Bermuda Health Council

2018 NATIONAL HEALTH ACCOUNTS REPORT

Bermuda health system finance and expenditure for fiscal year 2016-2017

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Introduction & Contents

The 2018 National Health Accounts (NHA) Report reviews health system finance and expenditure for the fiscal year ending 31st March 2017 (FYE 2017)[1] and analyzes it based on a combination of OECD[2], World Health Organization (WHO) and European Commission guidelines for developing Health Accounts.

Public sources of financing include Ministry of Health grants and subsidies, Department of Social Insurance funding for care of War Veterans, and grants provided to health organisations by the Government Ministries to assist with the provision of health services.

Private sources of finance include health insurance premiums, out-of-pocket payments for the uninsured portion of care and donations received by non-profit organisations to cover the cost of providing health services to the community.

Based on the data provided, this report tracks the flow of both public and private sector funds as they migrate through the health system. The analysis provides a basis for measuring impact of policy changes such as development of wellness programmes, reallocation of funds and restructuring of benefit packages.

Notable policy changes for FYE 2017 were

1. changes in hospital inpatient rates to a single rate per day after a set rate for an initial period of days
2. shift in dialysis coverage from Standard Health Benefit (SHB) (claims paid by individual insurers) to Mutual Reinsurance Fund (MRF) (claims paid by MRF.
3. inclusion of Zio Patch, peripheral artery disease screening and diagnostic imaging, high risk foot podiatry and plasma exchange under SHB

We continue to review the information provided in these annual publications in the context of achieving a quality, equitable and sustainable health system as we move toward making Bermuda the healthiest island in the world.

This NHA summary is structured as follows:

For raw data tables and previous reports, visit www.bhec.bm/national-health-accounts/.

1. Fiscal year ending 2017 is the period between 1st April 2016 and 31st March 2017.
2. OECD stands for Organisation for Economic and Co-operative Development

Overview

Table 1. Overview of Finance and Expenditure

Health Finance	Amount ($'000)	% of Total	% Increase	Health Expenditure	Amount ($'000)	% of Total	% Increase
Public Sector Finance				**Public Sector Expenditure**			
Ministry of Health	186,681	25.8%	0.22%	**Ministry of Health HQ**	10,045	1.4%	-21.99%
Dept. of Social Insurance	4,372	0.6%	-9.95%	**Department of Health**	24,787	3.4%	1.73%
Other Government Grants[3]	1,006	0.1%	21.20%	**Bermuda Hospitals Board[6]**	329,873	45.6%	4.95%
Public Sector Sub-Total	**192,059**	**26.6%**	**0.05%**	**Public Sector Sub-Total**	**364,705**	**50.4%**	**3.74%**
Private Sector Finance				**Private Sector Expenditure**			
Health Insurance[4]	433,241	59.9%	-0.79%	**Local Physicians**	57,589	8.0%	85.04%[7]
Out-of-pocket Expenditure[5]	90,742	12.6%	23.26%	**Local Dentists**	30,055	4.2%	-2.39%
Donations	6,957	1.0%	47.45%	**Other Local Providers[8]**	78,657	10.9%	-24.13%[7]
				Prescription Drugs	41,432	5.7%	-6.16%
				Overseas Care	86,842	12.0%	2.56%
				Health Insurance and Programme Administration	63,719	8.8%	4.41%
Private Sector Sub-Total	**530,940**	**73.4%**	**3.09%**	**Private Sector Sub-Total**	**358,294**	**49.6%**	**0.80%**
Total Public & Private	722,999	100%	2.26%	**Total Public & Private**	722,999	100%	2.26%

Data contributed by the Accountant General's Department, Bank of N T Butterfield, Bermuda Cancer and Health Centre, Bermuda Diabetes Association, Bermuda Heart Foundation, Bermuda Hospitals Board, Bermuda Life Insurance Company (Argus), BF&M Life Insurance Company, Colonial Medical Insurance Company, Department of Social Insurance, Department of Statistics, Government Employees Health Insurance Scheme, Health Insurance Department, HSBC Bermuda, Lady Cubitt Compassionate Association (LCCA), Ministry of Health, and PALS.

3. Ministry of Youth, Families and Sports provided additional grants to Lorraine Rest Home and Matilda Smith
4. This figure is a combination of claims paid for health services and products, and health insurance premium collected for health system and programme administration
5. We are currently working on improving the calculation of out-of-pocket financing through enhanced enforcement of the Health Insurance (Health Service Providers) (Claims) Regulations 2012. Currently, this figure is reported as the difference between finance and expenditure because it is presumed to occupy the largest portion of untracked financing of the health system – along with cash paying customers and pro-bono services.
6. Includes patient subsidies
7. Diversification of services provided by health service providers, namely physician offices has resulted in submission of claims for care not historically provided in these settings. For example, diagnostic imaging claims would be classified as "Other local providers" but when provided in a physician office, the expenditure may be recorded under "local physicians". The diversification is reflected as movement of expenditure between the three categories.
8. Includes all other local providers, services and products not classified elsewhere

Observations

Table 1:

» Health expenditure increased by 2.26% (per capita expenditure of $11,336)[9]

» Despite the large increase in expenditure on local physicians and decrease in expenditure on local dentists and other providers, the sum of these categories remained at 23% of total expenditure, which reflects a reclassification of claims within these categories.

Graph 1 and 2:

» Public financing remained at $192M after 3 consecutive years of decrease.

» Private financing has increased over the past 3 years from $486M in 2014 (70.1% of total financing) to $531M in 2017 (73.4% of total financing).

» Expenditure is more evenly distributed with 50.4% in the public sector and 49.6% in the private sector.

