Reviewer’s report

Title: Predictors of participation in preventive health examinations. Is there a “Healthy Screenee effect?”

Version: 1  Date: 24 July 2013

Reviewer: Ciaran O’Neill

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Major revisions

The paper would benefit from a fuller discussion of the tests included in the comprehensive screen, where these are offered by whom and in what context. For example, are the screens provided to all individuals (stratified by gender) by the same type of practitioner in the same type of clinical facility? Is there a hurdle mechanism by which they are offered for example by a family doctor but performed elsewhere (which seems likely)? If there are differences in where screens are offered that correlate with socio-demographic grouping this might explain variations in uptake. Equally if screens are offered (say) only by family doctors might observed variations reflect differences related to how doctors are reimbursed for other services and efforts they expend in securing this income stream? These issues need to be explored.

In respect of the methods, the categorization of any chronic condition in a single variable strikes me as destroying potentially useful information. Did the authors consider using a count of conditions or including a series of dummy variables for each condition? The stratification by gender I imagine reflects a recognition of differences by gender in the type and number of tests offered to males and females – though it would be useful to have a rationale provided. If this is the case might stratification by age group not also provide a useful line of enquiry? PSA testing, mammography and cervical screens will all vary by age.

A key finding of the paper is that (line 374) the check-ups are used by a high proportion of people who were not the primary target group. Given the range of tests that appear to be covered, the possibly of tests for primary and secondary prevention, that those not tested (e.g. by virtue of an existing condition) may be under routine surveillance by other healthcare professionals, this conclusion seems overstated.

Minor issues:

Line 53 – the authors I think confuse “more often” with “more likely” – they don’t have count data to work with.

Line 58 – the conclusion in respect of respondents with chronic conditions is not I think supported. Checks may relate to secondary prevention and as noted what if any other health checks, tests etc. respondents are in receipt of is unclear.
Line 163 – explain why Cronbach’s alpha is reported and what it tells us.

Line 216 ff. My understanding is that the comparisons reported must be stratified and remain separate for the two genders. For example, at lines 223-225 the base categories in two regressions differ making the comparison of females and males by age meaningless.

Line 315-317 – the results could be interpreted as showing differences in health consciousness but I don’t think they definitively show it.

Recommendation:
Major revisions required before publication.