Author’s response to reviews

Title: The effects of gatekeeping on the quality of primary care in Guangdong Province, China: A cross-sectional study using Primary Care Assessment Tool-Adult Edition

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Version: 1 Date: 17 May 2019

Author’s response to reviews:

Dear Editor Donnelly and Reviewers:

Thank you for your letter and for the reviewers’ comments concerning our manuscript entitled “The effects of gatekeeping on the quality of primary care in Guangdong Province, China: A cross-sectional study using Primary Care Assessment Tool-Adult Edition” (FAMP-D-18-00318). Those comments are all valuable and very helpful for revising and improving our paper. We have carefully responded to the reviewers’ comments and fully revised our manuscript with point-to-point response detailed below. All authors have read the revised manuscript and approved it for publication and authorship. All changes to the manuscript are indicated in the text by using track changes. Hope these will make it more acceptable for publication. Further, as recommended by the editor, proofreading was performed by English-language editing service Editage.

Thank again for your consideration of our manuscript for publication.

Yours sincerely,

Li Kuang, on behalf of all authors

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Comments from the editors and reviewers:

Reviewer #1:

Thank you for the opportunity to review an interesting paper on 'The effects of gatekeeping on the quality of primary care'. Overall the paper provides an important contribution to the literature. However in general the paper needs to be grounded further in the international literature. Specific suggestions by section are outlined below:

Abstract

1. Please provide a brief definition of gatekeeping in the abstract.

Response:

We thank the editor for the suggestion and we have added relevant definition of gatekeeping in the abstract section (Lines 16-19, Page 1).

2. All the confounding factors observed between the gatekeeping and non-gatekeeping groups were balanced. The PCAT mean score was a little higher in gatekeeping group (1.98>1.93, p>0.05) but without statistical difference.

I would not begin results with a non-significant finding.

Please limit the use of acronyms in the abstract

Response:

Many thanks for your comments. We have put the negative finding at the end of results section (Lines 39-41, Page 2) and reduced use of abbreviations in the abstract.

Introduction

3. Page 3 line 55 "many developed countries have adopt - please correct tense.

Response:
Thanks for your correction. We have revised our sentences and changed our sentence to: “Many developed countries have adopted the policy of gatekeeping and it has been implemented widely in countries such as the United Kingdom and Switzerland.” (Lines 59-60, Page 3)

4. Page 4 line China announced a healthcare reform plan officially please rephrase to China officially announced a healthcare reform plan

Response:

Thanks for your correction. We have now corrected “China announced a healthcare reform plan officially” as “China officially announced the Instruction of the CPC Central Committee and State Council on Deepening the Reform of the Medical and Health Care System” in the revised version (Lines 74-75, Page 4).

5. Page 5 Line 88 rephrase to These were both developed cities

Response:

Thanks for your comments. We have changed our sentence to: “These were both developed cities” (Lines 93, Page 5).

Methods

6. Page 8 Lines 157-158 Those who had very poor physical or mental health, and who had trouble understanding the questionnaire were excluded. Please provide further detail as to what constitutes poor physical or mental health

Response:

To avoid any confusion, we have added more details about the exclusion criterion of participants in the Method section in the revised manuscript “The exclusion criteria were as follows: (1) those who were in poor physical condition and could not complete the questionnaire; and (2) those who had trouble understanding the questionnaire.” (Lines 162-164, Page 8).

Results

7. Please provide axes labels for figures

Response:

We thank the reviewer for the suggestion and we have added axes labels for Figure 1. The horizontal axis is number, and the vertical axis is propensity score in Figure 1.

