choice, clinical independence, continuity of care and the need to establish a baseline before structural change becomes difficult to measure retrospectively.
- Requests monitoring of premiums, benefits, out-of-pocket costs, affiliated versus independent reimbursement, ownership and physician-employment concentration, network access, referrals, quality, outcomes, continuity and equity.
- Proposes a confidential route for patients and clinicians to report steering, referral restrictions, utilisation pressure or concerns about speaking openly.
- Supplementary submissions link market concentration to workforce resilience, Bermudian medical capacity and equity, and ask the methodology to recognise cumulative control through physician employment as well as acquisitions.
- Requests clearer treatment of equity characteristics, missing data, effective patient choice and existing vulnerabilities.

My Pharmacy LLC

- Supports advance review of genuinely major changes such as insurer-provider acquisitions, exclusive networks, related-party steering and essential-supply risk, but argues that the consultation draft reaches too far into ordinary small-provider operations.
- Requests a closed routine-operation negative list, statutory small-provider filter, access-preserving safe harbour, calibrated thresholds, one completeness notice, binding non-notifiable advice, bounded clocks, practical interim relief and strong supplier-confidentiality controls.
- Challenges the evidentiary basis and readiness for some proposed powers and asks for a power-by-power necessity case, back-testing, filing-volume estimates and a readiness report before commencement.

- Supports one common filing but differs from Atlantic Podiatry on institutional allocation: it prefers separate binding Health, CRA and, where applicable, BMA decisions rather than an advisory CRA competition opinion only.
- Requests stronger appeal/review remedies and a prospective transition model that inventories major legacy structures without retroactive penalties.

Northshore Medical & Aesthetics Center Ltd (NMAC)

- Supports the framework's objectives and the single-front-door model, while focusing on proportionality for small and medium providers, legal certainty for transactions already in development, and clearer definitions of who is caught by the regime.
- Requests that customary minority-investor protections not be treated as control, and argues that non-controlling minority investments should not automatically trigger Level 2 review solely because they exceed a percentage threshold.
- Supports calibration and annual indexation of financial thresholds using published Bermuda data, clearer criteria for essential-service designation, tiered notice periods with notice and review clocks running concurrently, and no fee for pre-filing engagement or voluntary interim notifications.
- Strongly supports the Health-led single-front-door model: one filing through the Health Council, a CRA competition opinion delivered within the Health timetable, one information-request channel, and the Minister of Health as the final ex ante decision-maker for the healthcare change.
- Proposes detailed transitional protections for pipeline transactions, including grandfathering of binding pre-commencement agreements, recognition of voluntary interim notifications, and a warning-and-cure approach for good-faith first-year notification failures.

Recommended policy updates

The recommendations below are designed to preserve the Cabinet-approved core while responding to the consultation. They distinguish changes that can be made within the existing policy mandate from matters requiring inter-Ministry or legal settlement.

Important area of divergence

The consultation supports coordination and avoidance of duplication much more clearly than it supports one specific final competition-decision model. Atlantic Podiatry and NMAC support the Health-led single-front-door model in the draft, while My Pharmacy supports one filing but separate binding Health and CRA decisions. The final statutory allocation should therefore be settled expressly with Home Affairs and Attorney-General's Chambers and should not be presented as a point of consultation consensus.

Policy area	Action	Recommended update	Consultation rationale
1. Core architecture	RETAIN	Retain statutory advance notification for material changes, Health Council whole-system assessment, Minister of Health final public-interest decision, emergency route and application to both public and private actors.	Strong overall support; consistent with Cabinet decision paper.

