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Erroneous, blurred, and mistaken—comments on the care need index

Sundquist et al present a care need index for allocation of primary health care resources. Unfortunately, their paper rests on an erroneous description of the allocation model presently used in Stockholm, a blurred conception of need, and a mistake in the handling of data.

The model used by Stockholm County Council to distribute funds between areas to purchase health care consists of four different components: (1) hospital based care, (2) private specialist care, (3) primary health care, and (4) pharmaceutical drugs. The primary health care model gives extra weight to neighbourhoods with high proportions of low income earners, immigrants, and single persons; and according to the proportion under 16 and over 64 years as they use primary health care more. This approach is as likely to capture health care needs in the population as the care need index (CNI) model, and it is not based on prior health care utilisation as suggested by Sundquist et al.

In the CNI model “need” is defined on the basis of pre-defined indicators that general practitioners have weighted according to their impact on GP’s waiting room. Models of health care utilisation usually differentiate between need and demand, as the probabilities to show up in the GP’s waiting room differ between persons and social groups, given the same need. GP’s experienced workload, however, is only affected by the patients in the waiting room; thus the theoretical basis for the CNI is demand rather than need.

The empirical analyses are based on the annual surveys of living conditions. In these surveys the number of response alternatives to the self rated health question was changed from three to five in 1996, but the authors seem to be unaware of this. We have indeed noticed that the number of response alternatives to the self rated health question was changed from three to five in 1996 and have accounted for this in our study. The dichotomisation was performed as follows: Before 1996: Those who answered that their general health was bad or something in between were considered as having poor self rated health. Those who answered that their general health was good were considered as having a good self rated health. After 1996: Those who answered that their general health was bad, bad or fair were considered as having a poor self rated health. Those who answered that their general health was good or good enough were considered as having good self rated health. If the response alternatives had been dichotomised as they claim, the associations would have been much weaker or even disappeared.

Finally, Burström and Lundberg have referred to an article that was not published when we submitted our article.1 We agree that there are many other needs based capitalisation formulas. However, one of the advantages of CNI (the Swedish UPA score) is the extensive documentation of CNI and different health aspects, such as utilisation of psychiatric hospital care, sales of tranquillisers and analgesics, as well as unhealthy lifestyle factors that reflect an increased need for preventive efforts within primary health care and incidence of coronary heart disease.5 In addition, every county in Sweden is free to choose an appropriate tool for the allocation of primary healthcare resources. In accordance with our findings we conclude that CNI constitutes one such appropriate tool, based on the health care need in the population.

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References


Authors’ reply

Burström and Lundberg claim that our article rests on (1) an erroneous description of the allocation model presently used in Stockholm, (2) a blurred conception of need, and (3) a mistake in the handling of the data.

We apologise for the somewhat erroneous description of the present Stockholm model, although we believe that the allocation model presently used in Stockholm has several weaknesses. Burström and Lundberg declare that the present Stockholm model gives extra weight to neighbourhoods with high proportions of low income earners, immigrants, and single persons; and according to the proportion under 16 and over 64 years as they use primary health care more. This approach is as likely to capture health care needs in the population as the care need index (CNI) model, and it is not based on prior health care utilisation as suggested by Sundquist et al.

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Donabedian was one of the first and the most well known of proponents of quality assurance. His “structure, process and outcome” model is part of healthcare language, used beyond those working in the field in quality field. Two strengths of the book are that it is easily understood and provides useful practical advice to practitioners and others in both the west and developing countries. Although Donabedian is right that the “fundamentals do not often change” and that “the new is ... mostly a continuation of the old”, there are more recent ideas that are missing in this book that would be useful to its readership: particularly the simple improvement models now in common use in the west, as well as discussion of theories and examples of how to get change—one of the most important issues in quality improvement, but only covered in one chapter of the book.

The book defines quality and quality assurance in health care, and describes the components of quality assurance. The main strength of the book is a practical exposition of how to do and use monitoring of quality and performance, covering pages 29–122, about 80% of the book, with appendices to help. Simple does not mean simplistic and Donabedian has avoided tackling difficult subjects in this book. One example of this is his clear short presentation of statistical process control—a subject baffling for many beginners, and others. Like many other difficult ideas, it can be only partly explained by an expert who has taught it many times yet still understands the difficulties of the beginner.

Readers across the world and especially those needing an easy and practical introduction to the subject will find this an invaluable book. Many experts would also enjoy the read, and find in it lessons about how to communicate in an unpretentious way. A fitting posthumous publication from a master in the subject, showing the relevance of quality assurance to all types of health care. A way must be found to publish a version at one third of the price.

John Øvretveit

Social reinsurance. A new approach to sustainable community health financing


Financing the health care needs of rural and informal sector workers in low and middle income countries has always been a great challenge for policy makers in these countries. Because of government and market failure in order to move towards a way of health care that do not work well and 1.3 billion poor people must rely on out of pocket expenditures to pay for the slight health care that they receive.

This book looks into community based microinsurance schemes to overcome the problems of financing health care for informal workers in these countries. Their central idea is to enhance existing community institutions to organise access to basic health care for the at risk populations along the lines of microinsurance. Because each of these institutions will only cover a small group of people, the authors emphasise the importance of reinsurance to enhance the overall health care and spread the risks across populations. The role of the government is to subsidise and regulate these microinsurance schemes.

The volume is a compilation of 22 articles by different authors and it comprehensively covers all of the issues related to community based microinsurance schemes in low and middle income countries. The volume is divided into four parts. The first part is devoted to the challenges facing community based microinsurance schemes in these countries, the second part analyses the theory behind insurance, microinsurance, and reinsurance, the third part is devoted to issues related to the implementation of community based microinsurance schemes, and the fourth part describes a pilot programme in the Philippines.

In summary, this volume is a very valuable contribution to the discussion regarding access to health care and financing in poor and middle income countries. I highly recommend this book to any reader interested in health financing policies in developing countries.

Gabriel A Picone