8. Please provide further description for Figure 3
Response:

Thanks for your suggestions. For better understanding, we have now added more detailed description for Figure 3 in the Results section in the revised manuscript (Lines 288-300, Page 15-16). The specific contents are as follows: The radar chart shown in Figure 3 provides more detail about the scores of primary care attributes reported by the gatekeeping and non-gatekeeping participants before and after PSM. The score gap between the two groups is clear in each domain. Figure 3 exhibits a large gap between the two groups in the domain of first-contact utilisation before matching. Before matching, we found that the non-gatekeeping group obviously higher scores in the domain of accessibility, family centeredness and community orientation. There were no differences in the domains of continuity, comprehensiveness, coordination and cultural competence. After matching, the largest difference was also in the domain of first-contact utilisation. Those in the gatekeeping group reported higher scores in the domains of continuity and coordination. The scores of family centeredness and community orientation between the two groups became closer so that there appeared to be no difference. The other domains showed a similar pattern to that before matching.

9. Figure 2 should actually be labelled as a Table. Please provide an appropriate title.

Response:

We agree with reviewer. We have split Figure 2 into Table 2 and a new version of Figure 2 (Lines 280-286, Page 15).

10. Please provide reliability and validity information for the PCAT-AE

Response:

Thank you for the suggestion and we have cited prior study that validated Chinese version of PCAT. We have added more explanation of the reliability and validity information for the PCAT-AE here. The specific content is: The PCAT-AE is an instrument with good reliability and validity in China (1-3). The accumulative variance is 58.91% and the overall Cronbach’s α is 0.74 (1) (Lines 182-184, Page 9).

Discussion

11. Gatekeeping group had lower scores in the domain of accessibility and continuity. Why do you believe this is so?

Response:

We thank the reviewer for this insightful suggestion. We have added more discussions in this section (Lines 332-378, Page 17-20). The shortage of GPs and the patients calling system indeed have effects on both two groups so that the score of accessibility and continuity in the gatekeeping group probably are not going to be higher than the non-gatekeeping group. Because
of the implementation of the compulsory gatekeeping policy, patients in the gatekeeping group should visit CHCs first whether the CHCs are convenient for them or not. Conversely, patients in the non-gatekeeping group were free to choose facilities, so they visited the CHCs when they though CHCs would be satisfactory and convenient for them. Studies have shown that countries with a gatekeeping policy had an average longer wait of days for an appointment than those without, due to the limited supply of physicians(4, 5). Li’s study suggested that patients with gatekeepers were less satisfied with waiting times than those without gatekeepers(6). Another explanation is that patients under gatekeeping were more likely to expect shorter waiting time, so they tended to exaggerate the waiting time according to the investigation on site.

In addition, studies revealed that a longer waiting time and lack of after-hours care were associated with lower levels of continuity(7). Halm(8), Grumbach(9), and Shi(10) pointed out that the negative effect of gatekeeping was probably related to perceived adverse influences on the physician-patient relationship. They suggested that gatekeepers undermined patients’ trust and confidence because of impeding access to specialists. What have been discussed above may explain why the gatekeeping group scored lower than the non-gatekeeping group in the domain of accessibility and continuity.

12. Page 17 line 344 please provide reference for person-based service model.

Response:

We are sorry for any confusion. Person-based service model should be corrected as patient-centred service model(11). As suggested, we have added the reference for patient-centered service model in the Discussion section (Lines 384, Page 20).

13. There are many explanations for results not based on literature. The discussion would benefit from more reference to international research.

Response:

We thank the reviewer for the recommendation. We have added more references in the revised manuscript to support our study. Those studies are very valuable to us. More details please refer to Discussion section.

14. Conclusion needs further elaboration.

Response:

Thank you for the suggestion. We have added the following clarification in the manuscript. The specific contents are as follows: Our study demonstrated that gatekeeping had improved first-contact utilisation and coordination, which provides a basis for policymakers to promote the implementation of the gatekeeping system. Other goals of the policy, however, such as accessibility and continuity have not yet been achieved. To establish a sustainable gatekeeping system and to strengthen the core functions of the community comprehensively, the current gatekeeping system of primary care service needs refinement. The government should vigorously
promote first contact, perfect the system of gatekeeping, establish supporting policies and measures, which must also be adaptable and anticipatory of future requirements and strengthen the construction of primary care and the community public service functions. The government should also give more support through resources. (Lines 422-432, Page 22).