Graph 3:

» Health insurance premiums continue to account for the largest portion of private financing, however for the first time in 7 years, the portion decreased (61.8% of total financing in 2016 to 59.9% in 2017).

» Out-of-pocket financing increased from 10.4%[10] of total financing in 2016 to 12.6% in 2017.

Graph 4:

» Health insurance administration increased by 4.41%, however its share of total financing only increased from 8.6% in 2016 to 8.8% in 2017.

Graph 5 and 6:

» In the 13 years of data available, expenditure for the Aged Subsidy has always accounted for the majority of total patient subsidies; for the last three years, this portion has been 68%.

Graph 7 and 8:

» The 2.26% increase in health expenditure and the 2.89% increase in GDP resulted in a very slight increase in health expenditure share of GDP from 11.51% in 2016 to 11.53% in 2017.

» Although health financing increased from 2016 to 2017, the decrease shown in the graph is a reflection of the actual population reported for 2017 being higher than the projected population used for 2016[9].

» When compared to OECD countries, 11.5% share of GDP places Bermuda behind only Switzerland (12.4%) and the United States (17.2%).

Graph 9 and 10:

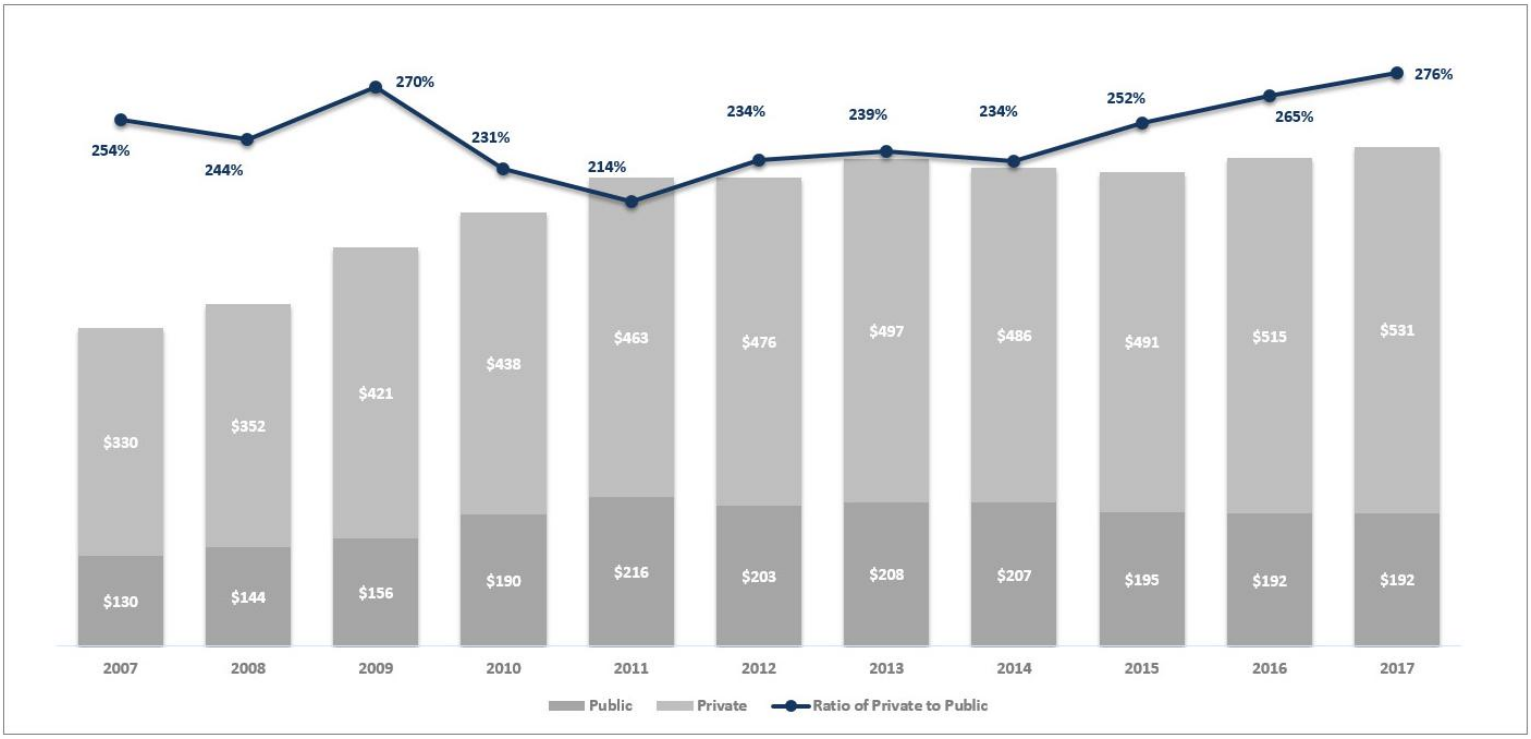
» Bermuda falls below the trend for health expenditure and life expectancy which suggests we are spending more without achieving greater health outcomes.

» This is further supported when we compare Bermuda to other jurisdictions of similar affluence (per capita GDP) such as Norway, where health expenditure is less but life expectancy is higher. Switzerland, also of similar affluence, has a higher per capita health expenditure but also has longer life expectancy.

