

- Increasing Response Rates amongst BME and other hard to reach groups
 - a review of literature relevant to the national acute patients' survey

SUMMARY

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EXECUTIVE SUMMARY

1 Introduction

This paper summarises the findings of a review of the literature on increasing survey response rates amongst black and minority ethnic (BME) and other hard to reach groups.

The review, and this summary, have been prepared by the Picker Institute Acute Co-ordination Centre on behalf of the Healthcare Commission as part of the development work for the NHS acute patient survey programme. In the next stage of this work this summary will be used to stimulate discussion in a series of stakeholder consultation meetings.

The response rates for the NHS acute inpatient surveys are reasonably high for a postal survey (63% in 2004 and 59% in 2005). Variations in response rates between different sub-groups have however been identified. For example, response rates amongst young people and amongst BME groups are low compared with some other groups. These findings have generated concerns about the extent to which the survey results are representative of the views of certain groups. In the context of evidence that it is these same groups that experience most difficulties in terms of accessing health services, these low response rates demand attention.

The review identifies a range of difficulties in including certain groups in postal surveys about people's experiences of healthcare services. Nevertheless, there remain clear reasons for continuing to use standardised instruments for measuring patient experience.

2 Why do variations in response rates matter? – Response Bias

Low response rates raise concerns about the reliability of the findings because responders may differ from non-responders. There is considerable evidence to suggest that response rates are lower amongst certain groups. Reasons for non-participation in a postal survey amongst some of these groups are self-explanatory – communication barriers that impede self-completion of a questionnaire and a lack of contact information. There is however limited published evidence examining non-response and the characteristics of non-responders. This is largely because information on non-responders is naturally hard to obtain.

Repeatedly, US studies have shown that people from black and minority ethnic groups are less likely to respond to postal surveys. Response rates are also generally lower amongst people living in areas with more residents who were non-white. Other groups less likely to respond to postal surveys include:

- the very old
- younger adults
- men
- those in poorer health
- the disabled
- people on low income
- those who live alone
- people with a lower level of education

Both methodological and statistical techniques have been used to reduce the risk of non-response bias in postal surveys. The methodological approaches to reducing non-response bias are explored in the review and include approaches to increase response rates amongst groups that are typically less likely to respond. Statistical approaches to reducing nonresponse bias include the imputation of, and adjustment for, missing values. These approaches are not covered in this review.

3. Why are response rates lower amongst certain groups?

Three main reasons for low response rates have been identified: disengagement, poor literacy and poor contact information. Research has shown rates of civic participation to be similar amongst all those born in the UK, regardless of ethnicity. It has therefore been suggested that theories of acculturation and literacy and language may be better explanations of low response rates in the national patient surveys.

4. Strategies for increasing response rates amongst BME and other hard to reach groups

Various strategies have been proposed to counter low response rates resulting from disengagement:

- Targeted information introducing the research
- The use of specialist media, community organisations and networks to communicate with BME and other hard to reach groups
- Emphasis on confidentiality

Strategies to address communication barriers largely centre on the production of questionnaires in formats that are appropriate for different visual and literacy impairments, including the use of simple, straightforward language and the production of culturally appropriate translations.

5. Measuring the impact of strategies for increasing response rates amongst BME and other hard to reach groups

There is limited evidence about the impact of strategies for increasing response rates amongst BME and other hard to reach groups. Evidence about increasing response rates in general, shows that unconditional monetary incentives and to some extent conditional incentives (though not token incentives) are associated with increased response rates to mailed surveys.

The evidence from studies manipulating questionnaire characteristics to determine effects on response rates really only shows that keeping a questionnaire short has a positive effect on response rates and, that varying the colour or the quality of the paper on which the questionnaire is printed is largely ineffective. The interest or relevance of the questionnaire to a participant also has a positive impact on response rates.

The reviewed studies suggest that both introductory contacts and reminders are likely to have a significant effect upon increasing response rates in both non-patient and patient populations.

There is also evidence that the use of recorded delivery and stamped reply envelopes is likely to enhance response rates.

6. The implications of this review for acute patients' surveys

1. Advance publicity and covering letters need to include messages targeted at specific hard to reach populations. It may be appropriate to translate some of this material. Attempts should also be made to communicate survey findings to hard to reach populations.
2. All material should have a statement in 16 point font about the availability of material in alternative formats (if these are to be supplied).
3. Further research is needed to investigate the readability levels of the inpatient survey and the literacy levels in the patient population.
4. The inclusion of patients with poor literacy needs further investigation e.g. providing the questionnaire in alternative formats, for example audiotape or CD with the questions clearly spoken aloud.
5. Further research is needed on the inclusion of people with learning disabilities.
6. Further evidence is needed to explain the variations in response rates amongst different groups. Targeted non-response studies are therefore recommended, if ethical approval can be obtained.
7. Approaches to improving the completeness of ethnic group classification in the sample data need to be explored e.g. improved collection at point of admission.
8. Further work is needed to develop strategies for the inclusion of patient groups for whom accurate contact data may be unavailable.
9. Empirical studies have shown unconditional monetary incentives, shorter questionnaires and introductory letters and reminders to be effective in increasing response rates amongst all groups. There is a lack of empirical evidence about the effectiveness of other strategies that might have potential for increasing response rates amongst BME and other hard to reach groups and further research is needed.
10. The use of mixed-modes methodologies to collect data has been identified as a potential approach to both including hard to reach groups in health surveys and to capturing their views using other methods. This forms the subject of a separate review.

7. Next steps

The next stage of the development project on response rates amongst BME and other hard to reach groups is a series of stakeholder consultation meetings. This review will be used to stimulate discussion during these meetings.

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