Special thanks to you for your comments.

Reviewer #2:

1. We divided the participants into two groups (gatekeeping and non-gatekeeping) according to their type of insurance. (Line 195)

How did the authors divide the participants into two groups? The methods or standard for category should be explained in details.

Response:

Thanks for your suggestions. We have added the details in the Methods. The specific contents are as follows: The regulations of medical insurance in Shenzhen require residents with type II and type III insurance to be subject to the gatekeeping group. Those with other insurance or no insurance were subject to non-gatekeeping group. According to the reimbursement standard in Dongguan, those with Urban Resident Basic Medical Insurance were the gatekeeping group. Those with Urban Employee Basic Medical Insurance or no insurance were the non-gatekeeping group. (Lines 203-208, Page 10).

2. in the discussion section, why did the participants in gatekeeping group have lower scores in the domain of accessibility and continuity? Please explain the reason for this phenomenon. At present, the listed reasons for this phenomenon (such as shortage of GP, patients calling system) have effects on both the gatekeeping and non-gatekeeping group.

Response:

We thank the reviewer for this insightful suggestion. We have added more discussions in this section (Lines 332-378, Page 17-20). The shortage of GPs and the patients calling system indeed have effects on both two groups so that the score of accessibility and continuity in the gatekeeping group probably are not going to be higher than the non-gatekeeping group. Because of the implementation of the compulsory gatekeeping policy, patients in the gatekeeping group should visit CHCs first whether the CHCs are convenient for them or not. Conversely, patients in the non-gatekeeping group were free to choose facilities, so they visited the CHCs when they though CHCs would be satisfactory and convenient for them. Studies have shown that countries with a gatekeeping policy had an average longer wait of days for an appointment than those without, due to the limited supply of physicians(4, 5). Li’s study suggested that patients with gatekeepers were less satisfied with waiting times than those without gatekeepers(6). Another explanation is that patients under gatekeeping were more likely to expect shorter waiting time, so they tended to exaggerate the waiting time according to the investigation on site.
In addition, studies revealed that a longer waiting time and lack of after-hours care were associated with lower levels of continuity(7). Halm(8), Grumbach(9), and Shi(10) pointed out that the negative effect of gatekeeping was probably related to perceived adverse influences on the physician-patient relationship. They suggested that gatekeepers undermined patients’ trust and confidence because of impeding access to specialists. What have been discussed above may explain why the gatekeeping group scored lower than the non-gatekeeping group in the domain of accessibility and continuity.

3. the survey method and results should not be presented in discussion section again.

Response:

Thanks for your comments. We have deleted the descriptions of method and result in the discussion section.

4. there are some places where the use of English could be improved. For example, the setting this investigation was that most CHCs use a 'patients calling system'(Line 330).

Compared to 2000 in Portugal, 1500 in England and 2100 in USA. (Line 317)

Response:

Thank you for your valuable suggestions. We have modified our sentences in the revised manuscript and tried our best to improve the manuscript. For example, we have corrected “the setting this investigation was that most CHCs use a 'patients calling system'” as “in the setting of this investigation, most CHCs use a 'patients calling system'” (Lines 363, Page 19), and “Compared to 2000 in Portugal, 1500 in England and 2100 in USA” as “According to The China Health and Family Planning Statistical Yearbook 2015 (12), each GP was responsible for 7200 inhabitants in Guangdong Province, which can be compared with 2000 in Portugal (13), 1500 in England (14) and 2100 in the USA (15)” (Lines 336-339, Page 18) in the revised version.

These changes will not influence the content and framework of the paper. All changes to the manuscript are indicated in the text by using track changes. We appreciate for editors/reviewers’ warm work earnestly, and hope that the correction will meet with approval.

Once again, thank you very much for your comments and suggestions.

Reference:


