Invitation to attend a health check in a general practice setting: the views of a cohort of non-attenders

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SUMMARY. Two hundred and fifty-nine men and women aged 20–45 years who did not respond to an offer from their general practitioner for a health check were interviewed at home to explore the reasons for non-response. There was no support for the view that the invitation aroused anxiety or that the administrative arrangements had been a barrier to acceptance. Many subjects were not really interested (44%) or just forgot to attend (24%). Crises at work or home (26%) and current attendance at a doctor (16%) were other reasons offered, while 11% felt screening to be inappropriate. There is little that can be done to change these rates except by a shift of public opinion to more consumer demand for health checks or by more opportunistic health checks when people attend their doctors for other reasons. The dangers of marketing health checks to increase consumer demand are discussed in the light of these findings and other work.

Introduction

WHENEVER a preventive service is offered to a defined group of people there will be those who do not come forward and health professionals will naturally seek reasons for this. Two main explanations are found in the literature; the first focuses on the characteristics of the individuals themselves, particularly their attitudes and beliefs and any practical constraints or barriers which may affect some people more than others,[1,2] while the second stresses the need to look at possible inadequacies in the way the service is provided.[3-5] Of course, both sets of factors need to be considered if we are to understand the level of uptake in a particular context.

In this paper the issue is the non-acceptance of the offer of a general health check-up in an inner-city general practice. Unlike immunizations or screening for a particular condition, the offer of a general health check with appropriate health counselling is not a familiar concept to British patients. We therefore felt that it was relevant to examine the views and attitudes of those who did not accept together with the administrative arrangements and the evidence for other possible constraints on attendance. The aim, therefore, was to review the evidence for a range of hypotheses and assess their relative importance in explaining failure to attend. This study is one part of a larger programme of research into health beliefs and behaviour.[6]

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Method

The sample consisted of 259 men and women aged between 20 and 45 years on 1 January 1985 who did not attend for a health check which had been offered by the general practitioners of an inner-city Cardiff practice. The details of the sampling process and method can be found in our previous paper.[7] A semi-structured schedule was administered by an interviewer in the non-attenders' own home. Respondents were asked to recall their initial reactions to the invitation and what they did about it. Their perceptions of a 'health check' were explored using both open and Likert-format questions and their attitudes to prevention and to health promotion by general practitioners were determined. Standardized scales using a Likert-format were also used to measure various aspects of perceived control over health and the interview was concluded by collection of basic socio-demographic data.

Results

Initial reactions to the invitation

Of the 259 people interviewed, 236 (91%) recalled getting the letter of invitation, eight (3%) said that they could not remember and 15 (6%) denied that they ever had one, despite the fact they were successfully interviewed at the address to which both the original letter and a reminder were sent.

Table 1 sets out the responses of the 236 people to the question 'How did you feel about the letter?' There was no evidence that the invitation caused anxiety (94% were not at all worried by it). On the other hand, a substantial proportion of the sample (45%) said they were not really very interested and almost half had made no effort to look at or do the questionnaire that accompanied the screening offer.

There was little evidence that the wording of the invitation had contributed to non-attendance; only 18 respondents (7%) reported some difficulty in understanding it.

The 236 respondents were then asked 'So what did you do about the invitation?' Very few (3%) rejected the concept of screening outright. Table 2 shows that the main reasons advanced can be categorized as practical reasons (26%); current or future attendance at a medical service (16%); negative feelings about what would happen (5%); a belief that screening was unnecessary in their particular case (11%); lack of interest (24%); or difficulties about the appointment (13%).

Table 1. Reactions of non-attenders to the letter of invitation.

Respondents' reactions to invitation	Percentage of respondents ($n = 236$)			
	Very	Fairly	Slightly	Not at all
Interested	*15*	*41*	*20*	*25*
Worried	*0*	*1*	*5*	*94*

n = total number who recalled receiving the letter.

Table 2. Reasons given for non-attendance at the health check.

	Percentage of respondents ($n = 236$)[a]
Practical barriers	
Busy/Lack of time (unspecified)	7
Shift work/Working nights/Overtime	7
Immediate crisis/Problems	4
Distance	<1
Two of the above mentioned equally	8
Already in contact with medical services	
Pregnant	5
Attending doctor frequently	7
Had recent check-up	3
Due to go into hospital/Due to have medical	<1
Check not necessary	
Feeling quite healthy/Fit	5
Only go when ill/No need to go	6
Lack of interest	
Did not get round to it/Lazy/'Forgot'	24
Problems with appointments	
Appointment was inconvenient/'Forgot' when on holiday	9
Not sent another appointment	4
Negative feelings about what would happen	
For example, do not like staff there/Do not like having to wait around	5
Rejects concept of screening	3
Misunderstood invitation	
Did not realize it was necessary to make appointment or do something else	3
Other reason	5

[a]Respondents gave more than one reason.

Administrative arrangements

None of the respondents commented that the appointment arrangements for the health check were inconvenient and accessibility was not a problem as the majority of both attenders and non-attenders lived within a one mile radius.

