Author's response to reviews

Title: What socio-demographic factors influence poverty and financial health care access among disabled people in Flanders? A cross-sectional study

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Author's response to reviews: see over
What socio-demographic factors influence poverty and access to health care among disabled people in Flanders? A cross-sectional survey

Answers to the Editor:

- Time and place were added to the titles of the tables.
- The tables are included at the end of the manuscript.
- A supplementary file was added, including a pdf of the revised manuscript showing the track changes.

Answers to the reviewers:

Reviewer 1

Pag. 4, concerning the five levels of dependency.

- The following paragraph was inserted into the manuscript to clarify how the levels of dependency are assessed: ‘The level of dependence is generally determined by a medical assessment, based on a score from zero to three on the following six items: transportation, nutrition, personal hygiene, housekeeping, danger recognition and communication and social interaction.’

The use of ‘independency level’.

- Reviewer 2 also mentioned this item. We changed the terminology with the focus on dependency, for instance: high level of independency has now become low level of dependency.

Pag. 7, concerning the issue of living with someone as a risk factor for poverty.

- We added a sentence to try to explain how this mechanism could work: ‘In this study, living with someone seems to be associated with a higher risk of poverty. This could point to an inadequate adjustment of the height of the allowances according to the family situation.’

Concerning the issue of the ‘social gap’.

- Some studies for Belgium on this topic are added and the following part is included in the manuscript: ‘Several studies have investigated the ‘social gap’ in Belgium. The starting point in these studies is the general population with a focus on socio-economic inequalities in health expectancy [33] or socio-economic differences in the utilisation of health services [34]. One study showed that compared to the highest educated population, differences in the prevalence of disability accounted for at least 66% of the inequality in disability-free life expectancy [35]. In our study, however, the starting point were the disabled people themselves, which opens a new perspective on health (care) inequalities in Belgium.’

Regarding more elaborated suggestions as to further research.

- A new heading is added to the manuscript, just before the general conclusion: ‘Suggestions for future research’. The following text is inserted: ‘We would like future research to focus on
possible structural measures in order to decrease poverty and impaired health care access amongst disabled people. Furthermore, some more research regarding medical costs for disabled people in Belgium is necessary. We suggest future research to include the duration of the disability (inborn or acquired disability) and the social background of the disabled respondents.’

Regarding the newly proposed funding systems in Flanders.

- In the Discussion section, we inserted a compact overview of newly proposed measures from the Flemish government with a short appreciation (from: ‘Current developments in Flemish policy include...’ to ‘...with the increasing welfare in September 2013 [32]’.

Regarding a comparison as to the level of institutionalization of disabled people in general and in this sample compared to other regions and countries.

- It is very difficult, if not impossible to have correct data on this issue. It is hardly possible to calculate the denominator. Institutionalization is not a homogeneous terminology. For instance, some disabled people reside in an institution for two days a week and receive volunteer aid on the remaining days. Nevertheless, we tried to give some numbers and the following part was included in the manuscript: ‘In Flanders in June 2010, 35,298 places in a licensed care institution for disabled people providing accommodation, support and care, were available. Of these, 24,511 places were residential or semi residential care institutions, 10,787 places were reserved for ambulant care and support [11].’

Reviewer 2

Major compulsory revisions

1. Abstract §5. We thank the reviewer for this remark. We reformulated the conclusion: ‘This research confirms that disability is associated with a higher risk of poverty and impaired health care access.’ We also changed the word ‘influence’ on page 3 into ‘association’.

2. Abstract §4 and Methods end of §2. Again, the reviewer has a point. The wording of the level of independence was not totally clear. Reviewer 1 made a similar remark. We changed this throughout the manuscript by writing ‘a low level of dependence’ instead of ‘a high level of independence’.

3. Introduction §1. The references as suggested by the reviewer were included in the manuscript (references 3 and 5) to support our statements. The references 1 and 5, referring to the Indian population were deleted.

4. Discussion §4. In an appendix, the description of the population is presented. This is referred to in the Results section: ‘See the appendix for a more detailed description of this convenience sample.’ Regarding the ‘Strengths and limitations’, we rephrased the sentence referring to the sample size as a strength of the study: ‘With a sample size of 889 respondents, this sample accounts for approximately 1.2% of all Flemish disabled people...’. The reviewer has right when saying that the wording ‘Our results can be compared with the general population’ was not correct. This is now rephrased: ‘By including questions from the
Belgian Health Interview Survey, we were able to explore differences and similarities between the study population and the general population.’

5. Methods §3. We changed the phrasing regarding the at-risk-of-poverty threshold as follows: ‘...the threshold is raised by a factor of 0.5 for the second and each subsequent person aged 14 and over and by a factor of 0.3 for each subsequent person aged under 14’ and we referred to Eurostat (reference 20) as suggested by the reviewer. Some examples were given for Belgium (at-risk-of-poverty threshold for a one person household, a single parent with a child aged under 14 and a childless couple or a single parent with a child aged 14 or over).

6. Methods §4. We did use the Chi-square test for categorical variables and student t-tests for continuous variables (for the descriptive statistics). This is now clearly formulated in the Methods section.

7. Methods §4. We defined the binary variable ‘impaired access to health care due to financial reasons’ more in detail in the manuscript: ‘After addition, zero was defined as ‘having no problems with financial health care access’ and one till four as ‘having (a) problem(s) with financial health care access.’

