Reviewer's report

**Title:** A qualitative examination of health and health care utilization after the September 11th terror attacks among World Trade Center Health Registry enrollees

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**Reviewer:** Thilo Kroll

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Review: A qualitative examination of health and health care utilization after the September 11th terror attacks among World Trade Center Health Registry enrollees

The study provides interesting insights into the uptake of specialist services available to survivors of the 9/11 WTC attacks in 2001. However, the study needs to be described in greater detail. Below are suggestions to the authors for the revision of their manuscript:

**Minor revisions**

1. There are differences in how the purpose of the study is presented in title, abstract, and research questions
   - clearly spell out a coherent research question that is reflected in all areas of the manuscript.
   - clearly articulate the gap in current knowledge that will be filled by this study. It appears that a lot of literature exists already in relationship to the questions that the authors intend to address. What is the specific novel element?

2. Attributions of causality (9/11 vs. aging vs current illness) related to the health problems may differ across individuals but also the real underlying causes may differ. Did the authors ask about the duration, onset, patterns of illness? It is reasonable to assume that 9 years + post 9/11 that the causes for illness are as varied as 1 yr post 9/11. Perhaps, aging-related concerns are the 'correct' attributions and consequently, not seeking care under the EHC provision is quite appropriate?

3. For the international readership, spell out the relationship between the health care coverage provided under the EHC and other health insurance available to NYC citizens, including public and private payers. What about dual eligibility? Is for some WTC coverage the only coverage, while for others in the sample a mix of Medicare plus Private or solely Private is an option? Is EHC completely free or is copayment required? Describe the scope of the service and its interface with other services.

4. The authors state that only a small proportion of people eligible under the
WTC Registry provision accesses EHC services. Can they provide any details about the characteristics of the sample of people who seek access?

5. The discussion mostly highlights the confirmatory character of the study, i.e. supporting findings from the literature.

6. The authors derived some recommendations for practice from their findings. However, from the presented data is not clear how these recommendations have come about. For example, did they ask about preferred information channels and formats and how consistent were the use within as well as between groups?

7. Provide additional literature about the service coordination between primary care provider and specialist services.

8. Is additional research needed? If so, which questions remain to be answered?

Major revisions

1. Provide a clear description of the chosen design and sampling strategy (e.g. purposive, maximum likelihood) as well as of inclusion/exclusion criteria

2. Provide a bit more detail about the focus group procedure:
   a. was the moderator trained?
   b. where were the focus groups conducted?
   c. how long did the focus groups on average take?

3. Provide more details on the data analysis based on the grounded theory by Glaser and Strauss. Typically this involves several steps of coding and it is not quite evident from the description how this was done in the present study. Also give some indication of how many codes were identified which were then reduced to the themes presented. Moreover, GT is typically used to explain (i.e. generate theoretical propositions) the relationship between different themes and topics. This is not done in the present study. Why was GT used and how was it used? Please provide a rationale for the choice of this approach.

4. What was done to ensure credibility, trustworthiness and transferrability of findings (e.g. member checks, inter-rater coding).

5. The findings are mostly descriptive, which is acceptable but also somewhat limiting; sample contains substantial comparative potential to compare the experiences of subgroups, not only those based on the criteria used for producing the focus group samples but in addition those including age, gender, income, education, and health insurance status or payer type (uninsured, Medicaid, Medicare, Private) would be quite interesting. Moreover, the way their routine health care is organised (e.g. primary care gatekeeper, specialist access) may play a role in how likely they are accessing EHC services.

6. One of the themes was labelled 'not connecting symptoms to 9/11'. This category likely includes a mix of true attributions as well as false attributions.
What are the implications?

7. There is no clear differentiation between knowledge and attitudes in relation to utilisation. Please clarify.

8. Please provide more information about intra group variability as well as comparisons across different economic, income, and gender groups.

Discretionary revisions

1. As the analysis mostly remains descriptive some very interesting ideas may have gotten lost. For example, different cultural views of illness and its controllability. It would be fascinating to expand on this, especially since some of the respondents are native Spanish or Mandarin speakers. These views may inform attributions of symptoms.

2. Similarly, the issue of stigma, especially related to mental health services remains rather superficial and not sufficiently contextualised in existing literature.

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

Quality of written English: Acceptable

Statistical review: No, the manuscript does not need to be seen by a statistician.

Declaration of competing interests:

'I declare that I have no competing interests'