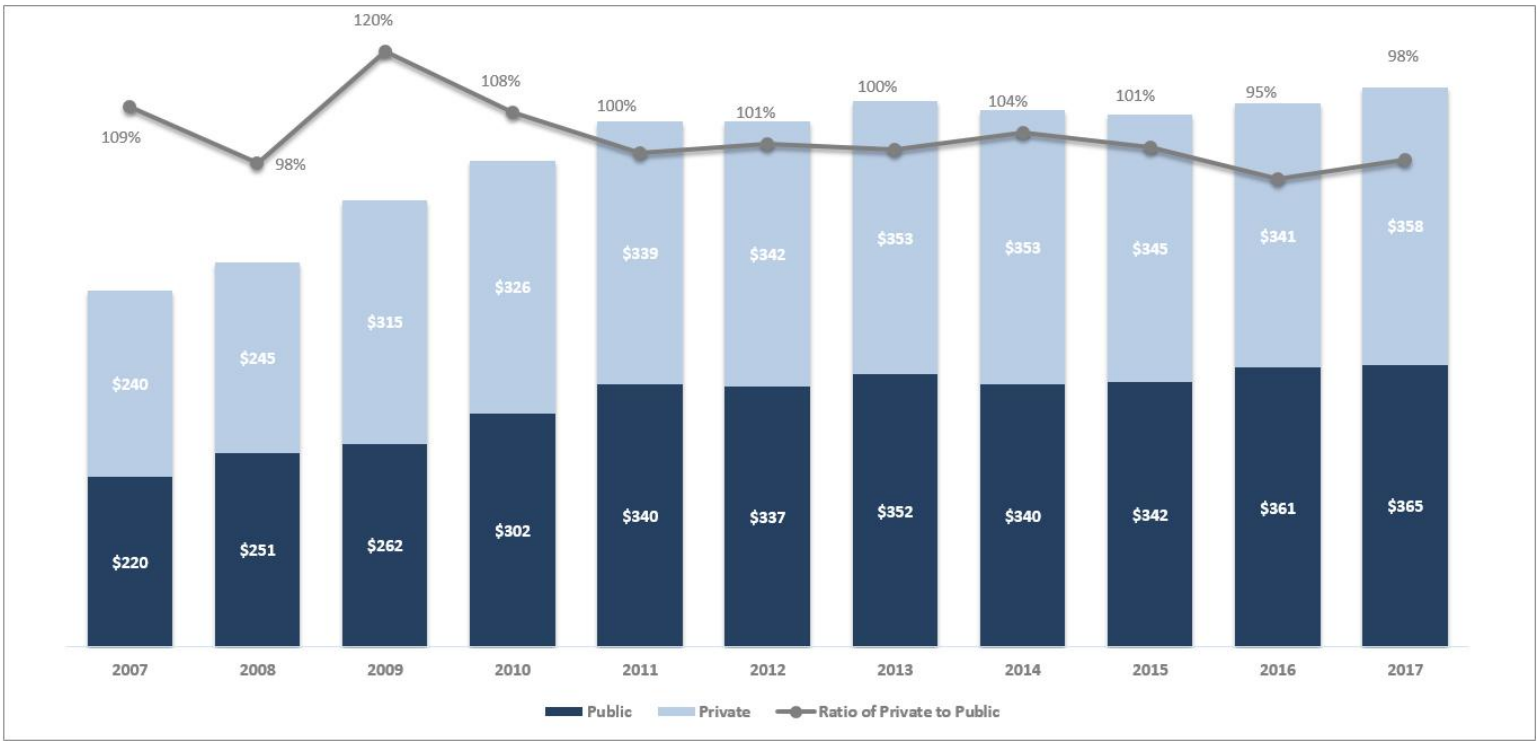
9. Actual population figures rather than projected figures are used where available. Per capita calculations for this report were impacted by the use of (1) a projected population of 61,735 for 2015/16 as reported in the Department of Statistics' Bermuda's Population Projections 2010 to 2020 and (2) an actual population of 63,779 for 2016/17 as reported in the 2016 Populaion and House Census. The projected population for 2016/17 was 61,695 which is a decrease of 0.6% from the projected population for 2015/16. When comparing the population counted in the two most recent census reports, the population decreased by 0.71% from 2010 to 2016.
10. Figure updated from what was reported in 2017 NHA Report

