Author's response to reviews

Title: Access to and utilisation of GP services among Burmese migrants in London: a cross-sectional descriptive study

Authors:

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Version: 2 Date: 25 May 2010

Author's response to reviews: see over
Dear Editorial Team

We are very grateful for the very constructive and helpful comments from the editorial team and the reviewers and have revised the manuscript accordingly. Details of our revisions are provided below and as Track Changes in the revised manuscript.

We hope that it will now become acceptable for publication.

Associate Editor comments:
Thank you for submitting this paper to BMC Health Services Research

You have four very helpful reviews from different perspectives.

Reviewer 1 takes a pragmatic GP perspective: his query about the comparative data from other young/adult populations living in London is very pertinent. 80% registration with a GP may actually be normal for healthy young adults (I know my son who has lived in London for 5 years has not got round to registering with a GP - and the reasons cited in the paper for not registering are exactly my son?s excuse!). Similarly most episodes of illness in this age group are self-limiting and do require medical attention: ?self-medication? is the correct response (and should not be included as a barrier).

We discussed in the article that GP registration of 80% is high in comparison to other international migrants in London (page 12 last para). Unfortunately, there does not seem to be a reliable figure for the percentage of the resident population registered with a GP.

“Barrier” in our research means a factor deterring migrants from visiting a GP when they get sick. We would therefore prefer to continue using the term “barrier” for the practice of self-medication. Furthermore, self-medication is not only over-the-counter medication (as revealed from the in-depth interviews), but also antibiotics and other medicines which should normally be given only against a prescription. This means that self-medication is an important issue to be addressed.

Reviewer 2 points out a number of statistical and presentational details that should be addressed

We have addressed these points, as detailed in our response to the comments from Reviewer 2.

Reviewer 3 highlights the need to more background information about the Burmese community in London, and requests more detail about the methodology. The mixed methodology might be better explained if the 3 phases (initial interviews, questionnaire survey, validation interviews) were described either in separate paragraphs, or possibly in a table. For each phase we need to know who was recruited and how (e.g. how were the 6 interviews for the initial interviews identified and recruited?). Who were the 25 volunteers
who distributed the questionnaires, and how were they recruited?

We have provided more background information about the Burmese community in London and the methodology we used. The in-depth interview respondents were recruited through community contacts, provided they met the selection criteria of having lived in London for over 5 years in at least 3 different areas. Through the in-depth contact persons, community clusters were identified, as well as contacts for the questionnaire distribution. We have provided more details about this in the section on Materials and Methods.

Reviewer 4 raises concerns about potential bias in the sampling strategy. I note that 70% of the respondents were university graduates. Unless there are data to suggest that the majority of the migrant Burmese population in London are graduates, I suspect this is a bias introduced as a result of the snowballing technique, and represents the populations to which the initial volunteers have access.

The principal investigator of the research study, as a Burmese, can confirm that Burmese migrants coming to the UK and other Western countries are from better socio-economic backgrounds, as it costs a fortune for people in Burma to cover the travel costs. As a result, Burmese migrants in the UK may have a better education level than Burmese migrants elsewhere. However, it is difficult to draw conclusions from our sample, due to the bias in sampling introduced by the snowball method. We have acknowledged this limitation in the Discussion section.

I would particularly like to know why was there an upper age limit of 60 years for the questionnaire (especially since older patients might be expected to need health services more than the younger people surveyed?)

An upper age limit of 60 years was used to avoid biased results, due to the higher utilization of health services by older age group.

Why was a threshold of 5 years resident in London used, and why did they have to have lived in three areas of London?

These selection criteria for in-depth interviews were introduced to make sure that respondents have sufficient knowledge of Burmese migrants living in different areas of London. We have added information about this in the revised manuscript.
I also agree with his observation that the qualitative work is under reported. The two rounds of interviews are a strength of the study, and greater use of some quotes from the interviews could add considerably to reporting of the quantitative facts: providing ?colour? and insight into the figures from the questionnaire survey.

We have provided some more quotes from the in-depth interviews to add more colour and insights to the results section.

