Reviewer’s report

Title: Facilitating Factors for Achieving Clinical Integration: A comparative study of Kaiser Permanente, Northern California and the Danish Healthcare System

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Reviewer: Ingvar Karlberg

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Re.

In this study evidence is collected to test the hypothesis that clinical integration is good – for several reasons. Assessments of the two systems studied indicate that the KPNC is more effective and efficient than the DHS and that this is partly due to a higher level of clinical integration. Among other factors mentioned are incentives.

The comparison is based on questions to primary care clinicians in KPNC and general practitioners in DHS. What then is primary care (clinicians) in KPNC? “A typical patient in need of primary care … will in KPNC be treated and cared for in an out-patient medical centre. The medical centre will have all necessary primary care facilities available, including paediatricians, internal medicine physicians, geriatricians, specialists (of what? my question), nurse practitioners, nurses, health educators, administrative personnel, a pharmacy, and an emergency department.”

In the Nordic countries and in the UK this is a hospital (there are several hospitals for day-surgery without beds) or part of a hospital, and certainly not a primary care centre. In some countries free-standing medical centers like the ones described from the KPNC cannot for legal reasons be part of a hospital e.g. Russia. In other countries there are few if any such separate policlinics. It is obvious that in contrast, in the KPNC such an all-inclusive facility without beds is called a primary care centre.

In the WHO “World Health Report 2008 – primary care: now more than ever”, the definition of primary health care (PHC) is, “health care provided by family practitioner (FPs), specialist in general medicine. The new primary care model entails a far more strategic role. Needs assessment, strategic planning, health promotion, disease prevention, community based health care and specialized nursing service.”

“Specialty care is the pride of the American health-care system. In fact, it dominates the system: only about a third of all physicians in the United States are primary-care physicians, compared with roughly half in most other industrialized countries. Yet the overall health of Americans is relatively poor. “ This statement by Barbara Starfield focuses on the notion that a policlinic with
several specialists cannot be turned into a primary care centre just by its label.

What about primary care in the DHS? According to the Euro Survey, the Danish people used to be very fond of their general practitioners working as family practitioners. The affection for the system may have deteriorated during the last couple of years; however, people still like the Danish GPs, even if their tasks and positions in the system are very different from the primary care clinicians in the KPNC.

Apart from the fundamental basic discrepancies between the two “primary care” providers are there other differences that will confound the study? Yes, certainly. In the KPNC it seems from the description in the paper that cooperation and integration between the medical centers and other parts of the KPNC are built into the system and supported by strong (i.a. financial) incentives. On the other hand, it seems as if GPs in the DHS have a more or less perceptible gate-keeping function, and although this is a one-payer system, there seems to be no incentives to support transfer of patients or information between the layers of the system. On the contrary, this division seems to be desirable. In conclusion, the statement in the paper is incorrect that “In Denmark the comparable profession to KPNC’s primary care clinicians is GPs.” (3.2).

It seems reasonable to assume that information, responsibilities and coordination are the key elements for integration. It also seems reasonable that these criteria were viewed differently by the respondents from different settings respectively. Whether this supports the basic hypotheses is more uncertain.

In this study response alternatives to statements and questions on qualitative variables are ordered in Likert scales. Such data are called qualitative or non-numerical. Numbers or letters can label the categories, not valuate. The numerical category label represents only a categorical ordering, not the distance between categories, and this restricts the application of common mathematical and statistical methods of analysis. These rank-invariant properties of ordinal categorical data are well recognised, and arithmetic operations are not appropriate for such data. (Mebertz et al “Ordinal scales and foundation of misinference” Arch Phys Med Rehab, 70,308-12,1989. Coste et al “Methodological and statistical problems in the construction of composite measurement scales” Stat in Medicine, 14,331-45,1995. Svenson “Ordinal invariant measures for individual and group changes in ordered categorical data” Stat in Medicine, 17, 2923-36, 1998. See also textbooks such as Everett, “Statistical methods for medical investigations”. Edward Arnold, London, 1994 and Siegel, “Nonparametric statistics for behavioural sciences” McGraw Hill, New York, 1988.).

For HIT it is unclear how data were handled. It is stated that “HIT was measured on an ordinal scale ...and treated as a continuous variable.” On the other hand it seems as if frequencies were used.

It is not acceptable to publish papers based on such easily preventable basic flaws.

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

**Quality of written English:** Acceptable

**Statistical review:** Yes, and I have assessed the statistics in my report.

**Declaration of competing interests:**

I declare that I have no competing interests