Editors Comments: Theo Bloom, Navjoyt Ladher, Steve Leeder	Responses
1) We note that all three reviewers comment about theory versus practicality. We wonder if you can consider how this article might be better grounded in practice and expand on what some of the changes you discuss might look like to draw out the practical value - particularly bearing in mind the real world context, where people are often overworked and resource constrained.	We have two related responses to this comment. Firstly, the manuscript was conceived as an elaboration of reference 11 published in 2015… to then be followed by a series of papers to illustrate the practical value of the HIHS design principles with a focus on priority populations. A manuscript addressing new care models for CAMHS has been submitted and resubmitted after review. Secondly, we have revised the manuscript extensively to move from theory to practicality and to draw out the practical value. We see HIHS principles as directly responsive to the Right Care series published last month in Lancet, and to the response of OECD and 7 other health ministers with the Forum – *People at the Centre: The Future of Health,* and the ministerial statement, *Next Generation Health Reforms.* Together, Tables 1 & 2 address the questions raised about failure of previous reform efforts and how HIHS design principles can be made practical to address those failures with new approaches to measurement and management. We now provide an extended example of introduction of the HIHS design principles and related measures to make them practical, to six NHSE MCPs and PACSs that came together to form a 'Place Based Care Network' (PBCN) to accelerate and scale learning how to implement new care models to advance the *Forward View* reforms. (Box 3)
2) We also wonder if the tone could be pitched towards readers who need to be convinced that this approach is worthwhile with the aim of bringing them on the journey with you. At the moment, the article seems pitched towards readers who already believe this is a good idea and might come across as 'sermonising' in tone.	Thank you for this comment. We have extensively revised the manuscript accordingly. Box 3 is meant to bring readers 'on the journey ' with six teams that are working to bring HIHS design principles to new care implementation using an integrating offering of measures and tools to support mutual accountability.
Reviewer 1: Martin Marshall	Responses
I think this is a stimulating and neatly-framed paper that is likely to provoke thoughtful BMJ readers in a highly productive way.	We appreciate this comment.
The term 'high integrity' perhaps felt a little too clever to me on first reading but on reflection it helpfully encompasses an increasingly-recognised set of ideas which are both simple and highly complex in nature. The essence of the argument	We appreciate the reviewer's thoughtfulness here. Indeed, the 'high-integrity' health system we envision is one that responds to complexity by identifying simple rules and related measures and tools to help persons who deliver and receive services at every level of the system hold themselves accountable for performing their roles with integrity.

for me is captured in the reflection that we are seeing 'lowering aspirations of service providers at a time when the expectations of service users continues to rise'. This is a very real problem.	
I like the way that the core components of a high integrity system (clarity of purpose, challenging the limitations of modern medicine, respect for patient preferences and a commitment to improvement through measurement and learning) are presented as challenges to front line practitioners and their patients, rather than being seen as the domain of system leaders and policy makers.	We see the descriptors of high integrity as the domain of all persons working within the system from frontlines to system leaders and policy makers. Our emphasis on the frontlines is because that is where there is the most to learn to inform decisions throughout the system We have revised to make the commitment to informed decisions at every level of the system more clearly linked to what we mean by 'high integrity'.
I have just two reflections which I hope a useful. First, the content of the case studies could be more explicitly aligned to the core components of integrity and it might be better to present fewer examples but in more detail.	We have decreased the number of examples and now focus on the 2 more ambitious US models of primary / community care (in Box 2), and on ongoing *Five Year Forward View* efforts in the UK to integrate care more effectively around patients' needs. As noted, Box 3 now aligns the practical use of measures and tools to the design principles of HIHSs.
Second, I'm concerned that the paper - important as it is - might be dismissed by many readers as a good intellectual critique but insufficiently practical - I am aware that some judged the original editorial in this way. I hope that this will be addressed by the idea of commissioning more in-depth practical examples of service redesign which are clearly focused on delivering greater integrity than is seen at present.	We very much appreciate this observation. As noted above, the authors always intended that this paper would make practical the ideas expressed in the editorial to establish a foundation for a series of papers including the CAMHS paper that has already been reviewed. But on reflection, we concluded that this paper should be able to stand alone as a guide to practical implementation of HIHS design principles. As noted in responses above, we have revised extensively to do so, and used the PBCN as an example.
Reviewer 2: Carolyn Petersen	Responses
In general, papers that provide commentary and/or analyze a particular situation are less well-suited for discussion between patients and their providers. This is perhaps even more the case when the subject of the paper is removed from clinical management of a condition experienced by the patient, such as with health policy papers like this one. This review therefore will focus on how patients may react to	We appreciate this comment. It surprised us and thereby led to think about how we had failed to communicate the importance of the design principles that address asymmetries of information and power at the front lines of care to effective clinical management. We have revised accordingly and hope that you find the revisions helpful.