2. Routine-operation boundary	AMEND - HIGH	Insert an explicit negative list and statutory/guidance safe harbours for routine low-risk activity: ordinary staffing, personal practitioner retirement/relocation, routine equipment replacement/upgrade, organic growth, routine procurement/source substitution and minor operating changes, unless a defined material-risk trigger is met.	Most frequent implementation concern; Cabinet memo already says routine/minor decisions should not be subject to formal approval.
3. Administrative vs exempt	AMEND - HIGH	Separate “exempt”, “administrative filing” and “Level 1/Level 2 review” as distinct legal categories. State clearly whether an administrative filing may proceed immediately and any call-in window.	Survey respondent identified ambiguity; current Annex B conflates “administrative / normally exempt”.
4. Classes of change	AMEND	Add explicit classes for material claims administration/payer processes and material workforce-capacity changes. Clarify that cumulative physician-employment concentration can be relevant where it materially changes system capacity or control.	Atlantic Podiatry and clinical submissions; recurring survey themes.
5. Materiality and call-in	AMEND - HIGH	Retain hybrid quantitative and qualitative triggers, but define the qualitative test around material risk to access, safety, continuity, essential capacity or system stability. Clarify that customary minority-investor protections do not of themselves constitute control. Require written reasons for below-threshold call-in.	Strong support for Bermuda-specific qualitative triggers, paired with concern about vague discretion; NMAC also requested clearer treatment of minority protections.
6. Small-provider / access-preserving filter	ADD - HIGH	Create a rebuttable presumption of no formal review, or streamlined review, for changes by small non-sole providers that maintain or increase access, capacity or competition and do not create control, exclusivity or essential-service risk.	Repeated survey concern; Atlantic, My Pharmacy and NMAC submissions.
7. Threshold calibration	AMEND	Back-test proposed thresholds using Bermuda claims, provider revenue, service volume and historical transactions before regulations are finalised. Reconsider transaction-value and ownership-percentage triggers that may capture routine SME or non-controlling minority investment. Test whether non-control minority acquisitions should remain Level 1 unless another material-risk trigger is met.	Already contemplated by draft; consultation reinforces need. NMAC specifically challenges automatic Level 2 treatment of non-controlling minority stakes.

8. Essential services	AMEND	Publish designation criteria and an initial schedule. Permit designation of critical service pathways, not only whole professions or institutions. Use published capacity/service-share evidence where appropriate and review the schedule periodically.	Provider submissions emphasise pathway-level fragility; NMAC requests published, reviewable designation criteria.
9. Timelines and standstill	AMEND - HIGH	Administrative: no standstill. Level 1: 20-business-day screening, with shorter notice rather than universal 90-day notice. Level 2: retain 90-day standard / 120-day complex notice. Ensure notice and review clocks run concurrently where practicable. Add an outside decision date and defined consequences for missed deadlines.	Atlantic, My Pharmacy and NMAC converge on bounded, tiered clocks; survey repeatedly requests timeliness.
10. Pre-filing and completeness	AMEND	Make written jurisdictional/non-notifiable advice reliable or binding for a defined period where facts are complete. Use one closed completeness checklist and consolidated deficiency notice, with later requests limited to genuinely new material information. Clarify whether presumptively complex changes proceed directly to Level 2 or first pass through Level 1 screening.	Predictability and burden concerns; NMAC identifies ambiguity in the presumptively complex route.
11. Evidence and data reuse	AMEND - HIGH	Adopt an explicit “tell Government once” principle. Map Health Council, BMA and other lawful datasets before creating new returns. Require only incremental or updated information needed for the specific review.	Strong cross-cutting theme and consistent with existing Health regulatory architecture.
12. Clinical and stakeholder participation	AMEND	For Level 2 and major service changes, require relevant clinical/professional input and direct engagement with materially affected patients/providers (consider central health professional committee). Keep Level 1 targeted and proportionate.	Strong provider/professional theme.
13. Decision safeguards	AMEND	Preserve the Minister as final decision-maker, but require publication of the Health Council recommendation, written Ministerial reasons, conflict disclosures and a clear explanation where the final decision materially departs from the Council recommendation. Use external assessment/alternative decision-maker when Ministry of Health/Council is proponent.	Addresses governance concerns without reopening Cabinet- approved Ministerial role.

