CORRESPONDENCE

Health Service Use Among Patients With Chronic or Multiple Illnesses, and Frequent Attenders: Secondary Analysis of Routine Primary Care Data From 1996 to 2006

by Dr. med. Johannes Hauswaldt, Prof. Dr. med. Eva Hummers-Pradier, Dr. med. Ulrike Junius-Walker in volume 47/2012

Methodological Flaw in the Study Design

I noticed in the article that a doctor-patient contact (DPC) on a specific date was considered to have occurred when at least one billing item was found that required personal contact between doctor and patient. The basis for this was the Uniform Value Scale (Einheitlicher Bewertungsmaßstab, EBM) EBM 2000plus, which was introduced on 1 April 2005.

However, this merely reflects the initial contact for chronically ill patients. For such patients, a further billing item is available. At the very latest, however, it is the third contact that will not be reflected, except for the very few cases where a billing position for the healthcare service delivered even exists. No billing item exists, for example, for conducting an ECG. Furthermore, EBM 2000plus does not include any billing items for a second instance of wound care, a second consultation without a psychosomatic background, a follow-up with a clinical examination alone, without "hi-tech medicine." A comparison with 1996 data, when every contact was included, is therefore not possible.

Because of this serious methodological flaw the study's meaningfulness seems questionable.

DOI: 10.3238/arztebl.2013.0254a

REFERENCES

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In Reply:

We thank Dr Bogusch for her justified comment, which provides us with an opportunity to explain our methodological approach and its problems in the use of secondary routine data from general practitioners.

A doctor–patient contact (DPC) on a specific date was considered to have occurred when doctors had billed for home visits, doctors' traveling expenses, emergencies, services at awkward times, out-of-hours care, minor surgery, sonography, exercise ECGs, screening and early detection examinations, basic psychosomatic care, and further services that cannot be delegated. We analyzed more than 17 million billing items and considered 24 (EBM96), 29 (EBM05), and 33 (GOÄ82/95) billing positions.

This means that DPCs from the available primary data were mostly included. We cannot rule out, however, that further DPCs occurred between 1996 and 2006 that were not billed and therefore not included in the routine data we studied.

This is one of the known problems if secondary data are used. The primary data generation was done for another purpose and not for the purpose of scientific study (1). Changes in circumstances, in the characteristics of the parameters, or in their interpretation over time make it necessary to use routine data with caution, in full awareness of the circumstances under which they were generated, and using a systematic method for the purposes of health services research (2). Conclusions will have to be drawn cautiously, and these limitations need to be borne in mind.

Since reliable data on the actual utilization of outpatient care are mostly lacking, the use of secondary routine data is inevitable, and not without promise. Technical (scientific use file, uniform AIS interfaces and data transfer protocols), organizational (sentinel practices, network of monitoring practices), and substantial (quality circle of researching general practices) measures will probably have to be implemented in future, in order to improve the quality, comparability, and productiveness of GPs primary data.

DOI: 10.3238/arztebl.2013.0254b

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Conflict of interest statement
The authors of all contributions declare that no conflict of interest exists.