Reviewer’s report

Title: Gender differences in the utilisation of health-care services among the older adult population of Spain

Version: 1 Date: 6 December 2005

Reviewer: Elizabeth Madigan

Reviewer’s report:

General

Major Compulsory Revisions (that the author must respond to before a decision on publication can be reached)

Last paragraph on page 4 is confusing—is the intent of the sentence that different social constructions of health and disease account for gender differences?

The Andersen Behavioral Model is used here but not referenced in the first part of the paper. Additionally, further explication of lifestyle factors and HRQOL as need variables is required. These choices are not consistent with much of the past use of the model so more explanation of why they are conceptually congruent is needed. E.g. how is quality of life and lifestyle factors indicative of “need” for health care utilization since need is conceptualized as objective and subjective factors reflecting the need for health care?

Page 8: what is the rationale for including these diagnoses as indicative of chronic disease? For example, heart failure is a common condition in older patients yet is conspicuously absent from the list.

Page 9: HRQOL is indicated as “the higher the score, the better the health” which more correctly should be stated as “the higher the score, the better the health related quality of life.” The equivalence of health and health related quality of life is still a matter of controversy in that there are some groups for whom the health is poor but the HRQOL is high.

The percentage change in excess crude odds ratio is central to you study and needs further explanation for readers who are not familiar with it. For example, logistic regression analyses generally report the odds ratio in a tabular format. Interpretation of the graphs is difficult because the reader has to make a number of decisions as to what the figures indicate. For example, the odds of having a hospitalization after adjusting for enabling factors changes by -200% to +700% but the OR is .79 so this means that women are less likely to have a hospitalization. But does the range have any meaning aside from interesting descriptive information? The alternative approach would be to simply put the OR’s in a table by type of utilization and category.

Minor Essential Revisions (such as missing labels on figures, or the wrong use of a term, which the author can be trusted to correct)

Abstract: fuller explanation of the meaning of the findings—what do these findings suggest?

First paragraph: the concept of compressed morbidity is receiving increasing attention and might be
worth explaining here. Specifically, the goal is that all people live long lives with disease and disability occurring only at the very end of life. Simply the fact that women live longer is associated with a higher level of functional disability.

In the analysis section, the use of p values is not as valuable because the very large sample size almost guarantees that even trivial results will reach statistical significance.

Of interest was the wide range for PCECOR of hospitalization in Graphs a and b. This is worth at least some discussion of why hospitalization is so different than the other utilization variables.

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Discretionary Revisions (which the author can choose to ignore)

What next?: Unable to decide on acceptance or rejection until the authors have responded to the major compulsory revisions

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

Quality of written English: Acceptable

Statistical review: No

Declaration of competing interests:

I declare that I have no competing interests.