14. Competition interface	RESOLVE BEFORE DRAFTING	Retain one coordinated notification pathway and concurrent specialist review. Preserve Health's whole-system public-interest assessment and Ministerial health decision. Require a formal CRA competition assessment on relevant cases and settle statutory primacy, appeal interaction and conflict rules jointly with Home Affairs/AG. Do not rely on an MOU alone.	Consultation strongly supports non-duplication. Atlantic and NMAC support the Health-led model; My Pharmacy prefers separate binding Health and CRA decisions, so final statutory allocation remains a matter for inter-Ministry/legal settlement.
15. Existing health regulation	ADD	Add an explicit savings/coordination statement that Advance Review supplements rather than replaces existing HSP licensing, health insurance, medicines/Drug Formulary, HRHT/technology and professional-regulation pathways. Clarify treatment of entities already licensed or supervised under another Government regime to avoid duplicate sector regulation.	Respondents want existing data and regulation used, not recreated; NMAC specifically requests clarity for entities already regulated under another Ministry.
16. Vertical integration and patient choice	AMEND	Strengthen the assessment methodology for payer-provider/pharmacy integration: effective patient choice, ownership disclosure, referral/steering patterns, reimbursement differentials, clinical independence, information firewalls and independent-provider capacity.	Survey and Premier Health & Wellness Centre submissions; current draft already recognises related-party steering.
17. Workforce resilience	AMEND	Make workforce capacity an explicit assessment domain and possible qualitative trigger. Measure dependence on single specialists, succession, recruitment lead time, locum/overseas dependence and cumulative employment concentration.	Major Bermuda-specific theme.
18. Equity and distribution	AMEND	Define "relevant equity characteristics" and how missing data are handled. Assess distribution of benefits/burdens and effective choice. Include race/ethnicity only where lawful, methodologically sound and appropriately protected.	Premier Health & Wellness Centre supplemental submission; aligns with existing equity domain.
19. Pharmaceutical sourcing	AMEND	Clarify that routine lawful procurement, inventory management and supplier substitution that maintain access are not formal-review events unless they create a documented material supply risk. Preserve rapid emergency sourcing and strong confidentiality for supplier-specific data.	Pharmacy survey responses and My Pharmacy submission.

20. Fees and expert costs	AMEND	No fee for administrative filings, pre-filing engagement or voluntary interim notifications; modest/reduced Level 1 fee; tiered Level 2 fees; external expert costs capped and estimated in advance; waivers/reductions for charities, distressed essential services and access-preserving changes. Consider proportionate fee abatement where Government materially exceeds the review clock without proponent agreement.	Atlantic and NMAC submissions; consistent with proportionality.
21. Review and appeal	LEGAL DESIGN	Retain rapid reconsideration for obvious error/new evidence but obtain AG advice on an expedited independent appeal/review route for refusal, material conditions, prolonged delay and penalties. Judicial review alone may not provide a practical remedy during standstill.	Governance survey comments and My Pharmacy submission.
22. Confidentiality and information governance	AMEND	Specify data-class gateways, role-based access, audit logs, retention, breach controls, redaction procedures and heightened protection for supplier-specific commercial information and PHI.	Written submissions; important for inter-regulator data sharing.
23. Transition and legacy	AMEND	Use a 3-6 month implementation period; grandfather existing lawful arrangements unless materially renewed/varied; define treatment of pipeline transactions and recognise voluntary pre-filing where appropriate; publish a legacy inventory of major structures for monitoring; avoid retroactive penalties. Consider a warning-and-cure approach for good-faith early notification failures during the first year.	Atlantic, My Pharmacy and NMAC positions; reduces incumbency and transition risk.
24. Readiness and performance	ADD	Before commencement publish operational readiness: staffing, specialist panel, SOPs, case system, security, conflicts and surge capacity. Publish annual performance metrics and conduct an independent two-year evaluation with threshold recalibration.	Formal submissions and survey concern about regulatory delay/capability.
25. Plain-language guidance	ADD - HIGH	Publish a short public guide, decision tree, worked examples and sector-specific FAQs showing what is exempt, administrative, Level 1 and Level 2.	Repeated clarity concern; some respondents found the consultation paper difficult to understand.

26. Targeted technical validation	ADD	Before finalising regulations, conduct focused sessions with insurers/approved schemes, digital-health/data stakeholders, BMA, Home Affairs/CRA design team, AG Chambers and CMO/professional regulators.	Insurer and digital branches had no survey responses; regulator branch was sparse.
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Where the changes should sit

Instrument	Recommended content
Primary legislation	Purpose and public-interest test; material-change definition; duty to notify; standstill; call-in authority and reasons; Health Council assessment; Ministerial decision powers; confidentiality gateways; core enforcement; conflicts; appeal/review architecture; statutory relationship with CRA/BMA; regulation-making power.
Regulations	Prescribed entities; classes of change; thresholds; essential-service schedule; exemptions and safe harbours; filing levels; notice/review clocks; tolling; emergency procedures; fees/waivers; consultation requirements; transitional rules; penalty bands.
Guidance / SOPs	Negative list and worked examples; pre-filing process; completeness checklist; evidence schedules; clinical engagement; confidentiality/redaction practice; data reuse map; sector-specific examples; decision templates and performance reporting.