the ideas presented in the paper and what additional information may be helpful for them in understanding how to more successfully work with their health care professionals.	
From the patient/carer perspective, many of the ideas in the paper have been demonstrated through experience, and thus do not represent new thinking. For example, patients are well aware that more health services don't necessarily result in better health, that clinical evidence is insufficient to determine best treatment and its delivery, and that stakeholders need to better understand sources of resistance to thinking and acting differently within the clinical setting, including sources of resistance within themselves.	We were a bit surprised by this comment as well. It is at odds with our clinical experience and understanding of the published evidence. While summarizing that evidence is beyond the scope of this paper, we have referenced two systematic reviews by Hoffman documenting the overestimation of benefits and underestimation of harms by both patients and clinicians. Also, as noted above, we have referenced last month's Lancet series on Right Care documenting overuse and underusse. We believe that the directions signposted in this manuscript, and the papers that might follow could make the Lancet recommendations more practical at the frontlines of clinical care.
Similarly, patients and carers are well aware of the value of shared decision making and self-management, and have sought team-based service delivery as a way to achieve improved outcomes.	We agree that patients and carers are more satisfied when engaged in care decisions and care management by teams that respect what matters to them. Our concern is that they are often left unsatisfied because it doesn't happen, or burdened with concern and anticipated regret because it is done poorly.
Many patients would welcome innovation at the front lines of provider-patient engagement, where patients' needs can most fully be described and addressed, and will be disappointed to find few specifics of how that can be accomplished in this paper. The "Examples of new approaches to discerning and meeting health needs" section attempts to address this point, but brief mentions of existing programs without noting their success measures and how success can be replicated elsewhere don't provide adequate detail for either provider or patient interests.	See above. We have substantially reduced the number of examples in this paper to provide more detail around the Atlanticare and Camden examples in Box 2 and the introduction of an integrated offering of examples of measures and tools to guide implementation of the design principles by NHS England MCPs and PACSs developing new care models in Box 3. Also, we expect that the CAMHS manuscript and others will add of practical detail for specific populations.
Patients and carers who have studied health care organization and/or health policy may find the paper quite similar in tone and content to publications describing the Learning Healthcare Systems approach now underway in various organizations within the United States.	We agree that the US IOM/NAM efforts to define elements of Learning Health Care Systems overlap significantly. We see our work as focusing more on designing frontline care models for learning which services recipients value. However, there is ample evidence that health systems generally do this do this very poorly.

Those with a background in organizational management or experience in patient engagement activities such as patient-family councils are unlikely to find the Plan-Do-Study-Act approach mentioned in the paper to be innovative or efficient.	We are not sure what reference the reviewer is making here. It could be Figure 1. We do not see Figure 1 as a PDSA approach, but we have revised to clarify the text so as to no longer need Figure 1.
Suggestions to strengthen the paper: Reconsidering and reframing the ideas in the paper in a way that addresses the reality of health care organizations in a market-driven, for-profit system. The paper notes, “A health system exists to sustain or improve the health and wellbeing of those it serves by equitably meeting their health care needs and wants—no less but no more”, but this is not the lived experience of both patients and providers in all environments. Acknowledging the influence of the profit generation goal on care delivery and patients’ decision making and describing what high integrity health systems must do to succeed in such circumstances would lend credibility to the piece and provide a framework for implementation.	Our goal is to make the ‘lived experience’ in the US and elsewhere more consistent with the high-integrity design principles and descriptors than it is today. The Lancet series underscores the problem we are addressing, and the Next Generation Reforms Ministerial Statement sets a direction similar to HIHS. We are trying to bring those ideas into action. We have tried to address this comment without pulling back from that goal by stating more clearly that the design principles address the failures that state-funded and market-driven health systems have in common. Also, there is nothing antithetical to the fiduciary responsibilities of a for-profit company that does not exploit information asymmetries. Some of the leading US care models designed for patient engagement are for-profit.
Suggestions to strengthen the paper: In addition, the statement “Radical redesign of front line care services linked to community assets in high and middle income countries should borrow heavily from success in low resource settings where community health workers are elected or otherwise chosen for their commitment to building upon the social capital that exists in the community.” further development. Many high and middle income countries have within them low resource areas (e.g., inner-city, rural), but such areas have not emerged as models of care delivery for more highly resourced areas of these countries. Describing such models and their application to higher resourced communities and health	Both AtlantiCare and the Camden Coalition have demonstrated impact in very low resource localities and with vulnerable low-income populations within the US. They do so with what is essentially a ‘community health worker’ model adapted from low and middle income countries. The AtlantiCare model is the value proposition of Iora Health, a for-profit company operating now in 11 US states in settings with resources levels that vary widely.

