Reviewer's report

Title: Priority Setting in Primary Health Care - Dilemmas and Opportunities: A Focus Group Study

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Reviewer: Sabrina Wong

Reviewer's report:

This is an interesting manuscript that discusses the priority setting within the primary healthcare (PHC) context in Sweden. The objective of the study was to examine family physicians and nurses perceptions of using three key priority setting criteria: the severity of the condition, expected patient benefit, and cost effectiveness. Overall, based on what data were collected, the analysis could be richer that what is reported in this manuscript. In addition, stronger links need to be made between using priority setting amongst clinicians providing direct care within the context of PHC. While the authors suggest priority setting has been limited to use in the acute care setting, these methods have been used at the organization and health authority level to strategize where they should place their efforts and resources. It is not clear what the utility would be of using priority setting in informing direct patient care—typically we want providers to do what they have expertise to do—provide healthcare services, preferably based on guidelines. It’s not clear we would want providers explicitly using a priority setting process in delivery of care. Values about what is considered cost effective have typically been set at the organization or health authority level (e.g. using generic drugs) with input from evidence-based guidelines.

Comments for each section:

Background:

- A definition or explanation of what the authors mean by priority setting would be helpful, especially if the target audience is supposed to be providers working in PHC

- It is not clear the link between the Swedish Parliament principles and the key priority setting criteria used in clinical practice. How does the human dignity principle relate to severity of condition or cost-effectiveness: “In Sweden three such principles were adopted by the Swedish Parliament in 1997: 1) the human dignity principle, 2) the needs and solidarity principle, 3) the cost effectiveness principle (3). These principles constitute the basis of the three key priority setting criteria used in the Swedish national guidelines for clinical practice: 1) severity of the health condition, 2) patient benefit, 3) cost-effectiveness of the medical intervention”

- There may be few examples of priority setting in PHC, but more literature about what we know about the area of priority setting would be helpful—see also work
by C. Mitton and colleagues.

-One of the gaps perhaps, in priority setting, is the notion that this should be taking place at the provider-patient level. More rationale as to why providers should be engaged in priority setting at the patient level is needed. National guidelines for clinical practice can serve to influence how organizations and health authority behavior. But suggesting that providers, who have little to no training in economics, should use the criteria of cost-effectiveness in delivering PHC needs more explanation. Some discussion is also needed as to how providers are reimbursed—in Canada, most physicians are reimbursed using a fee-for-service model—so this is the strongest driver of their behavior, they are not necessarily going to think about whether the medical intervention is cost-effective if it means less income to them.

Methods:

- How is this study related to the earlier study?

-If it is related to the earlier study, more explanation is needed. Were providers asked to fill out a questionnaire on each of the 4,300 patient contacts? “In the earlier study, which included 4,300 patient contacts over 2 weeks, the GPs and the nurses answered a questionnaire where they used the three key priority setting criteria and estimated the severity of the health condition, expected patient benefit and the cost-effectiveness of the planned intervention.” How were the health centres chosen?

-If the method was focus groups, then discuss the number of focus groups—looks like 8 focus groups were conducted?

- More information is needed about the analytic strategy. What exactly is involved in an editing analysis? What was the theoretical lens that informed your analysis (or was there one?)?

- Please discuss the trustworthiness, etc of the data. Did you go back to the participants to understand if you interpreted the data correctly?

- Typically for a qualitative study, one would describe the characteristics of the sample within the methods section—this needs to be added (positions, locations, gender, age, years of experience, etc).

- Given that the focus groups were split by GP (n=4?) and nurses and also by rural (n=4?) and urban, is there a reason why you did not look for similarities and differences across these groups?

Results:

- More explanation is needed about the statement, “The staff also found that using the key priority setting criteria stimulated systematic thinking rather than intuitive.” It’s not clear from the quote how their thinking is more systematic.....?

- Some key quotes in the results section would help the reader see the points you are trying to make; the tables should contain extra quotes and the reader should be able to read the tables as a stand alone document. Currently, the tables have little explanation as to how to read them and the results section makes little
sense without any quotes. For example, it seems that taking into consideration a patient’s viewpoint is completely separate from the point of a patient’s satisfaction. It may be that you need to reframe the three additional dimensions based on the three criteria (benefit, cost-effectiveness, and severity of health condition).

-please number the participants within each focus group. This will help show the readers that now all the quotes came from the same focus group or from the same participant.

Discussion:

- Based on what this reviewer has already written, it’s no surprise that providers did not find the three key priority setting criteria sufficient in helping them make decisions about provision of health services.

- It seems that what you have found is that what is relevant to priority setting differs depending on different levels. For example, organizational criteria for priority setting is likely going to be different than national criteria and individual-level provider criteria.

- These are no so much three additional criteria. Rather, these are different criteria based on provider’s perspectives.

- The first paragraph can be integrated into the results section. The second paragraph can be integrated into the methods section. Seems like the discussion really starts with “Although some GPs did not consider the patient’s view….”

- Evidence-based medicine is a new concept that is introduced in the discussion…..if you want to talk about this, this needs to be woven throughout the manuscript. Otherwise, it seems to come out of the blue for the reader

- The discussion will likely be completely different based on a richer deeper analysis.

**Level of interest:** An article whose findings are important to those with closely related research interests

**Quality of written English:** Not suitable for publication unless extensively edited

**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**

I declare that I have no competing interests