Author's response to reviews

Title: The European Primary Care Monitor: structure, process and outcome indicators

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Author's response to reviews: see over
We thank the reviewers for their valuable comments. We carefully changed the text as advised by the reviewers. In this document the authors notes per reviewer comment are presented.

We aim to submit this Manuscript for publication as a Research Article in BMC Family Practice.

Looking forward to hearing from you,
on behalf of the other authors,

Sincerely,
Dionne Kringos

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<td>1 (Reviewer 1)</td>
<td>I think that the authors need to define the scope of primary care. Otherwise, an indicator like GOV4 (Do formal requirements exist for physicians to work in primary care) is difficult to interpret.</td>
<td>The first sentence of the background defines the scope of primary care as we use it in this paper and in the indicator list: “Primary care is the first level of professional care in Europe where people present their health problems and where the majority of the population’s curative and preventive health needs are satisfied”. Where appropriate, this has been further specified with relevant indicators. For example, related to the Workforce development indicator WFD1 “Type of PC professionals”, we define them as directly accessible health care providers (no referral needed). However, to clarify this from the start of the indicator list, we have added a footnote to Additional file 1, repeating this definition. Even without having read the full text, readers more easily become aware of it.</td>
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<td>2 (Reviewer 1)</td>
<td>I will however make a couple of comments on the indicators themselves which may be helpful to the authors (even though this may be slightly outside the remit of the review requested). <em>First, I think they have made a mistake in the category ‘Economic</em></td>
<td>These are some very useful points that we will take on board for the continuation of the project, particularly when we evaluate the instrument after data collection has been completed. Although, indeed, these comments have no direct consequence for the content of this paper, we would like to shortly comment on them in this place:</td>
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conditions of the PC system'. The authors may not want to change it since it's the categorisation they've already published. However it is confusing and does not obviously mean anything to the unprepared reader. It includes two elements: funding of primary care (ECO1-ECO2) and remuneration / income of primary care physicians (ECO3-ECO5). The framework would be much clearer if this domain were renamed ‘Primary care funding’ and indicators ECO3-ECO5 were moved into PC Workforce development, which already includes issues like annual income of GPs (WFD2.2).

Second, there are some indicators which look unsatisfactory. There are not many, but I give two examples: WFD2.3. “Which % of all medical graduates (should be ‘what’ percentage) choose to enrol in postgraduate training in general practice”. It’s unclear if this means at graduation, at any stage in their career etc. Without further refinement, this indicator will be very difficult to answer.

Some ‘indicators’ are not really indicators in the strict sense of the word, they would be better termed descriptors – e.g. ECO4.1 “How are salaried GPs paid: flat salary / salary related to number of patients etc”.

I was very surprised that patient experience does not figure in the framework. There are some indicators which require patients’ views to be assessed (e.g. ACC4.2 and ACC5.1 on affordability and access) but nothing about inter-personal communication. This is a very surprising omission. Almost all frameworks of quality in primary care include communication, and there are well developed instruments for measuring patient experience across Europe.

However, as I said before, to the extent that this paper describes the process of developing indicators, the paper cannot perhaps be criticised for the indicators themselves. In general, they are OK.

- Discussions are possible indeed about titles of dimensions and the ordering of indicators under the dimensions (and both are related). We are inclined to maintain ‘Economic conditions of the PC system’ instead of the more simple title ‘Primary care funding’ because, in addition to the funding and remuneration / income this dimension also includes employment status and patient coverage for primary care services. We have avoided to duplicate indicators that could belong to more than one dimension. We attempted to arrive at a comprehensive set of indicators covering all relevant fields and we realise that their ordering will stay arbitrary at some points.
- Indicator WFD2.3 is intended to be measured within 1 year after graduation, in the most recent year for which data are available. This has been adapted (We also changed ‘which’ for ‘what’).
- We agree that it may be difficult to give a meaning to answers. We learn that some results should be used with care, and perhaps only for descriptive purposes.
- We fully recognise patient views as important indicators of health care performance and we have included a (limited) number of items related to patients’ experiences. (In addition to the ones mentioned by the reviewer we would like to point to CON3.2 asking about the doctor-patient relationship; available time; trust; giving information). These indicators are the ones we found to be most commonly used in international comparisons. More specific items on patient experiences used in national studies appear to be not suitable for international comparisons.

(Reviewer 2)

The first sentence in the abstract should include the word "primary care", then add what is missing prior to making the case that there is a lack of information.

We have added 2 sentences to the start of the abstract prior to making the case that there is a lack of information, stating: “Scientific research has provided evidence on benefits of well developed primary care systems. The relevance of some of this research for the European situation is limited."
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<td>4</td>
<td>(Reviewer 2)</td>
<td>The PHAMEU is an important concept but obscures that you have developed a monitoring process. A Monitor and the use of the word &quot;monitor&quot; escaped me until I realized you had developed a monitoring system. Such is the nature of English but others may find this noun and verb use as confusing as I did. (We, non-natives, gratefully use the English language, but details of its nature sometimes have escaped) We have clarified this in the abstract and in the main text by changing the aim of the paper. We now speak of developing a primary care monitoring system and assume that, for practical reasons, this can still be abbreviated as ‘PC Monitor’ in the paper. For example, the main text now states: “This set of indicators and its underlying structure of dimensions and features will be referred to as the Primary Care Monitoring System (in short: PC Monitor).”</td>
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<td>5</td>
<td>(Reviewer 2)</td>
<td>It was not clear to me why you limited the literature between 2003-mid 2008. I suggest one short sentence justifying the time span. For this literature review a period of 5 years was selected for two reasons: 1) As a consequence of our search strategy 30% of included studies were literature reviews. We assumed that key primary care studies published before 2003 would included in these literature reviews. 2) We have tested the use of different time intervals. For instance, a 10 year time period review in MEDLINE and PUBMED resulted in 51,046 articles on primary health care OR family medicine OR general practice. Co-authors and experts involved in the study jointly concluded that a 5 year search period would be both feasible and relevant. We have added a sentence to the main text explaining this: “For practical reasons, such as time and financial constraints, the review was limited to this 5 year period.”</td>
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<td>6</td>
<td>(Reviewer 2)</td>
<td>Equity in health needs a one sentence definition. The authors are reaching across many countries and not having a definition may produce some ambiguity or misunderstanding. We have added the definition: “Equity in health is the absence of systematic and potentially remediable differences in health status across population groups.”</td>
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<td>7</td>
<td>(Reviewer 2)</td>
<td>Should the Results Section include the number of papers identified for inclusion in the systematic review? Even though the review was not the result of this paper, for clarification we have added the total number of papers identified to the results section: “On the basis of the systematic literature review (which included 85 publications) a provisional set of 55 features and 864 provisional indicators were collected.”</td>
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<td>8</td>
<td>(Reviewer 2)</td>
<td>Conclusion: I suggest a better conclusion statement than stating the obvious - what you developed. This is a dynamic system created for widespread use and has enormous potential to improve an international understanding of care delivery. Perhaps if you state that comparing and contrasting health care resources across countries provides opportunities to enrich nations in decision making. We appreciate the suggestion and rephrased the conclusion (in the abstract and main text). The main text now concludes: “Based on scientific evidence and consensus among experts, an instrument for standardised description and comparison of primary care systems has been developed. Implementation of the instrument in the configurations of primary care in Europe will show the feasibility for producing comparable information. Widespread use of the instrument has the potential to improve the understanding of primary care delivery in different national contexts and thus to create opportunities for better decision making.”</td>
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