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Editorial request:
- Please note that it is our policy to request that authors reporting qualitative studies adhere to the standards outlined in the RATS guidelines (http://www.biomedcentral.com/info/ifora/rats). Can we therefore ask you to please ensure the revised manuscript incorporates the information requested under these guidelines.

This request has been addressed in the revised manuscript.

We would be grateful if you could address the comments in a revised manuscript and provide a cover letter giving a point-by-point response to the concerns. As substantial points were raised, we will need to seek further advice on the revised manuscript.

Please also highlight (with ‘tracked changes’/coloured/underlines/highlighted text) all changes made when revising the manuscript to make it easier for the Editors to give you a prompt decision on your manuscript.

Please also ensure that your revised manuscript conforms to the journal style (http://www.biomedcentral.com/info/ifora/medicine_journals). It is important that your files are correctly formatted.

We look forward to receiving your revised manuscript by 1 June 2010. If you imagine that it will take longer to prepare please give us some estimate of when we can expect it.

You should upload your cover letter and revised manuscript through http://www.biomedcentral.com/manuscript/login/man.asp?txt_nav=man&txt_man_id=1698632570375875. You will find more detailed instructions at the base of this email.

Please don’t hesitate to contact me if you have any problems or questions regarding your manuscript.

With best wishes,
Additional material submitted by the reviewers
-------------------------------------------------
Referee 4:
http://www.biomedcentral.com/manuscript/review/attachment/pdf/112511609386511.pdf
Referee 2:
http://www.biomedcentral.com/manuscript/review/attachment/pdf/2140102396385903.pdf

To submit your revised manuscript
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When you have revised your manuscript in light of the reviewer's comments and made any required changes to the format of your paper, please upload the revised version by following these instructions:

1. Go to
http://www.biomedcentral.com/manuscript/login/man.asp?txt_nav=man&txt_man_id=1698632570375875 and log on with your email address and password.
2. With the 'Manuscript details' tab, please update the title, abstract and author details if they have changed since the previous version. It is very important that all changes are updated on this page, as well as in the manuscript file as the information on this page will be used in PubMed and on BioMed Central if your manuscript is accepted for publication.
3. With the 'Cover letter' tab, please provide a covering letter with a point-by-point description of the changes made.
4. With the 'Upload files' tab, please upload the revised version of the manuscript and press 'Submit new version'. Please wait for the confirmation page to appear - this may take a few moments.
Reviewer’s report
Title: Access to primary health care among Burmese migrants in London: a cross-sectional descriptive study

Version: 1 Date: 17 April 2010

Reviewer: Peter Le Feuvre

Reviewer’s report:

Major Compulsory
1. Two important conclusions are a rate of GP registration of 80% and a percentage having a consultation with a GP for their last illness at 56.8%. It is suggested that these are both low. This may well not be the case, and such conclusions could only be reached after comparisons with other groups - even UK citizens. These are a predominantly young, educated working population, likely to be mobile and likely to be healthy. It may well be that a comparable group of UK citizens has a comparable registration rate. It is suggested that the rate of consultation with a GP for the last illness is low at 56.8%. Again, this may not be the case. In such a population the last illness is likely to be of a minor self-limiting nature which would not have necessitated a consultation with a GP. A comparison is needed. Most self-limiting acute illness is best dealt with by self care or a consultation with a pharmacist.

We did not state that the GP registration rate was low (page 12, reference 8 in submitted manuscript). In fact, we stated that “GP registration rate of Burmese migrants was comparatively higher than A&E attendees in inner London hospital” (Page 12 last para). Unfortunately, there does not seem to be a reliable figure for the percentage of the resident population registered with a GP.

Regarding the GP consultation rate, it was stated to be low by comparing with the GP consultation rate of international migrants from a research conducted by MDM in 9 European countries (Page 14, reference 11).

It is important to note that self-medication is not only over-the-counter medication (as revealed from the in-depth interviews), but also antibiotics and other medicines which should normally be given only against a prescription. This means that self-medication is an important issue to be addressed.

2. There needs to be more clarity over the use of the terms 'Primary Care' (as used in the tile) and General Practice (as is used in the text). This article is about general practice. There is much more to primary care than general practice.

We have changed the title to “Access and utilisation of GP service among Burmese migrants in London”.

