Author's response to reviews

Title: Uptake of health services for common mental disorders by first-generation non-Western migrants in the Netherlands

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Response to the reviewers

Reviewer: Rolf Kleber.

Major Compulsory Revisions
Points 1, 2, 3 and 4

In his first comments, the reviewer discusses several points, namely that the discussion section is too open, rather shallow, that the results should be dealt with more in depth, that the main message is somewhat blurred, and that more attention could be paid to explanations and dilemma’s. In the revised manuscript we have therefore made a number of alterations.

First, we have stated our main conclusions more clearly (both in the discussion and the abstract). For this purpose we paid more attention to our definition of equal access to health care, thereby discussing the Dutch referral system, in which GPs act as gatekeepers to specialised (mental) health services. We hope our conclusion is now less open, though we still want to leave some room for other interpretations.

Second, we went more in depth regarding the explanation why Moroccans were less likely to attend primary care services for mental health problems compared with ethnic Dutch, discussing the possible role of communication problems. Additionally, the explanation related to perceived need for care is now more elaborated upon by providing some examples of the possible influence of perceived need for care, or the lack thereof, on care utilisation.

Third, we now also discuss possible explanations for the finding that accessibility of specialised mental health services was relatively equal for all three ethnic groups. The first
explanation is related to the fact that this study provided the opportunity to correct for differences in mental health care need. Instead, many other studies have addressed this issue searching for an equal representation of minority groups in (mental) health care compared to their representation in the general population. Apart from that, Dutch mental health care nowadays has a history of ‘interculturalisation’, which means that numerous efforts have been made to adapt mainstream mental health services to suit clients from different cultures (as opposed to the development of health services for specific ethnic groups[1]). Though we acknowledge the limitations of our study, we suggest in our discussion that the process of interculturalisation proves to be fruitful.

Fourth, in the revised discussion we remind the reader that equal access - though a necessary condition for equal opportunity to health - does not guarantee equal result [2]. This revised discussion states, among others, that to achieve equal results (i.e. equal health) we will also need to resolve inequalities in the process of mental health care. In this respect improvements still can and have to be made [1]. What is more, “even a just health care system [in terms of equity] could not come close to producing an equally healthy population, given the unequal distribution of illness among people”. In other words, resolving inequities in mental health care is only part of the solution in improving ethnic inequalities in mental health care.

Finally, we more elaborately discuss the possible influence of SES under limitations. More specifically, we stress that SES was indicated by two dichotomous measures of educational and income levels, while the concept of SES is in fact broader [3]. Additional indicators could be, for example, the relative status of one’s occupation or neighbourhood characteristics. The study sample was unfortunately too small to include more and more sensitive indicators of socioeconomic status. Moreover, by far most non-Western migrants in the Netherlands have a
low SES, so that distribution of the SES indicators was unequal. As a result, the influence of socioeconomic position was very difficult to study in this particular sample, while it is a very important explanatory variable in the relation between ethnicity/migrant status and health (care utilisation).

Minor essential revisions

1. The reviewer argues that the theoretical foundations for our study should be explained better. We have altered our introduction so that it now explains more in detail why equal access to care, regardless of ethnic background, is necessary and important. Essentially the main reason is that inequity in access to care for some ethnic groups is regarded by some as one of the explanations of ethnic inequalities in health status. Equal access to available care for equal needs thus implies equal entitlement to the available services for everyone.

   In addition, we have provided extra information on why it is so important to include need factors if one decides to study this subject, thereby referring to Anderson’s behavioural model, and explaining the difference between predisposing, enabling and need factors.

2. The reviewer asks us to make a better distinction between equal access and non-response in the introduction. In the revised manuscript we have dedicated a line to this, although both subjects are influenced by comparable barriers.

3. The three research questions from the background are now repeated at the start of the discussion section.
4. We agree with the reviewer on this matter and altered this sentence into: Finally, the study was conducted in a large urban area, which makes the results potentially interesting for other urban settings.

5. In the discussion section we have dedicated some lines to differences between Turkish and Moroccan migrants in the Netherlands.

6. We have altered the title, but although we agree that ‘Mediterranean’ could be an appropriate term as well, we replaced the word ‘non-western’ into ‘Turkish and Moroccan’. The title now reads: “Uptake of health services for common mental disorders by first-generation Turkish and Moroccan migrants in the Netherlands”.
Reviewer: Margarita Alegria

Major compulsory revisions

1. The second reviewer notes that the sample size changes throughout the document, and wonders what the actual response rate for the eligible population is. We have altered the methods section of our manuscript as to provide clarity about this matter, and to provide more detailed and clear information of sample selection. The response rate for the eligible population (i.e. ethnic Dutch, Turks and Moroccans who participated in the AHM 2004 and who were willing to participate in any study in the nearby future) was 67.3%. This information is now also included in the altered manuscript.