Finance and expenditure

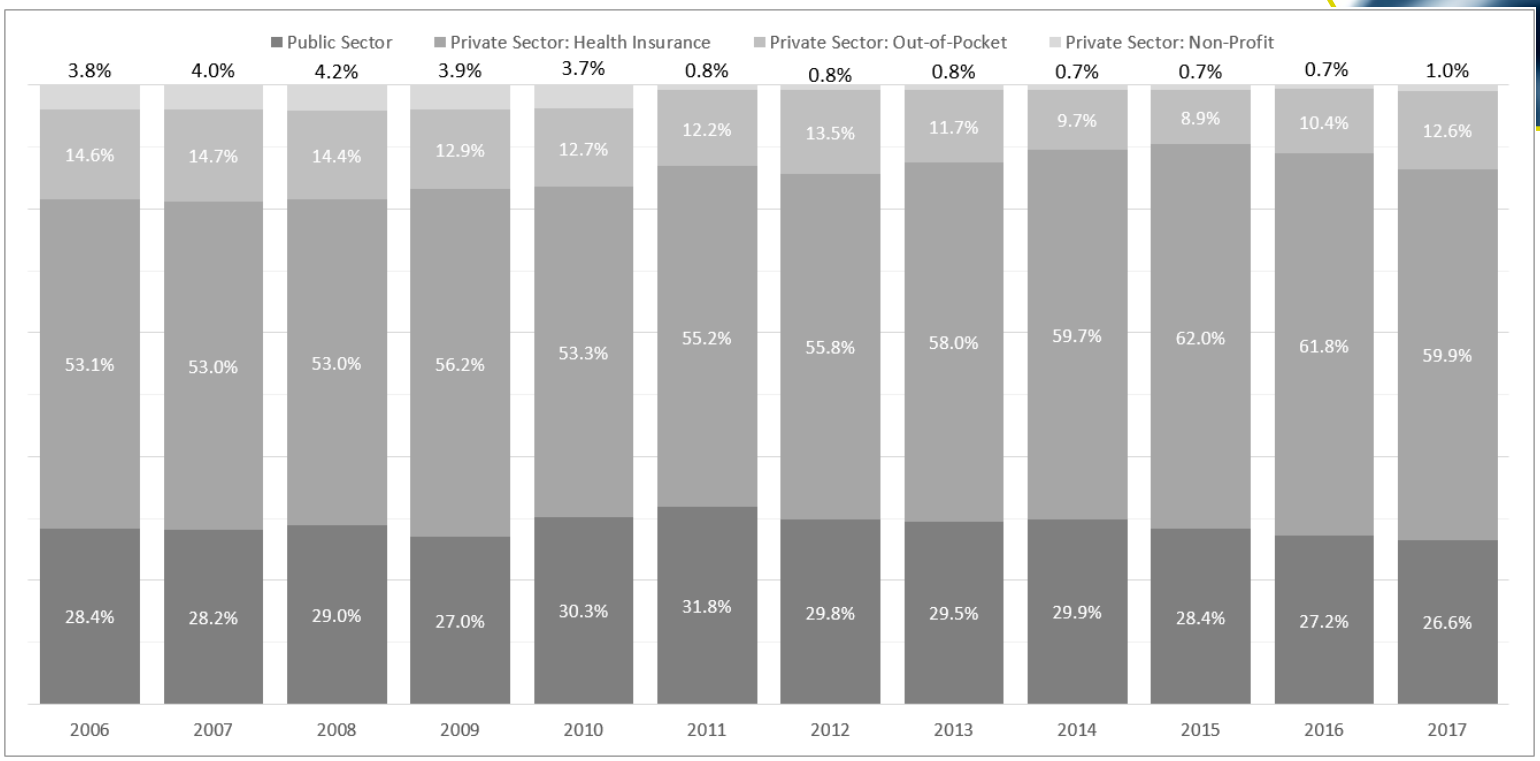
Graph 1. Public and Private Financing



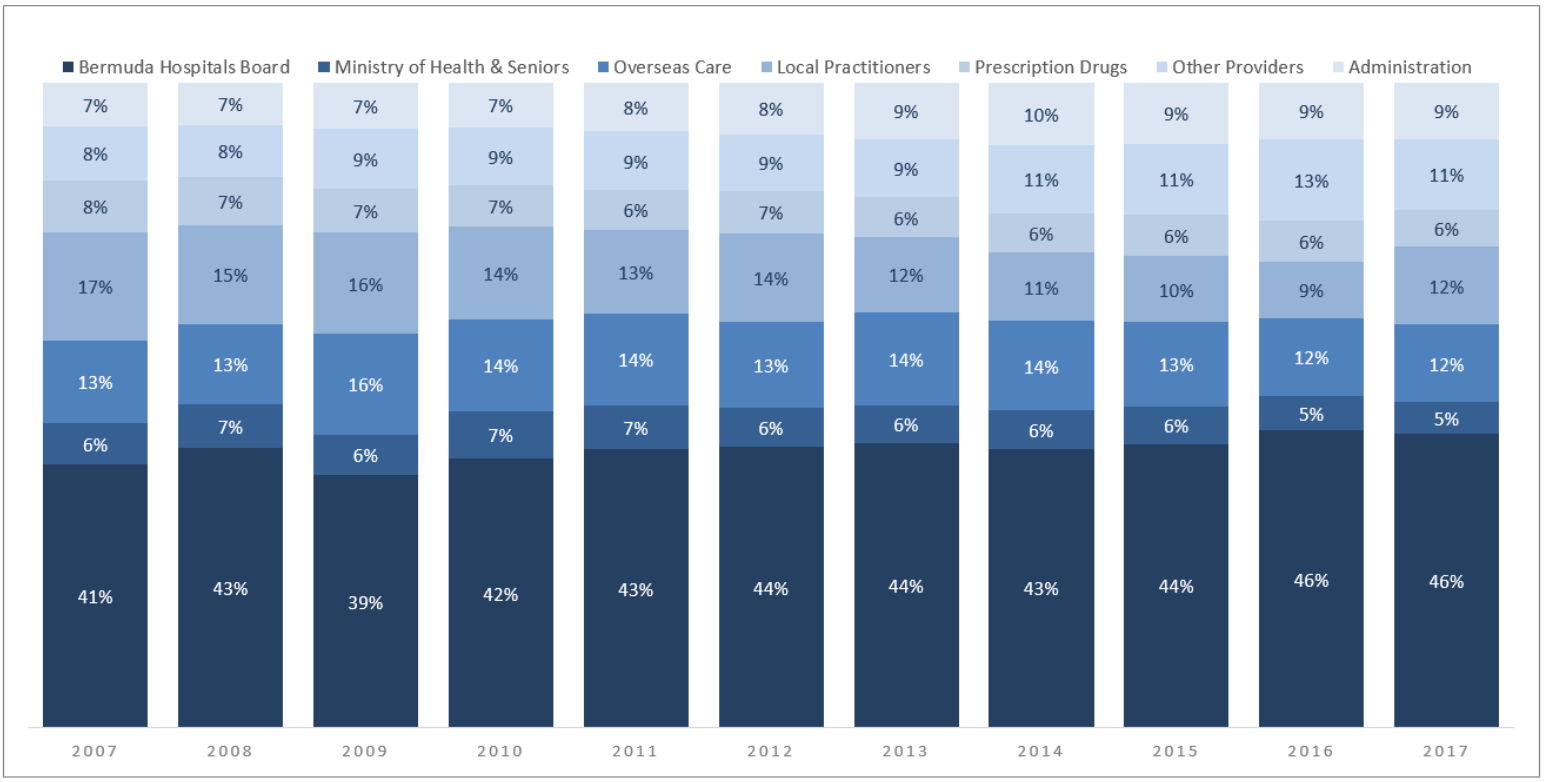
