Submission from ISPGM concerning risk equalization

1 Feb 2021

In the context of the consultation on risk equalization of private health insurance the Irish Society of Physicians in Geriatric Medicine (ISPGM), representing over 130 specialists in the care of older people, wishes to give the strongest possible endorsement to the principles of community rating and risk equalization.

On the basis of paying insurance premiums over the course of the life-span, adherents to health insurance schemes are most likely to benefit from these in later life, at a point when care is more likely to be complex but also to require a rehabilitative component to ensure return to previous levels of function and well-being.

We support the High Cost Claims Pool as proposed, but are particularly concerned about a number of elements of current practices, including:

a) failure by some insurers (Laya, Irish Life Health) to incorporate the rehabilitative elements of hospital care of older people
b) an emerging practice of discouraging effective discharge planning by gating hospital funding to the date of requesting home-care package support or listing for long-term care despite the patient continuing to require hospital-based medical care
c) the practice of introducing co-payments for commonly required procedures which are highly effective in not only personal terms but also societal cost benefit such as hip replacement
d) the complexity and number of the plans, as well as challenges to clarify what is included and excluded on open access websites, including that of the HIA
e) advertising strategies which are clearly targeted at younger subscribers.

a) A major concern currently for the funding of appropriate hospital care for older people in general and Category 2 hospitals whereby some private insurance companies do not include what is regarded as a central element of modern hospital care, medically-directed rehabilitation for the loss of function associated with the illness precipitating admission as well as the co-morbidities. This rehabilitation means multidisciplinary rehabilitation and discharge planning for people with frailty, complex comorbidity, disability, or dementia.

   Older people are the biggest users proportionately of acute in-patient services. Patients over 65 account for around 32% of in-patient admissions, 53% of acute hospital in-patient days and patients over 85 representing 13.1% of in-patient bed days: the average length of stay, given the complexities outlined above, increases from 2.6 days for ages 1-14 to 13.7 days for the over 85's[1]. Up to one in four acute beds is occupied by someone with dementia: in one cohort study, over 40% of admission aged over 70 had dementia, of which only half had been diagnosed prior to admission[2]. Multiple comorbidity is the norm in over 60s attending the emergency department[3] and frailty is highly predictive of hospital admission and re-admission[4]. Looking after these patients, and the inherent and

integrated restoration of functional loss, is now the core business of all acute medical and surgical in-patient services, as pointed out in the Kennedy Report in 1991[5].

In any aspect of adult hospital medicine, medical and surgical services will routinely encounter (generally older) patients with complex biopsychosocial problems. If we are serious about patient centred care, we can't marginalise them, and will suffer other serious problems (increased length of stay, increased morbidity and mortality, re-admission, entry to long-term care) if they are not addressed by integrated and early rehabilitation from the time of admission.

A patient who could walk last week but is now falling or immobile, or who was lucid but is now delirious, who had intact bones but has now broken one, has a diagnosable and modifiable medical problem. The notion that he or she is a "social" admission[6] ignores the medical skill and knowledge needed to help patients regain former levels of independence and return home (or vice versa). Comprehensive geriatric assessment is such a multidisciplinary biopsychosocial approach. Meta-analysis of 22 trials shows that doing this well has long term benefits for inpatients' survival and independence for months after they leave hospital[7].

Most older patients admitted acutely to hospital have some functional impairment already[8] but one-third lose some ability in common activities such as standing, walking, or dressing while on the wards[9] and they go home short of baseline even if the acute problem has stabilised. So most need, and benefit from, a skilled medically-directed multidisciplinary approach involving allied health professionals, and appropriately are not "medically fit for discharge" until it is clear that in-patient remediation has been maximized to the point of facilitating discharge to home. This may occur in general wards, geriatric medicine wards, or Category 2 hospital beds under direct medical supervision, usually by physicians in geriatric medicine. Irish health insurance companies, and their medical advisors, need to recognize realities of the core business, and incorporate multi-disciplinary, medically-directed, rehabilitation as an integral part of acute, and often elective, hospital care. **We recommend that all insurers include specialist-directed hospital-based rehabilitation in all plans**

b) In this, it is prudent to try and arrange a Home Care Package in anticipation of a planned future discharge based on expected goals: currently some insurers are trying to cease payment for in-patient care from the date of invoking a Home Care Package even though the patient is undergoing ongoing in-patient treatment. This is in effect penalizing prudent anticipatory practice. **We recommend that insurers not only encourage prudent discharge planning but also support hospitals to the point that discharge is feasible on the grounds of restored health and function.**

c) A key concern arising from current practices is the use of excess and co-payments for common procedures which benefit older people both personally but also with major societal economic and health benefit in terms of reducing need for care in the longer term such as hip replacement[10] and cataract operations. These can be seen as barriers to access, or else selective financial penalization, of older people and contrary to the principle of community rating and risk equalization. Of 262 plans open to public access on the HIA website, this reduces to 98 with full orthopaedic and ophthalmic cover, reducing further

to 59 at the average premium of €2,000 (approximating to the average premium of €2,059) noted in the 2019 HIA survey[11]. This is almost certainly linked with the over-60's, due to this combined effect of targeted product features and the difference in premiums for different products, paying premiums that are on average 30% higher than the premiums paid by those under the age of 60 for the most popular levels of cover[12]. **We recommend that co-payment for orthopaedic and ophthalmic procedures should be prohibited as undermining the spirit and practice of community rating and risk equalization.**

d) The excessive multiplicity of several hundred schemes, vague explanatory notes (ie, as per HIA website: "Cover for certain orthopaedic procedures in select private hospitals. Monetary excess may apply"), and the lack of a simple and comprehensive matrix for comparison in the complex nature of healthcare provision, is a real danger in terms of the choice overload hypothesis, whereby increasing provider choice in markets reduces peoples' motivation to switch away from poor performing services. In turn, this may lead to a situation where citizens become locked-in to a suboptimal provider simply due to an overload of choices[13]. It is not surprising that only just over one-third of a representative sample of the population believe that consumers are adequately protected in the Irish health insurance market[11]. **We recommend a reduction of plan options to under 10 to allow for simplification for what is included and the facilitation of choice made on open and transparent decision-making.**

e) Much advertising for health insurance clearly directs towards younger consumers, such as plans including children for 'free', and inducements towards sports membership directed towards younger subscribers, thereby tending to undermine the ethos of community rating and risk equalization. While clearly supporting effective and evidence-based strategies for preventive intervention in private health insurance, **we recommend that the HIA review all advertising to monitor for, and guard against, elements which would appear to favour younger subscribers over a life-span approach to subscribing to health insurance**.

On behalf of the ISPGM

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