Minor Essential. The insertion of figure 3 appears twice in the text.

The figure insertion has been corrected (page 10 last para and page 11 first para).
Level of interest: An article whose findings are important to those with closely related research interests

Quality of written English: Acceptable

Statistical review: Yes, but I do not feel adequately qualified to assess the statistics.

Declaration of competing interests: I declare that I have no competing interests
Reviewer’s report

Title: Access to primary health care among Burmese migrants in London: a cross-sectional descriptive study

Version: 1 Date: 28 April 2010

Reviewer: Edwin Amalraj Edwin Raja

Reviewer’s report:

The article on ‘Access to primary health care among Burmese migrants in London: a cross-sectional descriptive study’ by Nyein Chan Aung et al is interesting research work on public health point of view and this is an appropriate journal for publication.

There are very few studies on the migrants in UK. So It is important to add this into that literature. However, I have a few points (Discretionary Revisions) that need to be considered before considering for publication:

1. Methods:
   • Name it as ‘Materials and Methods’.

   We have changed the title as suggested.

   • Page 6. Some of the statements mentioned in the ‘Statistical Analysis’ are very general statements. The author is expected to mention specifically the variables considered for each statistical method (to facilitate Readers to understand better). For example, ‘linear association was carried out between continuous explanatory variables (?) and GP registration’.

   We have added the missing information in the revised manuscript. However, the discussion on linear association may be removed, as it was another way of presenting the association between explanatory variables and GP registration (since association between recoded binary variable and GP registration was tested and shown using chi square)

   • The criteria for selecting variables based on bivariate analysis for multivariate analysis do not go with conventional criteria. Conventionally, those variables which were significant at 5% or maximum of 20% level (p<0.20) will be included in the multivariate analysis. Why has the author chosen to include up to p<0.6?

   Many thanks for pointing this out. In fact, it was a gross mistake in the manuscript. A p value of 0.07 in the bivariate analysis was the maximum for an explanatory variable to enter the multivariate analysis. We have corrected this mistake in the revised manuscript.

2. Result:
   • A sentence/paragraph should not start with numbers. However, the number can be written in words.
We have corrected this.

Page 7 & 8.
• Put the description of 5-point scale as well as 10 questions (whatever you have put it in the brackets in the result section) in the materials and methods section instead of results section.

We have added more information on this as suggested.

Page 6 & 7.
• The author has mentioned in the ‘Study population and sample size’ that Burmese migrant lived more than 5 years in UK were recruited for the study whereas in the analysis it was observed that ‘nearly 38% of respondents were students with a stay of one or more’. Can you kindly clarify this?

For the quantitative survey, the selection criteria were: “Burmese migrants aged 15-60 years and residing in Greater London”. However, for the qualitative in-depth interviews the selection criteria were: “migrants from different socio-economic clusters were selected who had lived in London for more than 5 years and in at least 3 different areas of London”.

Knowledge Page 8.
• Instead of saying ‘out of 5 questions, 3 questions were answered….’. Please describe it. The author should provide the information directly to Readers instead of Readers trying to understand from different sources.

Good point, it is corrected.

Pages 8: second paragraph
• “… The registered population had less knowledge on health care entitlements of asylum seekers than the unregistered population”. Readers may like to have the table for this inference. Instead of presenting OR and p-value, presenting OR and its 95% Confidence Interval (CI) is recommended.

Thanks for this advice, the CI has been added. Regarding the table, no other knowledge question gave significant association with the GP registrations status and so we omitted others from the article.

Page 9: GP registration
• The ORs reported in the text do not match with table 1. It is better to have OR & its 95% CI than OR and p-value. When the computer output shows p value as 0.000, kindly report it as p<0.001 in the report.

Thanks for your kind guidance. We have checked and changed the way we present in the revised manuscript. Regarding the OR discrepancy, the table presented the odd ratio as a barrier to GP registration which is for “35 and above”. In the text, we discussed the factors favouring the GP registration. The odd ratio became reversed (reciprocated).
We have changed page 9 (second para), with factors favouring and factors deterring GP registration.