8. Methods §4. We rephrased the way in which the analyses were performed as follows in the manuscript: ‘Analysis took place in three steps: descriptive statistics (Chi² (χ²) for categorical variables, student t-tests for continuous variables), unadjusted multivariate logistic regression models and adjusted multivariate logistic regression models were calculated. Descriptive statistics provided a first screening towards influential variables for the logistic regression models. Inclusion of the variables in the final adjusted model was based on a significance level (p value) of p<0.001. Variables were checked for multicollinearity and no issues were identified.’

9. Results §2. Under the heading ‘Factors associated with poverty’, we rephrased the results for ‘living under the poverty threshold and we referred also to table 2.

10. Results §3. Table 3 and table 1 are referred to.

11. Results §5 and §6. We changed the name of R² into pseudo R²

12. General. An appendix was included with the structure of our sample.

Minor essential revisions

1. Abstract §1 & §2. In the title, the word ‘financial’ was inserted (What socio-demographic factors influence poverty and financial health care access among disabled people in Flanders?). In the Background, a sentence was inserted: ‘Disabled people often experience difficulties with health care access. Also in the objectives, a sentence was inserted: ‘To assess the current financial situation and poverty rate amongst disabled people in Flanders.’

2. Abstract §4. The results are reported at two decimal points now.

3. Introduction §1. The sentence is rephrased for the sake of clarity.

4. Methods §1. More details are given here. The following part is inserted in the manuscript: ‘...by manually checking the digital data with the paper survey versions.’

5. Methods §2. This correction has been made: ‘...whether respondents or members of their households had postponed...’

6. Methods §6. We changed this according to your suggestion: ‘Other topics in our survey...’

7. Results §5 and §6. Crude analysis was changed to unadjusted analysis.
Discretionary revisions

1. Abstract §4. In the results section of the abstract, we made clear that we used a convenience sample.
2. General comment. We use now a uniform terminology, ‘financial health care access’ throughout the manuscript. Also in the title, the word ‘financial’ is inserted to make clear that we do not focus on other barriers such as time, geographical, cultural, .... Furthermore, in the discussion section, the following sentence is inserted: ‘In this survey only financial barriers to health care were assessed. Other studies reveal other barriers that could possibly cause impaired health care access, for example waiting lists, impaired mobility, fear and others.’ (with a reference to Eurostat).
3. Introduction §1. We now begin our paragraph with the statement: ‘International research on poverty and health care accessibility among disabled people is scarce.’
4. Introduction §2. At the end of the introduction section, a paragraph is now inserted describing some important measures to reduce financial barriers in Belgium (‘Some disabled people can benefit from certain important governmental measures...’). The references suggested by the reviewer were included.
5. Methods §1. We added the following sentences: ‘As this is a first study in Flanders, we aimed to include as many respondents as possible. Therefore, we included people with all types and levels of disability and no distinction was made in duration of disability during the sampling stage. Hence, this convenience sample defines a heterogenic population.’ AND ‘The sample should be considered a convenience sample.’
6. Results §1. We added ‘of the respondents’ in the sentence. We deleted ‘also’ in the sentence beginning with: ‘Women and respondents with children...’
7. Results §4. Due to changes in the manuscript, the phrasing ‘The results... are shown...’ does not occur anymore in the text.
8. Results §5 and §6. We understand the question of the reviewer but we decided not to present the results together because the table becomes rather cluttered.
9. We did assess the risk of multicollinearity and this was mentioned as follows in the manuscript: ‘Variables were checked for multicollinearity and no issues were identified.’
10. Discussion §1. We rephrased the sentence as follows in the manuscript: ‘This means a larger proportion of our sample population lives in poverty, compared to the Flemish general population (one tenth) and the Belgian general population (one seventh).’
11. Discussion §1. We explained this further in the sentence: ‘...because we did not take disability-related expenses into account, which can seriously diminish one’s disposable income.’
12. Discussion §1. We combined the first part (‘The EU SILC poverty threshold is commonly used in other studies.’ with the second part: ‘The poverty threshold as defined by the EU SILC is commonly used in other studies and this instrument is the EU reference source for comparative statistics on income distribution and social inclusion at the European level and is also recommended by Eurostat.’ We have put it under the heading ‘Strengths and limitations’ of the Discussion section, because we think it is a strong point of our study.
13. Discussion §2. We changed ‘our’ into ‘the’ respondents. Elsewhere in the manuscript (Abstract and Results section, first paragraph), it is clearly mentioned that the sample is a convenience sample.

14. Discussion §3. This sentence is rephrased as follows in the manuscript: ‘Unemployment (i.e. the lack of an employment income) is a risk factor for living under the poverty threshold and impaired financial health care access. This might be interacting with the level of dependence. Unemployment could provide a higher risk for poverty for people with a low level of dependence, since they have a lower integration allowance to rely on.

15. Discussion §3. We rephrased the sentence as follows: These results indicate that the subpopulation of unemployed disabled people with the lowest level of dependence has a higher risk for poverty and for difficulty in accessing health care because of financial reasons.

16. Discussion §4. We changed ‘responder bias’ into ‘response bias’.

The authors would like to thank both reviewers for their valuable comments and suggestions, which made the manuscript a lot better than it was.