Proposed revised policy position

The final policy can be simplified into the following proposition:

The Bermuda Government should require advance review only where a proposed healthcare change is reasonably capable of materially affecting patients or the health system. Routine operations should proceed without unnecessary regulatory delay. Review intensity should increase with system risk. The Health Council should undertake the whole-system assessment, using existing Government information wherever possible, with relevant clinical, competition, prudential and other specialist input. The Minister of Health should make the final health-sector public-interest decision, supported by transparent reasons and review safeguards. The process should operate through one coordinated Government pathway and should not duplicate existing health regulation.

Recommended next steps

Step	Action
1. Confirm policy response to consultation	Review and approve the retain/amend/resolve positions and identify any items requiring Minister/Cabinet direction.
2. Hold focused technical validation	Short sessions with insurers/BMA, digital/data stakeholders, Home Affairs/CRA/AG, and key clinical/professional representatives to close consultation gaps and test thresholds/process.
3. Recalibrate thresholds	Back-test the threshold matrix against Bermuda data and recent transactions/service changes; estimate filing volumes by actor size and review level.
4. Produce revised policy paper	Incorporate the negative list, tiered clocks, governance safeguards, data reuse, workforce/equity refinements and updated inter-regulator model.
5. Publish consultation response	Publish a concise “what we heard / what we changed” report and plain-language guide before or alongside the next legislative stage.
6. Settle statutory interface	Ministry of Health, Home Affairs and AG Chambers to agree Health/CRA/BMA roles in primary legislation, including filing route, referral duties, decision boundaries, clocks and appeals.
7. Prepare operational readiness	Forms, completeness checklist, pre-filing advice, secure data environment, external specialist panel, staffing, decision templates and performance dashboard.

Conclusion

The consultation supports the central policy objective and provides a sufficiently clear mandate to proceed. The strongest message is not that the framework should be weakened, but that it should be more precisely targeted. Stakeholders want Government to be able to act before major healthcare changes create avoidable harm, while also protecting routine clinical and business decisions from unnecessary delay.

The final framework should therefore be stronger where the system risk is greatest - insurer/provider control, material network steering, essential-service loss, major reimbursement changes, supply concentration and other changes that can reshape patient access - and lighter where the risk is demonstrably low. That combination is consistent with the Cabinet-approved purpose, Bermuda's small-island realities and the feedback received.

Appendix A. Closed-ended survey results

Question / response	Number	Percent / denominator
Strongly support advance review	49	71.0% of 69
Support advance review	14	20.3% of 69
Neutral	1	1.4% of 69
Unsure	4	5.8% of 69
Do not support	1	1.4% of 69
Support safeguards / modification / delay/ refusal	42	63.6% of 66 answering
Support, but only in clearly defined circumstances	23	34.8% of 66 answering
Unsure on intervention power	1	1.5% of 66 answering
Willing to be contacted for clarification	49	76.6% of 64 answering

Appendix B. Patient/community branch selected impacts

Impact	Selections (n=8)
Cost to patients	8
Access to medicines	7
Waiting times	6
Choice of provider	6
Need to travel overseas	6
Location of services	5
Continuity of care	5
Impact on families or caregivers	5
Accessibility	5

Appendix C. Evidence reviewed

- Online survey export: Targeted Consultation: Advance Review of Major Healthcare Changes (69 responses).
- Advance Review and Approval Framework for Material Changes in Bermuda's Healthcare System - consultation policy paper.
- Ministry of Health Cabinet decision paper / proposed legislative framework.
- Atlantic Podiatry formal consultation submission, 14 September 2026.
- Premier Health & Wellness Centre formal submission on patient choice, clinical independence and payer-provider integration, plus supplementary submissions on market power/workforce resilience and equity/meaningful choice.
- My Pharmacy LLC submission package: executive summary, detailed consultation response, evidence annex and cover correspondence, 2 October 2026; related 15 September evidence request / Home Affairs allocation position considered as contextual material.
- Northshore Medical & Aesthetics Center Ltd (NMAC) formal consultation submission, 2 October 2026, addressing small-provider proportionality, minority investment/control definitions, threshold calibration, essential-service designation, tiered notice periods, fees, Health-led single-front-door coordination and transitional arrangements.

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