- It was attempted to find out correlation co-efficient between a continuous variable (age, etc.,) and nominal variable (GP registration). It is not appropriate. Instead, the author may compare summary measures (Mean (SD) if variable is normally distributed in each nominal group or Median (IQR) if variable is not normally distributed in one of the nominal groups) between two groups: people registered with GP and people not yet registered with GP.

- Multivariate analysis may be repeated after considering all the above points
  
  We would suggest to remove the correlation test as advised by Ilse Blignault (comment 20).

3. Discussion

- “Our study found a relatively high …….”. Is it related to migrants from other nearby countries (such as Nepal, etc.,) to UK? Have you looked into the literature? If so, support with reference.

  The first paragraph of discussion on page 11 is just an introduction of the overall discussion and literally repeating the later discussion as a summary. The comparison with reference is discussed in page 12 last paragraph.

- “The statistical analysis showed that being 35 years or older, .......... were the main barriers hindering Burmese migrants from accessing PHC services “. Where is the result for this statement? Whereas the number in the table 1 provides different conclusion.

  Many thanks for pointing this out. It was a careless mistake (as age was described all the time with 35 and above), which has been corrected to “age being younger than 35 years.”

4. Figure captions

- It is recommended to have the figure caption, possibly, inside the graph or write it at the bottom of the graph instead of having it separately.

  Done

Figure

- In order to make graph simple and easy to comprehend, kindly provide information related to the time of survey in each graph.

  Done

- Let the category ‘Others’ should be at the end or bottom of the graph instead of 1st category or middle (fig 1, 3, 4).

  All the figures have been changed according to the advice.
• Fig 2. The order of the category may be reversed in order have the order as it is in the questionnaire

Done

5. Tables
• Table 1: There is no need of chi-square statistics, degrees of freedom and p-value. CI and p-value are related and CI is more informative than p-value. Thus the columns in the table will have headings such as No (%) for each category of GP registration, OR and its 95% CI. The OR against reference category of the independent variable may have the value of 1. This will facilitate Readers to understand which reference category is.

Done

• Table 2: The author may provide numbers with similar heading as suggested for table 1

Done

Level of interest: An article of importance in its field
Quality of written English: Acceptable
Statistical review: Yes, and I have assessed the statistics in my report.
Reviewer's report
Title: Access to primary health care among Burmese migrants in London: a cross-sectional descriptive study

Version: 1 Date: 29 April 2010

Reviewer: Ilse Blignault

Reviewer's report:

This study addresses an important issue: How well are services in high-income countries responding to the challenges presented by unprecedented migration from around the world, with the instance under study being access to and use of GP services in Greater London by migrants from Burma. Unfortunately, I was unable to access a copy of the survey questionnaire. Survey questionnaire and qualitative interview guidelines were added as additional documents.

I found the study interesting (Burmese migrants in the west are a relatively small and little studied group), but somewhat confusing to follow. In particular, the approach and methods need to be more fully described and the results need to be related to existing literature on health service utilisation by immigrant groups. Specific suggestions and comments are listed below. The majority I would classify as major essential revisions.

1. The paper would also benefit from a brief description of the Burmese in London: Who are they? When and why did they migrate? How many have refugee backgrounds and/or were exposed to trauma and torture? What are their general circumstances now? (Incidentally, I would appreciate early clarification of the term ‘migrant’ as used here, as I would not usually use it to cover tourists and students who will return to their home country after their studies.)

   The originality of the current research makes it difficult to get such information on Burmese migrants in London. However these were touched on in the Results section under socio-demographic characteristics.

   Furthermore, as our study population size is very small, it was difficult to make a study with the specific group of migrants. In addition, there are less Burmese tourists (except for some visiting dependents which is also very rare) and students just come for a study. This is why the research is targeted at the Burmese-born population currently residing in Greater London.

2. Similarly, a brief description of how the primary health care system works in the UK (GP registration etc), and the entitlements of citizens and others to services, would be useful for an international readership.

   A brief description of the health system in the UK was added on page 4-5 (last-and first paragraph) of the revised manuscript.
3. p.2, first line of Results: Needs qualification such as “… of [roughly] equal
gender”.

