

# Unmet Health & Social Care Needs among Older People

## Data, Measurement & Policies the case of England

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# Structure and focus of the presentation

- Measuring the levels of unmet needs among older people in England
  - How different data sources may provide different findings
  - Potential implications on workforce policies
- Drawing on two studies:
  1. Measuring unmet needs: Recently completed project – Policy Research Unit on Commissioning Health and Social Care in England.
  2. Workforce policy implication: ESRC Centre for Care, Care Workforce Change.

# A word about definitions ...

- ***Unperceived unmet need***: an individual is not aware of this unmet need;
- ***Subjective, chosen unmet need***: an individual perceives an unmet need but chooses not to demand available health services;
- ***Subjective, non-chosen unmet need***: an individual perceives a need for but does not receive health care because of access or other barriers;
- ***Subjective, clinician-validated unmet need***: an individual perceives a need for and accesses health care, but does not receive treatment that a clinician judges as appropriate (e.g., treatment of a primary care complaint at an emergency department rather than in an ambulatory setting);
- ***Subjective unmet expectations***: an individual perceives a need for and accesses health care but does not perceive the treatment to be suitable.

# Available data

- For measurement purposes **subjective** health and social care needs are usually classified into mobility needs, activity of daily living (ADLs) and instrumental activities of daily living (IADLs) needs
  - In most data sources, it is difficult to distinguish between different types of subjective unmet needs, particularly chosen and non-chosen
- Association of unmet needs and social determinants of health with health inequalities and disparities and access to health and social care services
- Different potentially useful data sources in England
  - The English Longitudinal Study of Ageing (ELSA) data
  - GP Practice Survey data
- Questions are usually related to a certain time period, (last month, in the two cases here)

# Study 1: English Longitudinal Study of Ageing (ELSA)



**Data:** ELSA (Wave1 (2002/2003 to Wave 9(2018/2019), two years survey intervals

**Age range:** 50 years and over

Unmet needs with: (i) Mobility difficulties; (ii) Activities of daily livings (ADLs) difficulties; and (ii) instrumental activities of daily living (IADLs) difficulties

## Statistical analysis

**Descriptive statistics** - frequency distributions, percentages, means and standard deviations.

**Regression analysis**- panel logistics regression model (fixed effect regression model was estimated after Hausman test was carried out)

### Mobility difficulties

1. difficulty in walking 100 yards;
2. sitting for two hours;
3. getting up from chair after sitting long period;
4. climbing several steps without resting;
5. stooping/kneeling/crouching;
6. reaching or extending arms above shoulder level
7. pulling/pushing large objects;
8. lifting or carrying weight over 10 pounds; and
9. picking up 5p coin from a table

