Reviewer's report

Title: Setting priorities in primary health care - on whose conditions? A questionnaire study

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The authors address an actual and relevant question: who and how are patients & disease states who/which are seen as high priority in general practice by doctors, nurses and themselves?

The critical point is: does the study and/or the manuscript answer the question.

The study has some relevant limitations.

The data refer to 2004 – and the authors state correctly (p. 4): “However, values in society and in health care are changing worldwide.” 2004 was the year when the very first priority list (on cardiac care) was introduced in Sweden. By the way: the final report of the Swedish Parliamentary Commission was published in 1995, not 1997 (p. 3). Since then, the process of prioritisation has gained there more and more momentum and more than a dozen guidelines have been published so far. In some counties/regions they now seem to be used as tools for hard rationing. They all prioritise condition-treatment pairs, not individual patients or disease states.

No data on the quality of the questionnaires seem to be available. Was there no qualitative and quantitative pretesting?

The questionnaires obviously did not use all relevant criteria/variables of the Swedish model of prioritisation: at least 6 separate items reflecting severity (present/future symptoms, functional capacity, quality of life) were collapsed into a single trichotomous variable, which additionally impairs the precision of point estimates of measures of occurrence and association. Neither burdens and risks of interventions were included nor the quality of any relevant evidence relating to all other criteria.
It would be interesting to read the exact wording of the question addressing the overall priority of a patient. It could help to understand the authors’ concept of “priority” (Spicker 2009).

The number and proportion (48%) of complete data sets is low compared to the overall number of registered patients. It is further reduced where and when only two disease subgroups are analysed (are little more than 600 data sets?). A non-response analysis is mentioned – its range seems limited though GPs’ registers usually cover much more relevant data than age and gender.

In summary: an interesting and relevant question – and some important and credible answers – on a comparatively weak study and data (and analysis) basis.