   Revised to: “had more or less equal gender distribution”

4. p.4, para 1: Reference to estimated number of Burmese migrants in London as
being approximately 10,000 is inappropriate here, as it is a result. It would be
useful though to have an idea of the official figures/estimates, along with a brief
description of the community as described above.

   We have added national data (Department of Work and Pension, Office of
National Statistics and 2001 census data, together with local estimates (page 4:
second last para)

5. p.4, para 2: References need for last sentence.

   Reference added


   Thanks.

7. p.5, Study design: How did the in-depth interviews help estimate the
population, and prepare the questionnaire?

   Revised and also pre-survey in-depth interview record sheet was added as
additional file.

8. p.5, Study population and sample size: Would probably be easier for the
reader if all the information re population estimation was in one place, and you
gave the various figures – 2001 census, any later official figures on new arrivals,
national insurance number registrations, and key informant estimates.

   Revised as mention in the comment 4.

9. p.6, para 1: How were the socio-economic clusters selected? What was the
spread?

   The respondents for the in-depth interviews were from different social clusters,
such as students, refugees, general workers and office staff. As these were key
informant interviews, the spread by area coverage couldn’t be counted.
However, to ensure them having knowledge on different areas of London with
Burmese migrants, they were recruited with the selection criteria of those who
had lived in London for over 5 years in at least 3 different areas.

10. p.6, Data collection: Exactly How did the snowball approach work – Did one
informant hand the questionnaire to the next informant, or did he/she give the
volunteer the name of another person to approach? Was the informed consent
verbal or written?
Each questionnaire distributor distributed the questionnaire to the first respondent in their area and he/she asked the first respondent who he should continue to approach.
There was an information sheet attached to the questionnaire, explaining the research and how information provided would be kept confidential. The consent was included as a first question in the questionnaire (ticking the box, no signature).

11. p.7, para 1: Why p (not p') value less than 0.6? That seems high.
   
   Sorry, it was our careless typing mistake, we have corrected to 0.07.

12. p.7, para 2: The figures cited for English proficiency (listening, speaking and describing illness) are conflated and don't match the figures in Table 1. Where does the 85% come from?
   
   When presenting language proficiency, the fair, well and very well were aggregated for to one group which in all three skills have more than 85%. But in calculating the odds ratio, well and very well are aggregated to one group and the rest (fair, poor and very poor) were aggregated to one group (on one reported to have very poor in all three skills).

13. p.7, paras 2 & 3: Try “reported having” instead of “reported to have”.
   
   Thanks, changed

14. p.7, para 3: Do you mean “reported that they were working”?
   
   Thanks, changed

15. p.7, para 3: I have problems reconciling the figures here with Figure 1.
   
   The current immigration status (black bars in the figure 1) was stated in para 3 of page 7. The gray bars represent the entry immigration status.

16. p.8, para 1: The relevance of the questions on family planning and abortion is not clear.
   
   As part of assessing knowledge on primary health care entitlement, knowledge on reproductive health care entitlement was also assessed. We consider this as an essential knowledge.

17. p.8, para 2: Odds Ratio or OR. How do you explain this result?
   
   People who are registered with a GP have a lower knowledge (less than half, 45%) on health care entitlements than unregistered people. We have modified the text to be clearer.

18. p.9, para 1: What happened to the few respondents who were unable to
register with a GP? What was the problem?

There were five respondents who reported they were unable to get registered: 4 with documentation problems and 1 with a communication problem (added in the manuscript)

19. p.10, para 2: The results reported all make sense.

Thanks

20. p.9, para 3: Here you seem to be reporting the results for several of the same variables (age, income, duration of stays) as continuous variables. Correlations, though significant, are in the low range. This paragraph doesn’t add much.

In case the word limit proves problematic, this paragraph will be removed, as the relationships of these variables with GP registration have already been discussed as binary variables. Please let us know.

21. p.10, para 2: Do you have data on the nature or severity illness experienced? This would help interpret the use of self-medication.

Yes, according to your advice, after aggregating the multiple response answers, I have tried chi -squared and odd ratios between the self medicated and medical doc group with the severity of illness. The odd ratio was just around one and p value not significant. Please find below the detailed information.

