Social reinsurance. A new approach to sustainable community health financing

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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 allocate 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 a set of pre-defined indicators that general practitioners have weighted according to their impact on GP work load. 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 treat this as if there were three response alternatives throughout the period. As a consequence those with “good” health have been counted as ill in a third of the sample. This will cause the illness prevalence for 1996–97 to be overestimated and introduces a bias in the relation between health and other variables.

The main practical consequence of applying the CNI rather than the existing model would be to “take from the poor to give to the poor”. Although the SS area is more deprived than the SW area according to the CNI a reallocation from the first to the second is suggested. There must be more useful tools for allocation of primary care resources.

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References


Authors’ reply

Burstrom 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. Burstrom and Lundberg declare that the present Stockholm model gives extra weight to neighbourhoods with high proportions of low income earners and immigrants. However, they define low income earners as men (women are not included) in the three lowest income quartiles and have not justified the reason for this broad definition of low income earners. In addition, immigrants are defined as foreign born people from all other countries in the world in contrast with Swedish born people. However, many immigrants in Sweden were born in western countries and have a similar health status to Swedish born people. Although we agree that the present model is not based on prior health care utilisation it is based on morbidity, defined as proportions of people with long term sick leave >30 days, which we have assumed to be taken from prior healthcare registers. They also claim the conception of need in care need index (CNI) is blurred. We do not agree with that statement. CNI as well as UPA score include need based items in their modelling of the allocation of healthcare resources. These instruments for allocating resources to primary health care have defined “need” according to the higher need for health care among a certain group in the society. CNI includes weighted neighbourhood proportions of a total seven different demographic and socioeconomic items, such as people with low educational status, foreign born people from non-western countries, and single parents. Our article also shows a strong relation between CNI and self rated health, which is a good proxy for health care need in the population. Previous studies of CNI (13 original articles and two theses) have demonstrated a significant relation between CNI and different health outcomes, all relevant for primary health care.

The documentation of the present Stockholm model is not that substantial. In addition, in their critique, statements about the GPS’ experienced workload and the GPS’ waiting room are included even though none of them are working as GPS. In contrast, three out of the authors of our paper were working as specialists in family medicine.

We do not understand what underlies their statement that we were mistaken in the dichotomisation of the outcome variable. 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 health status. After 1996: Those who answered that their general health was very bad, bad, or fair were considered as having a poor self rated health. Those who answered that their general health was good or very good 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, Burstrom and Lundberg have referred to an article that was not published when we submitted our article. We agree that there are many other needs based capitation formulas. However, one of the advantages of CNI (for 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, unhealthy lifestyle factors that reflect an increased need for preventive efforts within primary health care and incidence of coronary heart disease. 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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An introduction to quality assurance in health care


This book is not for experts in quality assurance—in fact it was written with the “student of the subject in my native Armenia” in mind, although not priced with them in mind at a hefty £27.50. It is a conveniently readable book that many beginners everywhere will find to be a comparatively painless introduction to one approach to quality improvement. 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 and of the arguments in the current debate among health economists with regard to “welfarism” compared with “extra welfarism”. While I naturally agree with the existence of limits in the application of welfare theory, it has to be recognised that welfarism, which finds its theoretical foundation in welfare economics, shares a number of these limitations and is based on the hypothesis that health interventions only affect health and not other aspects of wellbeing. So I regret that the demise was not more clearly (and impartially) exposed. Whatever, this book represents a good contribution that could be a starting point for reflection in order to move beyond the eliciting preferences to help resources allocation decision in health care. This is a relevant book that I recommend to economics students or general economists who are newly interested to physicians and public health workers as well as our health economics colleagues.

Christel Protiere

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 failures in order to move to a way of sustainable community health care do not work well and 1.3 billion poor people must rely on out of pocket expenditures to pay for the little 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 enlarge the risk pool 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 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.

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