### Activities of daily living difficulties

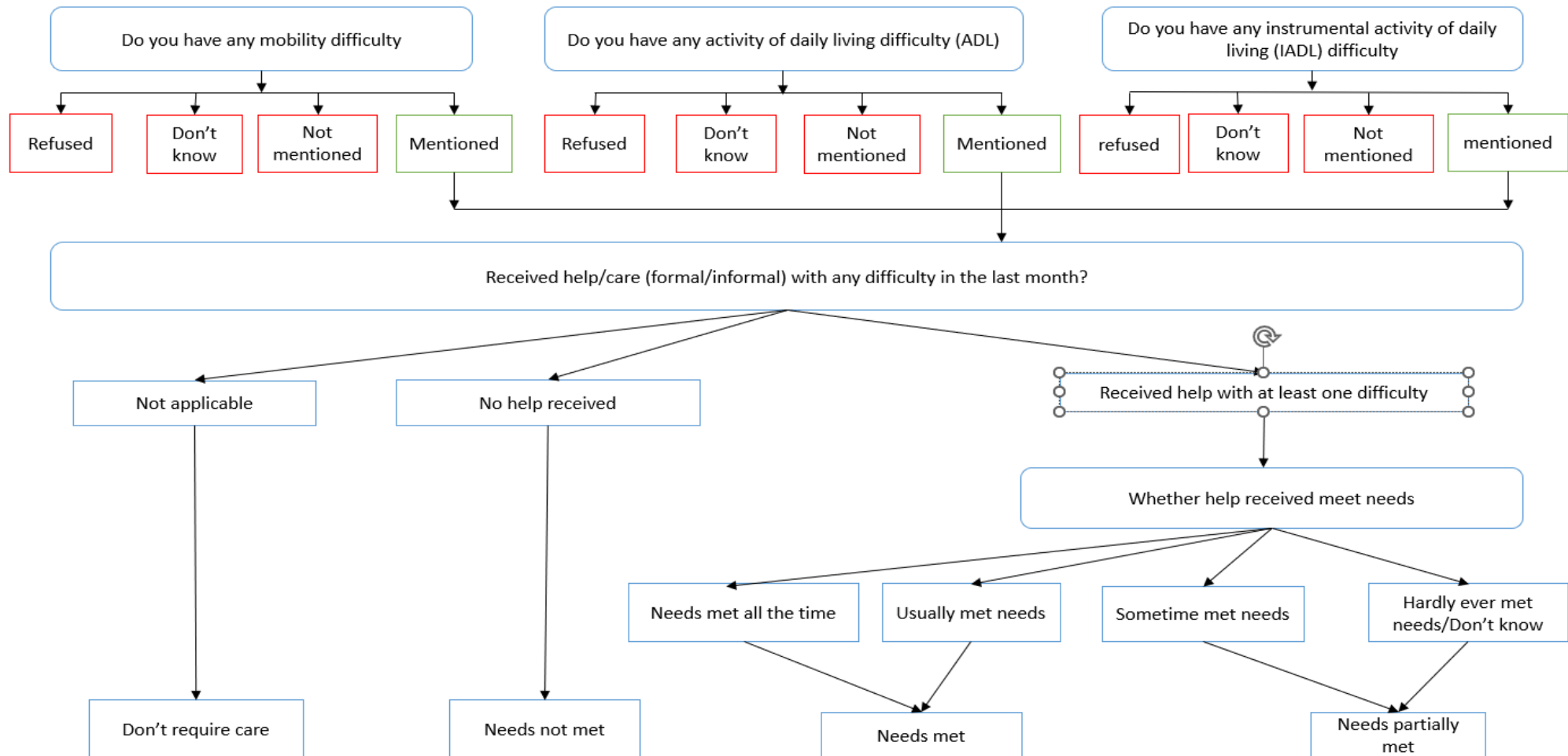
1. dressing;
2. walking across a room;
3. bathing/showering;
4. eating/cutting up food;
5. getting in and out of bed; and
6. using the toilet were used

