Reviewer’s report

Title: Health service brokerage to improve primary care access for populations experiencing vulnerability or disadvantage: A systematic review and realist synthesis

Version: 0 Date: 24 Oct 2018

Reviewer: Toby Freeman

Reviewer's report:

This paper is on an important topic, and provides a good review and synthesis of studies on brokering primary care. It appears by the tracked changes to have gone through a cycle of peer review already, which I was not a part of. I have kept this in mind while reviewing the paper and offering feedback.

By the end of the article, I thought it had a lot to offer, however, I did have to persevere through a negative reaction to the terminology and framing used. My suggestions to strengthen the paper would be:

1. I acknowledge the new section on the contention around the terminology of vulnerability. However, I still feel the approach of the paper would be greatly served by using phrases such as 'people or populations experiencing vulnerability or disadvantage' rather than 'vulnerable people', or 'marginalised people'. As you state vulnerability is not a characteristic of a person, but is an interaction between characteristics of people and populations, and their environment, and power structures in society. I also think an explicit grounding in a social determinants of health approach would be valuable here to ensure the problem is not located with people experiencing disadvantage or vulnerability - i.e. that some populations experience adverse social determinants arising from how power and resources are distributed, racism, stigma, history of colonisation etc., including racism in health services. At the moment, the paper veers dangerously close to victim blaming in some sections, particularly when "lifestyle risk factors" are raised.

2. The paper concerns primary care. I feel the few references to 'primary health care' - which is a much more comprehensive philosophy - should be deleted.

3. What is meant by advocacy in this paper - is it more individual advocacy rather than collective advocacy that comprehensive primary health care would pursue? A comprehensive primary health care approach could start to address the adverse social determinants for the populations they serve, not just broker access to primary care - there are ACCHOs in Australia that are excellent models for how to go about this. It may be possible
to squeeze in a sentence to this effect in the discussion - that brokering primary care is only one aspect of reducing health inequities.

4. I was interested in the extent to which interventions directed what the health priorities were - trying to support people to be the kind of 'good' health consumers desired by researchers/the health system (e.g. getting screened), versus allowing people to set their own health priorities and goals, and supporting their access to the health system for them to use as they see fit. For me, this is tied up with commonly stated goals of reducing 'avoidable/excessive' ED use - it risks not necessarily empowering citizens, but may be more about controlling healthcare costs by trying to make people use the health system in a particular, cheaper way. When I looked at the table though, it didn't really explain the effective vs non-effective split, so it is probably out of scope for this article, I'm not recommending any particular change here.

5. For this reason, though, I did feel it was a bit muddled in the abstract to talk about overcoming barriers to access to health care while wanting to reduce avoidable ED visits and hospitalisations - especially since brokers often have to go into bat to get people decent access to tertiary care as well. I would suggest removing the reducing avoidable hospitalisations bit from the abstract.

6. Where do accessibility theories fit in here? e.g. Levesque and Harris's (Levesque J-F, Harris MF and Russell G. (2013) Patient-centred access to health care: conceptualising access at the interface of health systems and populations. International Journal for Equity in Health 12: 18.) who I note are involved in this study. I think it would be valuable to locate this study and candidacy theory in this landscape and explain how the authors see the two approaches complementing or connecting. While as you say some theoretical approaches like the transtheoretical model only focus on patient factors, access theories are in some ways the opposite, largely focusing on service factors.

7. I found it strange that candidacy theory, which frames your whole analysis, is not introduced until the results. Even if your use of that theory emerged from the review, I think it would still be a good idea to move it to the intro or methods.

Minor issues:

p. 5 line 95-97: syntax since tracked changes needs to be fixed.

p.10 line 204 and 205 - Table is usually capitalised, isn't it?

p. 12 what do you mean by 'synthetic construct'? Suggest deleting 'synthetic'.
p. 13 line 294 - syntax - "about the state of health"??

p. 16 lines 368-373 are excellent. Consider moving to bottom of Results section?

p. 17 lines 386-392 are excellent, and one of the most important parts of the paper.

Table 1: Capitalise Indigenous. Suggest Indigenous is outside of parentheses, given it applies to largely US studies, and Aboriginal moved inside parentheses.

Table 2: Need to fix 'Countr' and 'y' on next line in first column.

Are the methods appropriate and well described?
If not, please specify what is required in your comments to the authors.

Yes

Does the work include the necessary controls?
If not, please specify which controls are required in your comments to the authors.

Yes

Are the conclusions drawn adequately supported by the data shown?
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Yes

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