Reviewer's report

**Title:** Systematic Analysis of Four Studies in a Comparative Framework Reveals: Consent Rates on British Cohort Studies Higher than on UK Household Panel Surveys

**Version:** 3  
**Date:** 28 July 2014

**Reviewer:** Lisa Calderwood

**Reviewer's report:**

Overall, I found this paper very interesting. It is a worthwhile contribution to the literature in an emerging and important field. The paper was well written, structured and clear, and used appropriate statistical methods. The comparative nature of the paper, and the fact that it utilises some of the UK's largest and most important longitudinal studies, also contributes to the strength of its' findings.

I do not have any major compulsory revisions or minor essential revisions.

I have the following discretionary revisions:

1. Title - I would strongly recommend including 'Health Linkage' prior to 'Consent Rates' (or similar) in the title to make it clearer what kind of consent rate is being refereed to,

2. 'Health-focus' - one of the major strengths of the paper is its' ability to compare different studies and it uses the different levels of 'health-focus' to test an important hypothesis. While I agree with the categorisation of the different studies by the degree of health focus, I know these studies well and I wonder it is might be helpful to a reader who is less familiar with them to bring this out more clearly. At the moment, this comes in the study descriptions and could be a bit lost among the rest of the descriptions, so I wondered if the authors could draw this out more clearly e.g. summary table on how 'health focused' each study is. Related to this, there is actually no mention of any health data in the description of BHPS - I assume because there is none, but worth stating this. I wondering if you could use some kind of summary measure e.g. proportion of the questionnaire that is about health - all/most/some/a little/none, or something along those lines.

3. Description of NCDS linkage protocol (and Table 1) (lines 176-197)

I felt that the description of the protocol could be clearer that an information leaflet about linkage was given, and about when and how this was given. Table 1 states that this was given at the interview by the interviewer but this is not clear from the description.

4. Written versus verbal consent

One of the other main differences between the studies in the protocols was that
NSHD and NCDS required written consent whereas for BHPS and UKHLS it was verbal. Is that correct? I think it would be helpful to state this more explicitly and perhaps include in Table 1.

5. Level of Interviewer experience of asking consent (Table 1)

Table 1 implies that there are differences in the level of interviewer experience in asking consent and that NCDS, NCDS and UKHLS differ in this regard. I wasn’t sure where this information comes from, as this is not discussed in the study descriptions. If this is the case, and is central to the argument of the paper, it should be better evidenced. I would anticipate that these different studies varied in the amount of emphasis they placed on linkage during project-specific interviewer training, but given that they are all using lay-interviewers working for a fieldwork agency, I would be a bit surprised if the interviewers really did vary systematically in this regard. I would suggest considering dropping this from the table.

6. Other differences between studies

As well as their health focus, there are also a number of other differences between the studies. Some of these e.g. everyone same age in cohort studies, is mentioned in discussing the results. But I wonder if some of the others (annual interviews, multiple respondents, baseline vs later wave) need to discussed a bit more, in order to rule them out as the driver of the observed differences in consent rates.

7. Socio-economic vs. health variables

One of major findings is that socio-economic variables are more related to consent in household panel surveys and health are in cohort studies. Though, of course, by design there are more socio-economic data in panel surveys and less in cohort studies, Similarly, there is more health data in cohort studies and less in panel surveys. Ideally you would want all the measures in all of the studies, but you don’t have this. I agree that you have enough of each in all the studies to draw this conclusion, but I would suggest perhaps discussing this issue more directly in the text.

8. Implications

I wondered if you could draw out the implications for other studies a bit more clearly? e.g. there is a debate in the literature about the placement of consent questions, do your results speak to this? Or do you feel that you can give any practical advice to studies asking for health linkage consent, particularly if they are not about health i.e. they need to work harder to explain the benefit/rationale.

I have one minor essential revisions:

9. Table 1 - always capitalise 'Hospital' in the final row.

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