### Instrumental activities of daily living (IADLs) difficulties

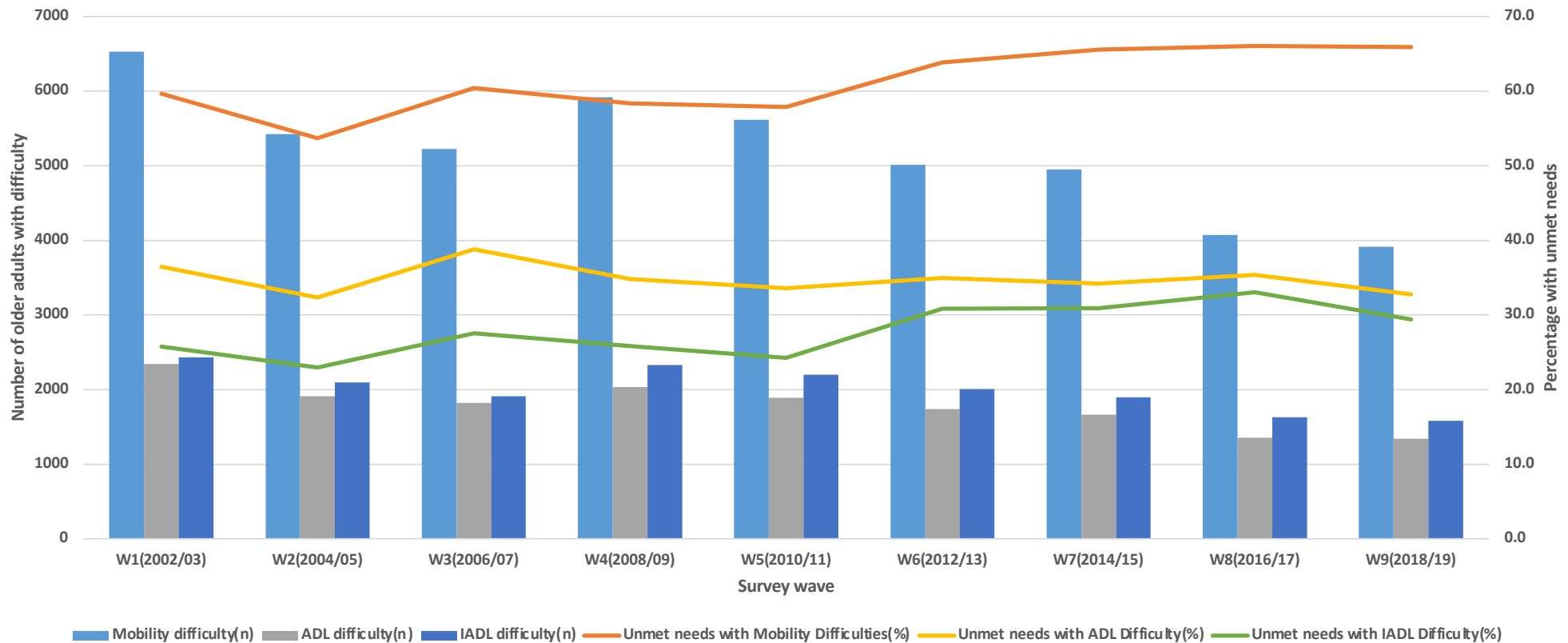
1. using maps to figure out how to get around strange places;
2. recognising when in physical danger;
3. preparing a hot meal;
4. shopping for groceries;
5. making telephone call;
6. communication(speech/hearing/eyesight);
7. taking medication;
8. doing work around house/garden; and
9. managing money/paying bills/keeping track of expenses

Survey wave	Sample
Wave 1 (2002/03)	11,522
Wave 2 (2004/05)	9,171
Wave 3 (2006/07)	9,343
Wave 4 (2008/09)	10,749
Wave 5 (2010/11)	10,095
Wave 6 (2012/13)	9,491
Wave 7 (2014/15)	9,491
wave 8 (2016/17)	8,355
Wave 9 (2018/19)	8,557

# Analytical Framework



# Results: Distribution of older adults with mobility, ADL and IADL difficulties and trends in unmet needs



@DrShereeHussein

# Unmet needs: mobility, ADLs, IADLs

## Unmet with mobility difficulties

- Relatively higher number of older adults with mobility difficulty with a decreasing trend over the survey period
- Higher proportion with unmet needs (61.3%, average) with an increasing trend over the survey period.
- Higher among those below 75 years
- 10% higher among males compared to females
- Higher in the middle and southern regions except London, compared to the regions in the north

## Unmet with activities of daily living (ADLs) difficulties

- Relatively lower number of older adults with activities of daily living with a decreasing trend
- Moderately higher proportion with unmet needs (34.8%, average) with slow but decreasing trend.
- 11.8% higher among those below 75 years
- 12% higher among males compared to females
- Higher in the South and Middle regions compared to the regions in the North of England

## Unmet with instrumental activities of daily living (IADLs) difficulties

- Relatively lower number of older adults with activities of daily living with a decreasing trend
- Moderately lower proportion with unmet needs (27.8%, average) with slow but decreasing trend.
- Higher among those below 75 years
- 10.3% higher among males compared to females
- Higher in the South and Middle compared to the regions in the North of England



# Factors Associated with Unmet needs

## Unmet needs with Mobility difficulty

- **Age:** higher likelihood for older adults 66-75 years (2 times), compared to those 50-65 years.
- **Region:** higher likelihood for older adults in North East (2.7 times), North West (1.6 times), Yorkshire and the Humber (2.2 times), East Midlands (1.7 times), West Midlands (1.5 times) and East of England (1.7 times) compared to London region.
- **Household size:** Living in a single household increases the likelihood of expressed unmet needs by 35.4%.
- **General health:** those who assessed their general health as very good/excellent were more likely to express unmet needs.