Other commitments

When asked about other commitments which could have prevented their attending only 18 non-attenders (7%) mentioned specific problems associated with shift work, overtime or long hours and 39 (17%) overall gave lack of time as a reason for non-attendance (Table 2). However, non-attenders were significantly more likely than attenders to report being responsible for children under five years old (chi-square test, $P<0.01$) or other dependants such as older children still at home, elderly relatives, and neighbours and friends ($P<0.001$). They were, therefore, more likely than attenders to perceive themselves as having more calls on their time ($P<0.01$) and say that they did not find it 'very easy' to get away from home and other commitments for a couple of hours during the day ($P<0.01$). Interestingly, among women, those who worked outside the home were more likely to attend ($P<0.01$), suggesting that they may give health preventive behaviour a higher priority than perceived time constraints.

The influence of others

One hundred and fifty of the 236 non-attenders who recalled receiving the invitation (64%) reported that they had mentioned the invitation to someone, and there was little evidence that they had been actively discouraged from attending. Only 12 of them (8%) said that the other person had told them not to bother or said they would not go themselves (Table 3). The remainder reported positive encouragement to attend (39%) or a laissez-faire attitude (17%) and there was no evidence that the nature of the advice varied substantially according to who was giving it (Table 3).

There was also nothing to suggest that non-attenders might have received unfavourable reports of the screening procedure. Of the 40 who knew someone who had attended, 12 claimed that they had been encouraged by the person to attend while the remainder reported that no attempt had been made to influence them.

Perceptions of the health check

Respondents were asked what they thought happened when someone attended surgery for a health check and why, in their view, some people might go. Twenty per cent of the 259 non-attenders said they had 'no idea' what happened at a health check and 55% indicated that they viewed it essentially as a passive screening procedure where various things would be done to them, for example taking blood pressure, examining the chest, eyes and so on. However, 22% thought that the health check would involve a chance to ask questions or discuss health matters (other ideas mentioned by 3%).

In considering why some people might go there was a strong feeling among the non-attenders that the motivation must be concern or worry about their health (25%) or malaise and actual symptoms (19%). Five per cent of the whole sample could suggest no reason why someone might wish to go. Ninety-three (36%) felt the major reason must be the need for reassurance and the desire to make sure that 'nothing was wrong' (other reasons suggested by 15%).

When asked about attitudes towards going for a health check 85% of the non-attenders agreed or strongly agreed that a health check was 'well worthwhile' and 73% agreed that it 'should be done quite frequently' (Table 4). Just under two-thirds disagreed or strongly disagreed it was a waste of time unless you had some symptoms and 80% disagreed with the idea that it was only necessary for unhealthy people.

However, 52 respondents (20%) indicated that they might find a health check embarrassing. Ninety-six (37%) expressed fears

Table 3. Advice given about invitation for a health check according to relationship of advisor to respondent.

	Number (%) of respondents advised by:			
Advisors' reactions to invitation	Spouse ($n = 86$)	Other relative ($n = 36$)	Other/ friend/ neighbour ($n = 28$)	Total ($n = 150$)[a]
Said it was a good idea/respondent should go/would go themselves	35 (41)	15 (42)	9 (32)	59 (39)
Said it was a waste of time/not to bother/ would not go themselves	7 (8)	3 (8)	2 (7)	12 (8)
Said it was up to respondent	16 (19)	8 (22)	1 (4)	25 (17)
Gave no advice	23 (27)	10 (28)	12 (43)	45 (30)
Respondent could not remember advice	5 (6)	0 (0)	4 (14)	9 (6)

[a]Number who reported discussing the invitation with another person.

Table 4. Attitudes towards going for a health check among 259 non-attenders.

Going for a health check:	Respondents' replies (%)				
	Strongly agree	Agree	Un-decided	Disagree	Strongly disagree
Is a waste of time unless you have some symptoms	7	20	8	52	13
Is not at all embarrassing	12	60	8	17	3
Is well worthwhile	26	59	8	5	2
Is only necessary for unhealthy people	4	10	6	68	12
Should be done quite frequently	14	59	16	9	2
Is worrying because of what they might find	4	33	6	47	10
Should be done by a doctor	32	57	4	7	0

that health checks were worrying because of 'what they might find'.

Finally, 230 respondents (89%) either agreed or strongly agreed that health checks should be done by a doctor. It was, of course, made clear in the original letter that a health promotion worker and not a doctor would be carrying out the check although the invitation itself came from the patients' own doctor. It is difficult to assess how far this may have affected any decision not to attend but it is worth noting that no one spontaneously gave the fact that the doctor himself would not be personally involved as a reason for not attending.