<table>
<thead>
<tr>
<th></th>
<th>Self med</th>
<th>Med doc</th>
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<th>Others</th>
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<td>Mod</td>
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<td>Mild</td>
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</tbody>
</table>

OR 1.001451

22. p.11, Discussion: The figures for GP registration and use should be compared with the figures for the general population, if not with other migrant groups for whom the data is available. Similarly, the results (being 35 years or older etc) should be discussed in relation to results of other relevant studies in this setting and elsewhere.

The first para of page 11 is an introduction to the discussion with our main findings. It is also a repetition; otherwise these issues are discussed in later paras.

The GP registration rate of Burmese migrants was compared with the GP registration rate of A&E attendees of an inner London hospital (page 12, last para).
It was our gross typing mistake again, actually younger population had less GP registration than 35 and above (already corrected in manuscript).

23. p.11, para 3: A more useful comparison would be the study sample with the broader Burmese population in London or even the UK.

Lack of previous research and population profile of Burmese migrants has limited our ability to conduct a broader discussion.

24. p.11, para 2: Problems with incomplete data and sensitive questions well noted – good.

Thanks.

25. p.12, para 2: Here you introduce data on hospital use (by Burmese migrants? by other migrants? by both?) but I have difficulty understanding the point you are trying to make.

It was the findings of a research conducted on international migrants among an inner London hospital’s A&E attendees. Their GP registration rate was lower than that of Burmese migrants. We have made this easier to understand.

26. p.13, para 3: I am not sure of the relevance of this comparison. I would regard African migrants living with HIV/AIDS as a very different group.

We feel that it is relevant to some extent, as migrants in general who come from developing countries and face socio-economic problems could face similar barriers of health care service utilisation.

27. p.14, para 2: Good, relevant discussion.

Thanks.

28. p.14, Conclusion: As above, “[roughly] equal gender’. You don’t have to repeat the figure here.

Have changed.

29. p.15, para 1: I would be very surprised if this information did not exist in the UK. It certainly does in Australia, New Zealand, Canada, and the US.

We have not been able to identify research comparing the service utilisation rate of individual migrant groups in the UK.

30. p. 15, para 2: Any suggestions as to how those migrants “with an unstable immigration status and not presently engaged in formal employment” could be encouraged to use services, or services to reach out to them?
We would suggest information sheets and telephone hotlines for health and immigration issues and have added this to the revised manuscript.

31. p.15, para 3: Discussion on self-medication is good; please reference the “corroborating research”.

It was stated in page 14 second para at the end. But references were added again here.

32. Captions to Figures 3-5: I don’t understand “case-wise” and “response-wise”. If you allowed multiple answers, what did you code case-wise – the first response? In general, I think just reporting percentage of overall responses is the simplest way to present such data. Looking at the graphs, the overall pattern seems similar.

I am not sure if my way of thinking is correct: In case-wise, I used total number of response under study (not only the first response, it could be first or second or third ….) over total respondents which give prevalence of response under study among the respondents. In response-wise presentation, it gives proportion of each response to total response within 100%.

I do agree that they both have similar pattern, but I still like to give the idea on the prevalence of each response among the population.

Level of interest: An article whose findings are important to those with closely related research interests
Quality of written English: Needs some language corrections before being published
Statistical review: Yes, but I do not feel adequately qualified to assess the statistics.
Declaration of competing interests: I declare that I have no competing interests.
Reviewer’s report

Title: Access to primary health care among Burmese migrants in London: a cross-sectional descriptive study

Version: 1 Date: 29 April 2010

Reviewer: Fu Keung Daniel Wong

Reviewer’s report:
Comments on the manuscript “Access to primary health care among Burmese migrants in London: a cross-sectional descriptive study”

1. Is the question posed by the authors well defined?
‘Access to primary health care’ was operationally defined in the study as ‘Access to GP services’. This operational definition is subjected to debate because ‘GP services’ is only one aspect of primary health. Moreover, it would seem more preferable to include “a utilization’ dimension in the definition of access because I imagine the underlying reason for doing this study was to try to understand how much and how well Burmese migrants have been using primary health care. Indeed, as the authors mentioned, while the GP registration was high, the actual utilization was much lower.