Graph 2. Public and Private Expenditure



Graph 3. Sources of Health Financing

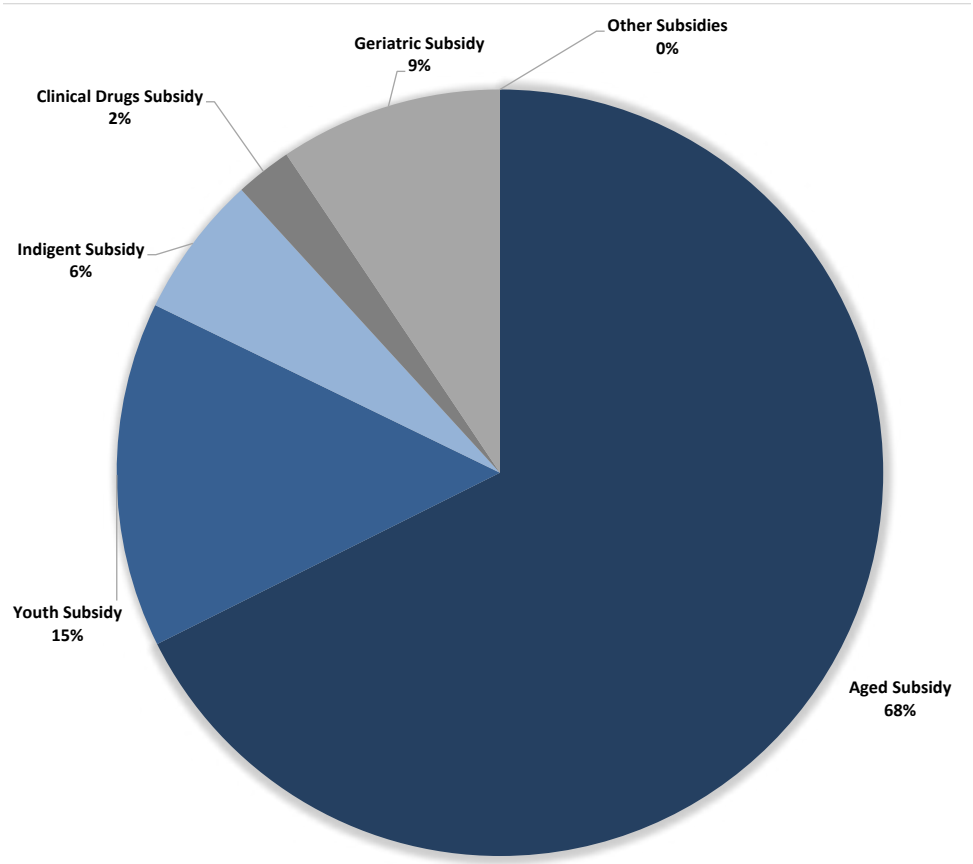


Graph 4. Categories of Health Expenditure