care organizations would be of interest to patients and carers. This discussion also should reconcile achievement of this redesign with the fiduciary responsibilities of for-profit entities.	
The paper also would be enhanced by discussion of how to improve care and outcomes among patients who prefer not to take an active role in shared decision making. Although some health care organizations have begun actively seeking to involve patients in decision making, not all patients with to engage in this way, and it is important for health systems to improve care for and outcomes within these patients.	The reviewer references what is a first principle of shared decision making that has been regularly articulated in the literature over three decades and referenced above. While an exhaustive review of SDM is not in the scope of this paper, it is addressed in many of the manuscripts references.
Reviewer 3: Kenneth Sands	Responses
This is a timely and provocative position paper. The author advances the concept of the high integrity health system, identifies flaws that are pervasive in the current system, and outlines the key concepts underlying the high integrity system. There is a lot of appeal here, but there are ways I feel the manuscript could be strengthened.	We appreciate the reviewer's sense of the timeliness and provocativeness of the concept. As noted above, we have revised to make it more current.
First, the definition of "high integrity health system" could be more explicit. It is a little vague whether "high integrity health" is being used as a descriptor or as a defined characteristic. It seems that the author is striving for the latter, but the MS falls short of providing a definition and instead describes a number of associated qualities. The earlier Mulley article (reference 2) comes close to giving a definition; if the goal is in fact a definition, would restate it in this MS.	We found the reviewer's distinction between a 'definition of a high-integrity health system' and 'descriptors of high integrity health systems' very helpful. We have used descriptors and think that is a better approach than specifying a definition at this point. We have, however, revised significantly to sharpen the descriptors, and clarified the key role of learning what patients need and want and using that knowledge to inform decisions at the frontlines and throughout the system.
Would also be explicit in how to distinguish "High Integrity" from "Patient centered" as these seem to be closely related.	We have tried to make that more clear in this version.
Second, the flaws in the current system are discussed on the basis of "prevailing assumptions" and "bias," without a lot of discussion on the	We certainly agree that the assumptions are a product of training and the behaviour formed by incentives, financial and otherwise.

forces within healthcare delivery and reimbursement that have led to the current system. Is this really a matter of changing assumptions and removing our biases? Are these really prevailing "assumptions" or are they prevailing "behaviors" based on models of training, professional organization, and reimbursement?	The assumptions and biases are offered to challenge people to think differently and understand the sources of resistance to change and adopt behaviours that may be more consistent with intrinsic motivation. The addition of references to the Lancet series and the OECD ministerial statement highlights the relevance of both Tables 1 and 2.
The vision laid out by the author is very appealing but would seem to require a major redesign of the relationship between, for example, providers and public health entities, which will require more than shedding biases.	We agree. We are in fact arguing just that. The provider-public health integration is the 1978 Alma Ata vision that has proved so elusive. Taking that further, the argument of the *Forward View* is that health care economies will not be sustainable without integration of primary-acute, mental-physical, and health and social care – all with population health public health measures supporting. This comment was very helpful in shaping this revision including Box 3.
Reviewer 4: Angela L Scioscia, MD	Responses
This seems to be and more of an opinion piece rather than an analysis.	Analysis papers in the BMJ are articles that discuss topical clinical, scientific, ethical, and policy issues that matter to doctors and patients. We believe the manuscript qualifies as such, especially following the revisions made to provide more detail about implementation using fewer examples.
The author raises a number of valid points; however, the article is difficult to read, it is rambling and disjointed.	The manuscript has been extensively revised to address this comment including changes in the title, headings, text, and boxes.
The data to support the author's conclusions is not concisely presented.	We have tried to be more concise. We have also tried to provide a description of a 'proof of concept' currently underway in NHS England with examples of the measures and tools referenced.
Figure 1 is a useful construct and it might be more effective to present it earlier in the paper creating a cohesive element.	We initially moved the figure forward in the paper as suggested, but do not think it is needed following revisions we have made to the text.
Box 2 seems out of place, perhaps better positioned in the body of the manuscript.	We have eliminated the Box 2 of the original submission. We hope the intended purpose of Box 2 in the original submission is now better served by Boxes 2 & 3 in the revised submission.