The article title has been changed to “Access to and utilisation of GP service among Burmese migrants in London”.

I am not sure why ‘knowledge on health care’ was included, as it was not adequately discussed in the Background section. Indeed, there is need to provide more information about Burmese migrants and about the health care system in the UK.

Knowledge on the health care system (rights and entitlements) is likely to have significant influence on health care service access and utilization. We have added information on the current health care system in the UK regarding migrants. However, information on Burmese migrants in London is very limited - this was the main reason why the research has been carried out.

One other point is that, student migrants are usually separately researched from refugee or ordinary migrants. However, this study appears to have lumped all of these categories together. Why? This might have introduced biases in the sample and might have made the interpretations difficult.

The reason for this is that the study population is small and doing research on separate group would not yield enough sample size and statistical power. Furthermore, the hidden nature of migrants with unstable immigration status made it challenging to pursue research solely on these groups.

2. Are the methods appropriate and well described?
The sampling method was one of snowball, and convenience sampling. Given the difficulty in recruiting migrants (i.e. common difficulty found in migrant studies), I believe the authors had done a pretty good job in recruiting subjects.
Having said this, the sample could still be biased, with a younger, and student migrants in the sample. Can the authors provide information about Burmese population in London or Europe and make an attempt to compare their similarities and differences.

To our knowledge, no research has so far been conducted on Burmese migrants in London or elsewhere in Western Europe. The lack of previous research was the main reason to conduct our study. We hope that future studies will benefit from our results.

It was a good attempt to use qualitative data to triangulate the quantitative findings. However, very little was mentioned about the qualitative part of the study that was conducted. Besides giving the readers the number of participants, can the authors tell us more about the questions asked (i.e. interview schedule), the ways the data was analysed, and to use the data more systematically in the results and discussion.

The qualitative interview guideline was added as an additional document and we also provided more extracts from the qualitative interviews.

Can the authors put in a paragraph about the objectives of the study?

The objectives were stated under the aim in the last paragraph of the Background.

3. Are the data sound?
The statistical methods used were appropriate. However, as mentioned, the sampling method might have resulted in certain biases in the data. Therefore, the authors need to discuss the data in a more confined manner so that it would be more reflective of the sample characteristics of the study.

Lack of prior research and population data on Burmese population were the study limitations. Bias in the sampling has been discussed in the second paragraph of Page 11 (first submitted version). Furthermore, we also mentioned in the same paragraph that generalisation couldn’t be easily made according to the existing inevitable bias in the study.

4. Does the manuscript adhere to the relevant standards for reporting and data deposition?
I have no further question about the quantitative aspect of the reporting, but have raised my concerns about the qualitative aspect of the reporting.

We have addressed this issue by adding more qualitative results to the manuscript, improving our triangulation.

5. Are the discussion and conclusions well balanced and adequately supported by the data?
The study did raise some interesting issues such as the reason why there were delays in seeing GP: cultural preference for self-medication. The authors mentioned that socio-demographic factors had stronger effect on GP
registrations. Why?

Page 12 last para and table 1 show the effect of social demographic factors on GP registration. We used “seem to have stronger effect” as compared to knowledge on health care entitlement as per research finding knowledge score didn’t show significant association with GP registration, though other socio-demographic factors do.

Can the authors discuss each of these factors and provide explanations as to how they might have influenced GP registration in the UK?

Effects of socio-demographic factors on GP registration were stated on page 9 first para and discussed in Discussion (Page 12 last para), with a comparison with other studies.

6. Are limitations of the work clearly stated?
Yes.

7. Do the authors clearly acknowledge any work upon which they are building, both published and unpublished?
Not applicable.

8. Do the title and abstract accurately convey what has been found?
I would suggest the authors to rewrite the title to “access to GP services” rather than “to primary care”.

The title has been changed to “Access to and utilisation of GP services among Burmese migrants in London”.

9. Is the writing acceptable?
Yes.

Major Compulsory Revisions (which the author must respond to before a decision on publication can be reached) are required.

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

Quality of written English: Acceptable

Statistical review: Yes, and I have assessed the statistics in my report.

Declaration of competing interests:
I declare I have no competing interests