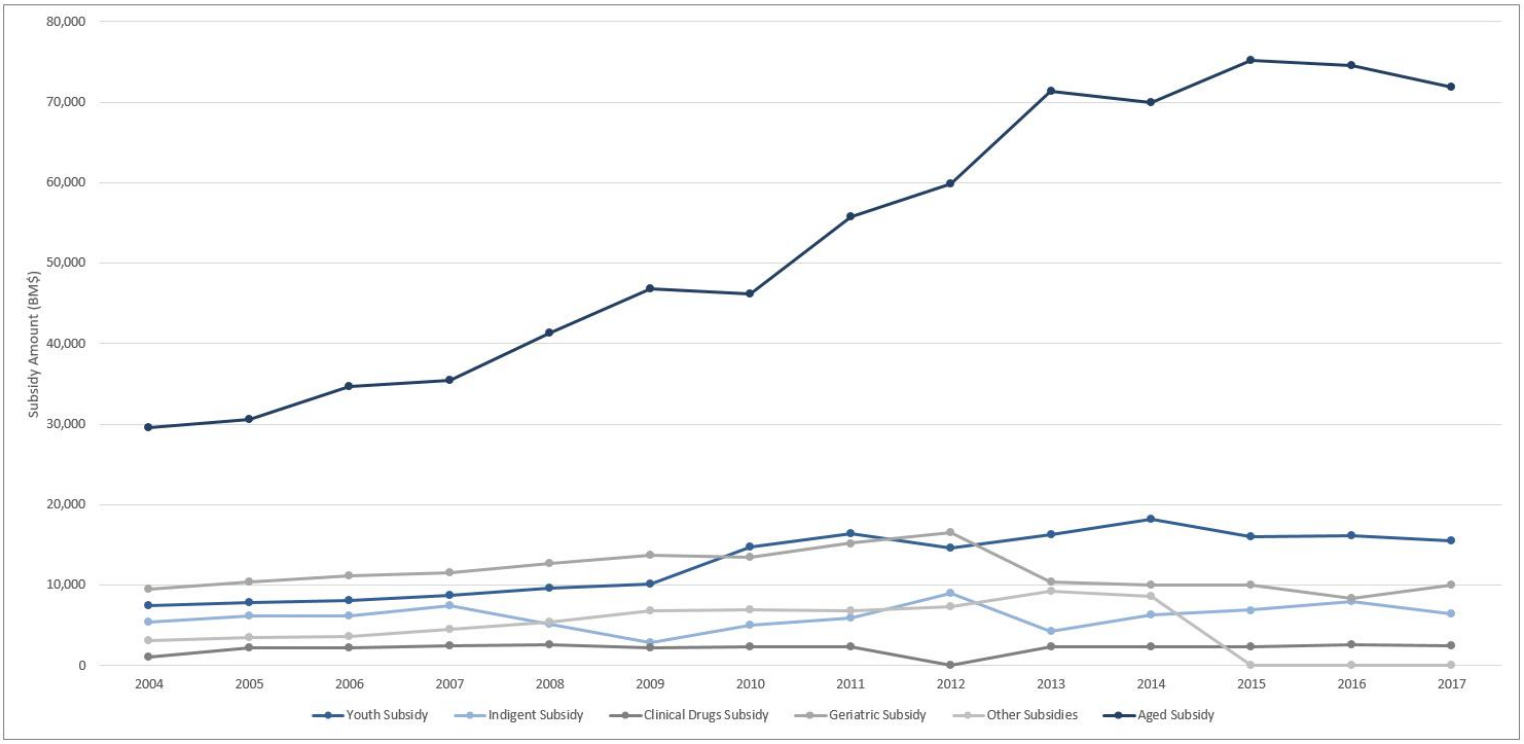


Patient Subsidies

Graph 5. FYE2017 Subsidy Distribution

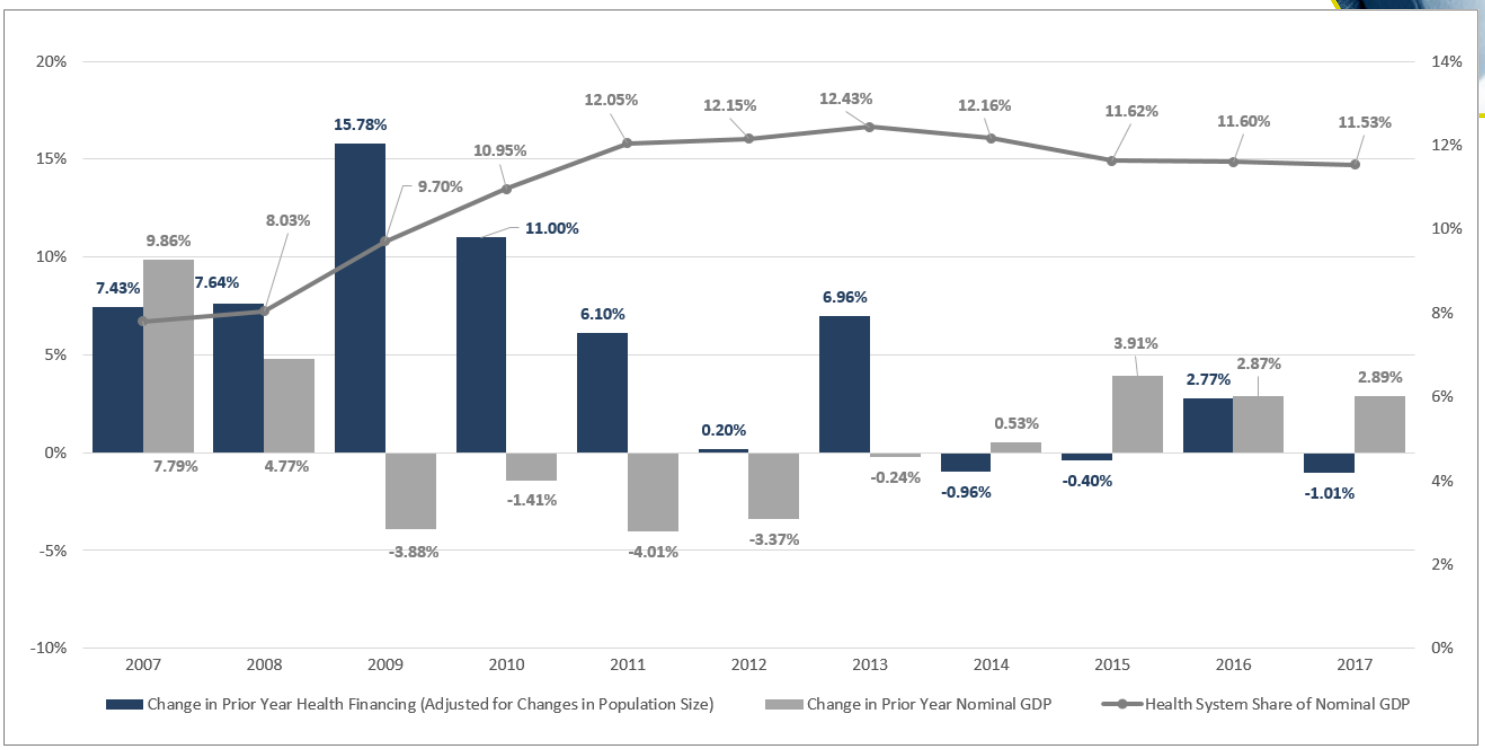