Discussion

The results show that there was little support for the view that an invitation for a general health check aroused anxiety among those who received it or that they were unduly influenced by negative attitudes of those closest to them. There was also little evidence that accessibility or the administrative arrangements had a significant effect on failure to attend; indeed, considerable efforts were made to accommodate patients with appointments offered at every time of day on six days of the week.[7]

However, 26% of non-attenders gave practical problems as a reason for not taking up the invitation. There is a temptation to dismiss the reasons given by the respondents themselves as mere rationalizations and, taken individually, explanations such as 'domestic crisis' or 'lack of time' may appear less than convincing to the health professional. As Maclean and colleagues have pointed out in the context of breast screening,[8] people may have practical reasons for non-attendance and these private and incidental considerations cannot be arbitrarily altered by outsiders.

It is worth noting also that a proportion of non-attenders (16%) reported that they were already receiving continuous monitoring by their general practitioner or the hospital or had had recent contact with medical services and therefore felt that an additional contact was superfluous. A further 11% felt that screening was unnecessary in their particular case. It is clear that the broad category of non-attenders contains several sub-groups and it is therefore misleading to stereotype them all as apathetic or irresponsible.

Having said that, the conclusion must be that consumer attitudes and beliefs are the most important determinants of whether a patient decides to attend or not. The priority accorded to screening is balanced against other demands on time, and factors such as perceived need for this service, beliefs about what is entailed and the possible implications of attendance will all affect the final outcome. It is important that the personal invitation did not succeed in arousing a high level of interest among the sample; 45% reporting that they had been 'not at all' or only 'slightly' interested. When asked directly, 24% of the respondents were quite frank that they had just 'not got round to it', been lazy or simply forgot.

Many of the respondents had a hazy idea of what a 'health check' might involve. They may also have felt that attendance would lay them open to suspicions of hypochondria since attenders were defined clearly by the non-attenders as people who were worried about their health and in need of reassurance.

It is perhaps relevant here that the concept of health maintenance is not as widely accepted in Britain as it is in the USA and even those professionals and lay people who are committed to the concept do not necessarily agree on the part that primary care should play in promoting and maintaining health among its practice population. On the one hand checks can be seen as the human equivalent of a Ministry of Transport certificate where a car is assessed for roadworthiness. This contrasts with the counselling model which assumes that the patient will take a more active part in the interview, ask questions and negotiate possible courses of action with the professionals. It seems clear that the majority of the non-attender sample viewed the health check as an MOT rather than a counselling opportunity. Moreover, despite approving of the idea, they considered that there was little point in going if one was already seeing a doctor, unless there was reason to suspect that something might be wrong or reassurance was needed. If one perceives oneself as healthy the motivation to attend will be low, particularly if there are many other demands on time.

Screening for symptomless disease is not a familiar concept to many people and can well be interpreted as unnecessarily looking for trouble. Indeed, 37% of this sample expressed fears about 'what they might find' — a theme that has been noted in other studies of non-attenders for screening.[5,8]

We have already shown[7] that this group of non-attenders were significantly less likely than those who attended the check-up to expect that they could influence what happened in their lives or to value their health, and more likely to believe that external forces, either other people (usually doctors) or impersonal forces such as luck or fate controlled their health. It would be premature, however, to assume that non-attenders would not change aspects of their lifestyle in the interest of health. This sample did accept the legitimacy of the medical profession's concern with lifestyle[7] at least in the setting of a patient-initiated consultation. They were less attracted by, or less likely to understand, the offer of an opportunity to discuss their health outside this traditional context.

Campaigns to increase public expectations and demands for the 'medical MOT' are not really part of the health promotion philosophy as they are likely to lead to inappropriately frequent requests for screening tests among the healthy anxious. The price for reaching the rest of the population could be very high unless optimum use is made of spontaneous patient generated contacts in primary health care to achieve appropriate screening and lifestyle counselling. Enthusiasm for screening in general practice is now widespread and nurses are playing an increasingly active part. Questions about its effectiveness and efficiency[9-11] are still being ignored as success at case finding is emphasized more than the outcomes.

However, the marketing of healthy lifestyles and screening for early disease seems here to stay and general practitioners will

need to begin to study the long-term implications of these trends for their practices and for their patients. For example, there is already some evidence that screening for hypertension increases the level of absenteeism from work significantly among men labelled as hypertensive, who have been previously unaware of any health problem.[12] In another study individuals wrongly labelled hypertensive subsequently had more depressive symptoms and reported a lower state of general health than a comparison group.[13] Such findings indicate the need for caution in how health promotion and screening programmes are conducted. Indeed the question must be asked 'Can health promotion and screening damage your health?'

The British Government's white paper on primary health care has added weight to the trend towards screening and health promotion[14] without questioning the outcomes properly.[15] We would sound a word of caution as the family doctor service could very easily drown in a tidal wave of inappropriate demand for screening services if the consumer is encouraged to expect such services. An overload by the healthy anxious could easily displace the very opportunities family doctors and nurses now have for care of the chronic sick and disabled and for screening and health promotion among the unhealthy less demanding sector of the population.

Family doctors may have to decide whether the cash induced activities proposed by governments are going to be allowed to modify the professionalism involved in an integrated and broad approach to every patient.

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