## Unmet needs with Activities of daily living (ADLs) difficulties

- **Age:** higher likelihood for older adults 66-75 years (1.7 times) & 2.2 times for those 75+, compared to those 50-65 years.
- **Region:** higher likelihood for older adults in North East (9.3 times), Yorkshire and the Humber (4.2 times), East Midlands (4.4 times), West Midlands (3.1 times) and East of England (2.3 times), compared to those in London region.
- **Private insurance:** those with private insurance were 48.8% less likely to express unmet needs compared to those with no private health insurance.
- **Working status:** those who were still working were 2.2 times more likely to express unmet needs compared to those who were not in work.
- **General health:** those who assessed their general health as very good/excellent were more likely to express unmet needs.

## Unmet needs with instrumental activities of daily living (IADLs) difficulties

Similar to that of ADLs.

## Study 2: GP Patient Survey data (2018) compared to ELSA

GPPS: n= 409,118; ELSA wave 8 (2018/19) n= 7,922

Focused on seven (7) Long-term health conditions commonly measured in both data:  
**Alzheimer's, Angina, Arthritis, Asthma, Cancer, Diabetes and Stroke**

Age: 55+

GPPS needs classification:

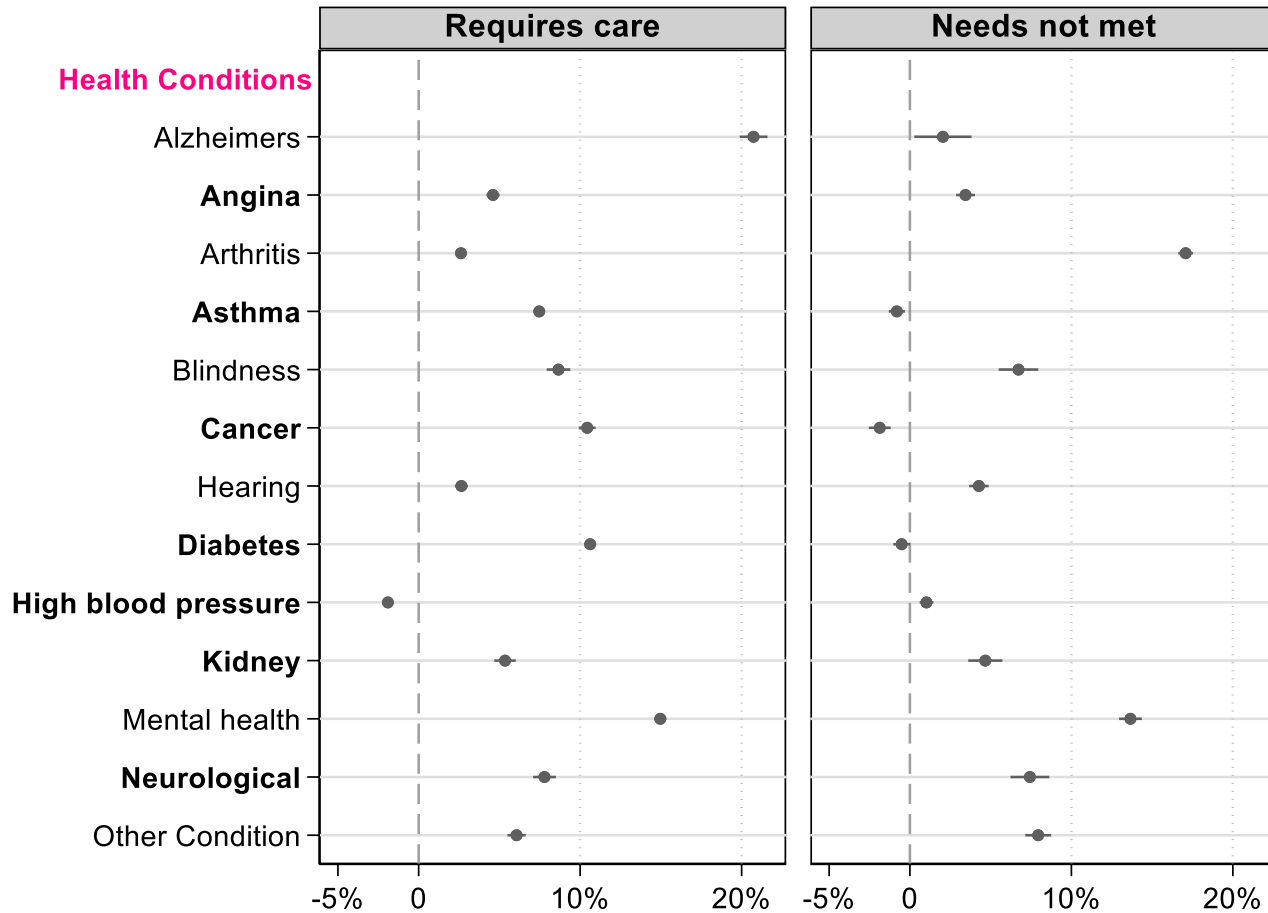
- I. Don't require care
- II. Needs are met
- III. Needs partially met
- IV. Needs not met