Graph 6. Patient Subsidy Amounts by Year

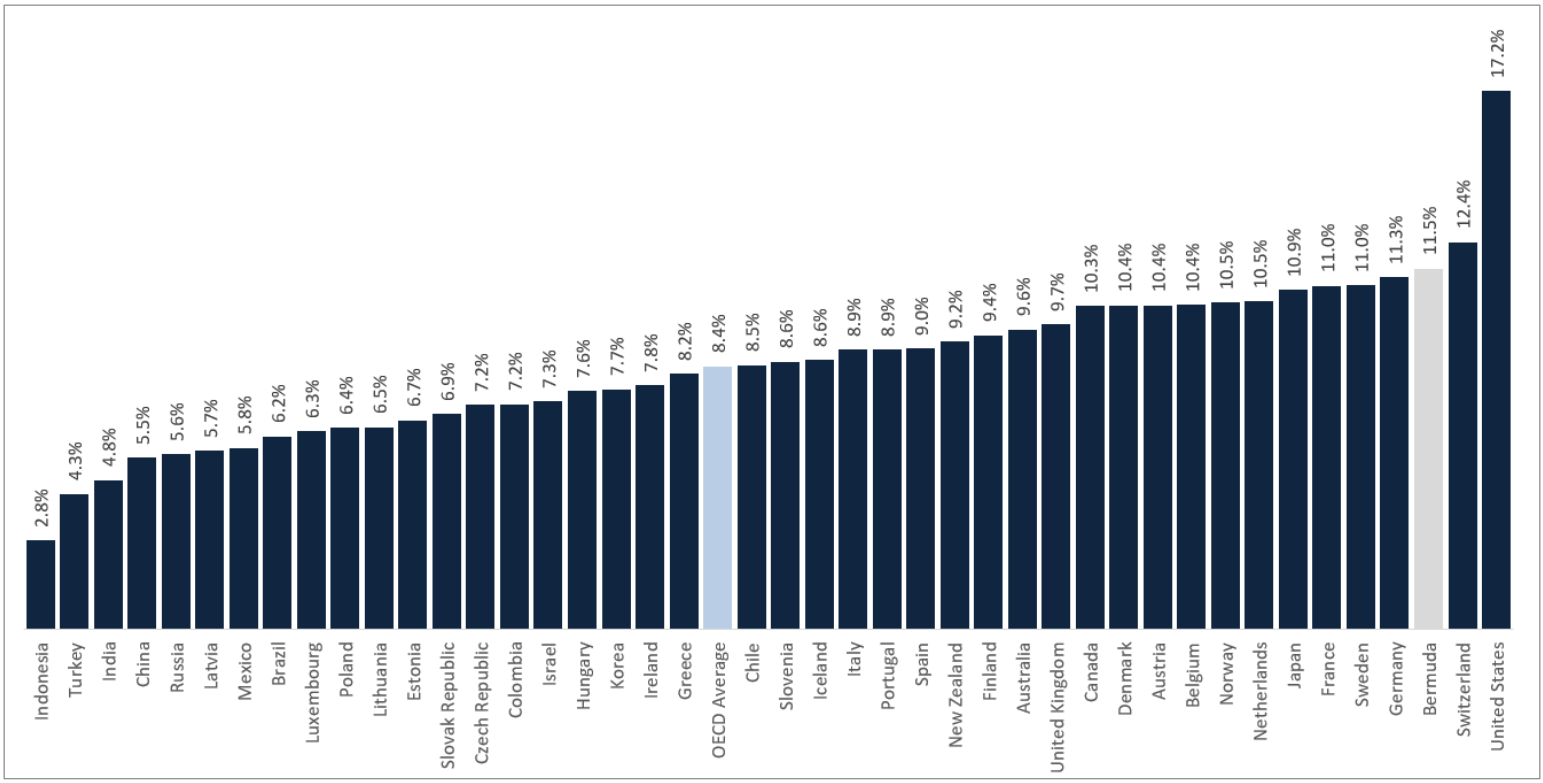


Health In Context

Graph 7. Health Expenditure and Gross Domestic Product (GDP)