Furthermore, the weighting for table 2 was done with respect to the composition of the Amsterdam population in 2004; this was described in the Methods-section (under analysis), but is now mentioned more explicitly. Finally, in confirmation with the reviewer’s comments a more detailed description of how the sample was selected to ensure inclusion of the migrant population is now included.

2. According to the reviewer, the analyses presented in table 3 do not tell us whether there are ethnic differences in access to service use among subjects with a mental health care need compared to those who do not have such a need. However, the question whether or not differences in mental health care uptake are different according to mental health care need is answered by correction in the analysis by need factors. Indeed, mental health is driving the service use, in a similar way across ethnic groups. This was statistically tested in by adding an interaction term (i.e. between
ethnic background and mental health). This extra step in the analysis is now described and discussed in the revised manuscript.

3. In an earlier stage of our study we indeed repeated the regression analyses with Turkish and Moroccan migrants assembled into one non-western group. In other words, both first-generation migrant groups were merged into one group, and subsequently compared to the same ethnic Dutch reference group. However, since this only confirmed our previous findings, but also because this step tends to ignore the fact that Turkish and Moroccan migrants form different groups with respect to several ethnocultural aspects, we decided this analysis was of no additional value. We have therefore deleted this passage in the analysis section from the revised manuscript.

4. Our response to the fourth comment from the author, with respect to the interpretation of the results, would be that the Kessler psychological distress scale (K10) gave respondents more opportunity to also express their subjective need. Why the inclusion of an additional measure of subjective need was necessary is now better explained in the introduction, by explaining to the reader how Dutch health care is organised. That is, subjective need is important for seeking help in general practice, where general practitioners (GPs) act as gatekeepers to specialised mental health services. Objective need can subsequently used as a criteria by GPs whether or not to refer to specialised services. In our opinion, inclusion of the K10 thus represents a different step in the analysis than inclusion of CMD. We hope our explanation on this matter, mainly in the background section, is more adequate in the revised version of the manuscript.
5. The definition of ethnic background was corrected in the revised methods section. A subject was considered to be a first-generation Turkish or Moroccan migrant if that person was born in Turkey or Morocco, regardless of where his or her parents were born. Respondents were considered ethnic Dutch if both parents of the respondent were born in the Netherlands.

6. Information about income was measured, but more often missing as information on patients’ health insurance. This is because information about people’s income is more often perceived as impolite. Moreover, people in the Netherlands are legally obliged to have medical insurance. As we have explained in our manuscript, there used to be two types of insurances in the year 2005, namely private and public insurances, each linked to a certain income level. Because inclusion of the income variable would have lead to a loss of extra cases, and because before 2006 (before the health care reforms) health insurance type was a quite common indicator of SES in Dutch scientific research, we decided to concur with this.

Finally, the reviewer argues that differences may be due to poverty, as higher poverty might be related to worse mental greater mental health problems. According to the reviewer, this possibility is not adequately corrected for. We agree with the reviewer that in the present study the issue of poverty or low socioeconomic status in general may not be ruled out sufficiently. The disentanglement of ethnic and socioeconomic influences should be a serious matter of future research. We have mentioned this under limitations in our discussion section.
7. The models may indeed be sensitive to model specification, which is now discussed in the limitations section. There the revised text reads:

Third, the results of the statistical analyses may have been sensitive to model specification, which in this case could have resulted from the failure to include other important variables. For that matter, we fully acknowledge that Anderson's behavioural model specifies other relevant variables that could have been acting as confounders. Examples are marital status, health beliefs, and acculturation (predisposing), social support (enabling), and somatic comorbidity (need). Inclusion of these variables would have probably resulted in more accurate results. At the same time, however, the limited sample size urged us to be very conservative in the number of covariates that we could include, and to only include the most relevant information.

In addition to the reviewer’s comment, we have removed statistical trends (p-value < 0.10) from the revised results section.

8. The sentence that is referred to by the reviewer says that we compared socioeconomic information from the sample to information from the statistical office of the Amsterdam community, but that we could not test differences statistically. Only raw comparisons were made, since data were available at different levels (e.g. spendable household income per year from the municipality vs. self-reported monthly family income after tax from the AHM) [4]. We have changed this in the revised manuscript. The revised text now reads:
With respect to differences in income and unemployment, only raw comparisons were made, since data were available at different levels (e.g. spendable household income per year from the municipality vs. self-reported monthly family income after tax from the AHM) [32]. Among subjects in the AHM, 38% reported a family income of €17,550, 48% reported an income between €17,550 and €41,600, and 14% had an income of at least €41,600. This is comparable to the distribution of income in the general Amsterdam population, since 31% of the population in 2004 had spendable household incomes below €15,800, 54% had incomes between €15,800 and €39,900, and 15% had an income of at least €39,900 per year. Regarding employment rates, 5% of AHM respondents reported to be jobless, while 7% of the general Amsterdam population was known to be unemployed in 2004.

References