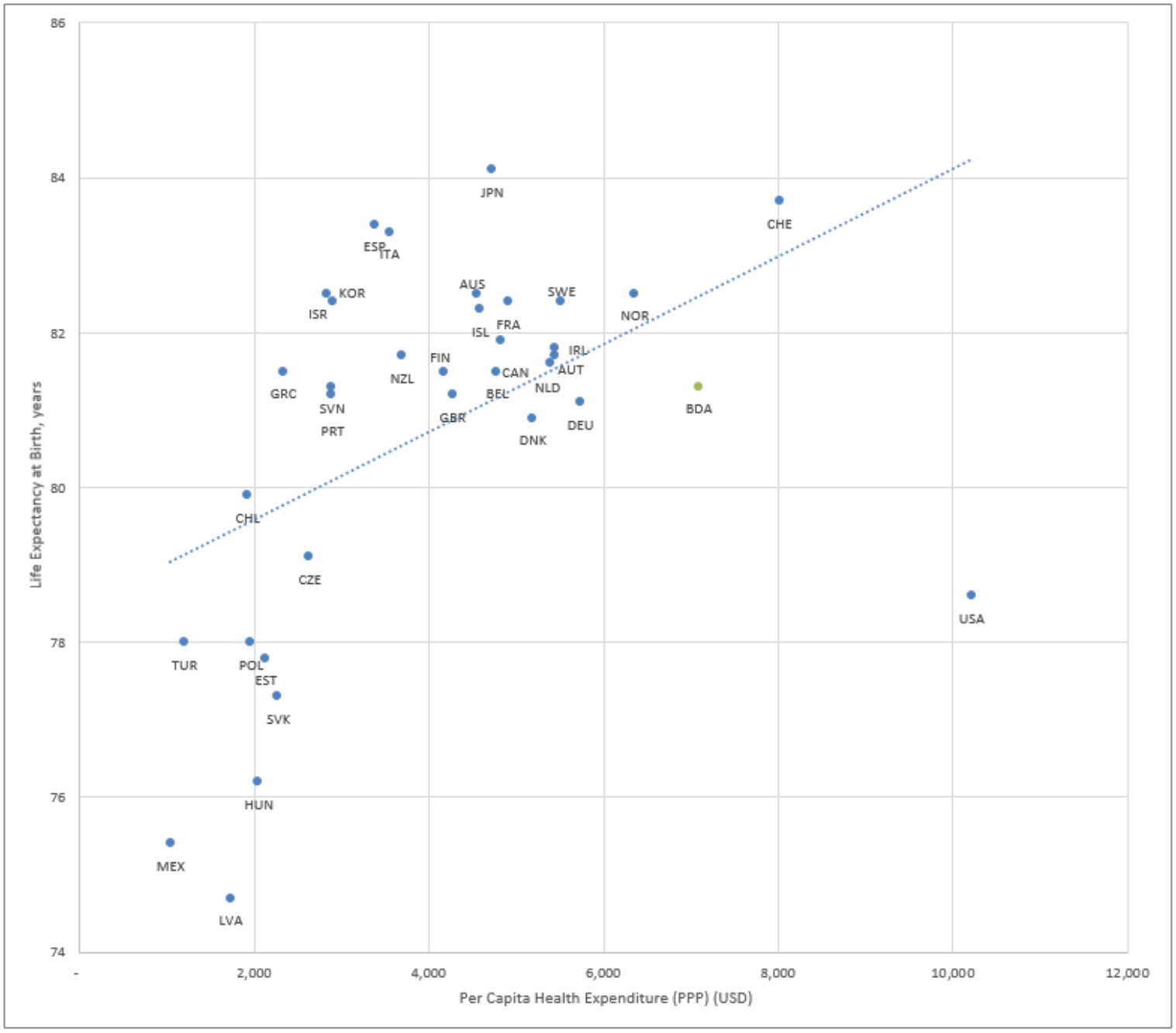


Graph 8. Health Share of GDP

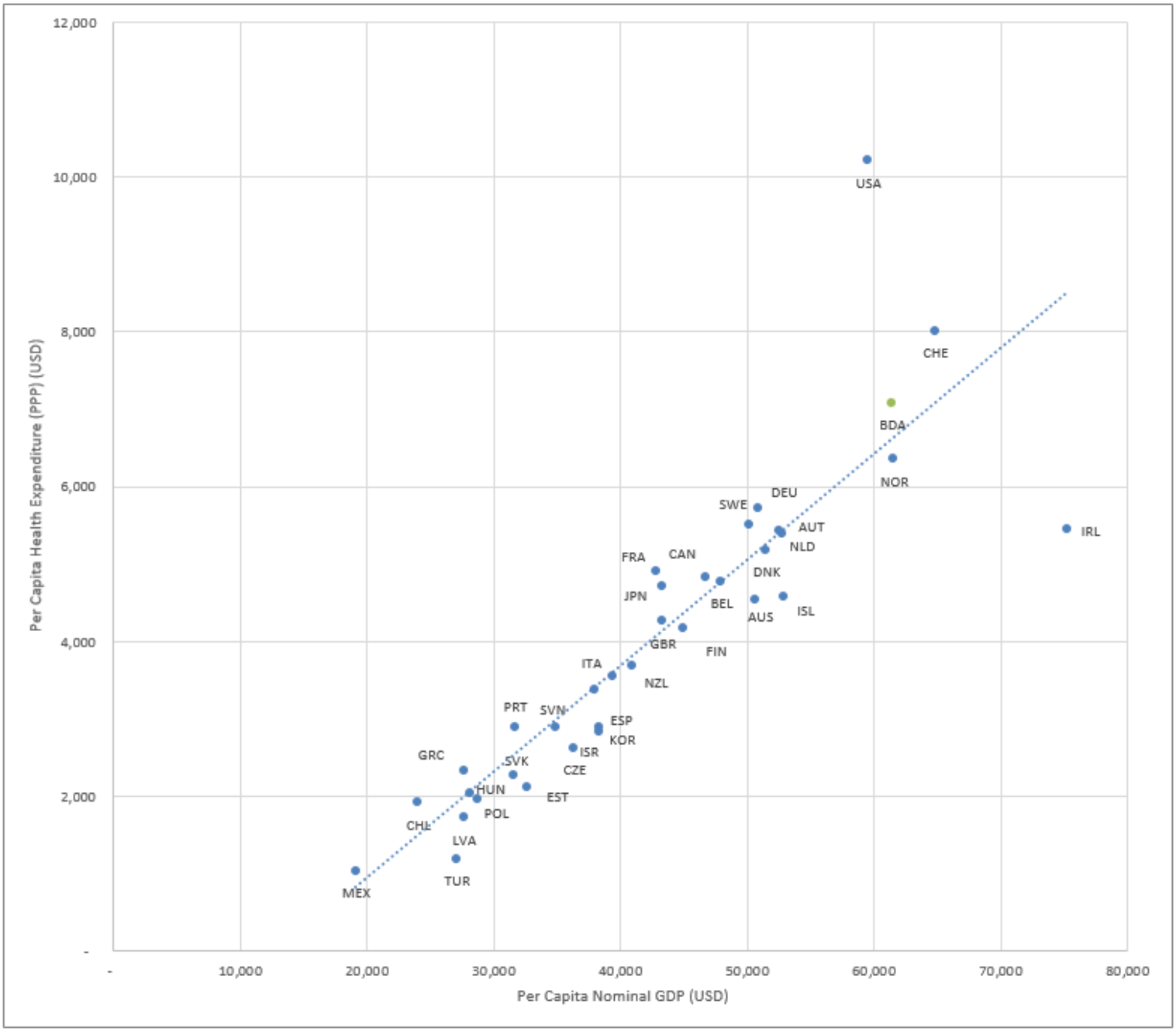


Health In Context

Graph 9. Per Capita Expenditure vs Life Expectancy as a Measure of Health Outcomes



Graph 10. Per Capita Expenditure vs Per Capita Nominal GDP



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