Where (iii) and (iv) are two forms of unmet needs for health and social care

# GPPS – unmet needs

	Don't require care		Needs Met		Needs partially met		Needs not met		
	Count	Row %	Count	Row %	Count	Row %	Count	Row %	Total
<b>Health Conditions†</b>									
Alzheimer's	500	9.0%	1,992	36.0%	2,150	38.8%	893	16.1%	5,535
Angina	14,875	27.3%	18,717	34.4%	13,693	25.1%	7,181	13.2%	54,466
Arthritis	48,084	30.3%	41,398	26.1%	44,059	27.8%	25,135	15.8%	158,676
Asthma	18,944	23.8%	28,758	36.1%	21,128	26.6%	10,744	13.5%	79,574
Cancer	6,893	23.7%	11,982	41.3%	7,056	24.3%	3,103	10.7%	29,034
Diabetes	14,376	22.1%	24,431	37.5%	17,554	26.9%	8,810	13.5%	65,171
High blood pressure	52,507	33.9%	51,056	33.0%	33,503	21.6%	17,777	11.5%	154,843
Kidney	3,173	21.3%	4,713	31.6%	4,435	29.8%	2,580	17.3%	14,901
Mental health	5,866	12.3%	13,533	28.3%	17,269	36.1%	11,132	23.3%	47,800
Neurological	2,351	19.6%	3,629	30.3%	3,709	30.9%	2,299	19.2%	11,988
Other	10,908	31.0%	11,220	31.9%	8,205	23.3%	4,821	13.7%	35,154
<b>Last used GP practice</b>									
Last 3 months	70,956	26.9%	90,743	34.4%	68,075	25.8%	34,183	13.0%	263,957
3 to 6 months ago	24,444	33.7%	22,581	31.1%	16,470	22.7%	9,006	12.4%	72,501
6 to 12 months ago	15,659	39.2%	11,387	28.5%	7,859	19.7%	5,034	12.6%	39,939
over 12 months ago	9,378	48.1%	4,417	22.7%	2,820	14.5%	2,868	14.7%	19,483
N/A	766	40.9%	465	24.8%	313	16.7%	331	17.7%	1,875
Missing	3,214	28.3%	3,902	34.3%	2,726	24.0%	1,521	13.4%	11,363
<b>Respondents</b>	<b>124,417</b>	<b>30.4%</b>	<b>133,495</b>	<b>32.6%</b>	<b>98,263</b>	<b>24.0%</b>	<b>52,943</b>	<b>12.9%</b>	<b>409,118</b>

*Linear Probability Model regression estimates on respondents' health conditions by levels of self-perceived unmet need for health and social care— GPPS*



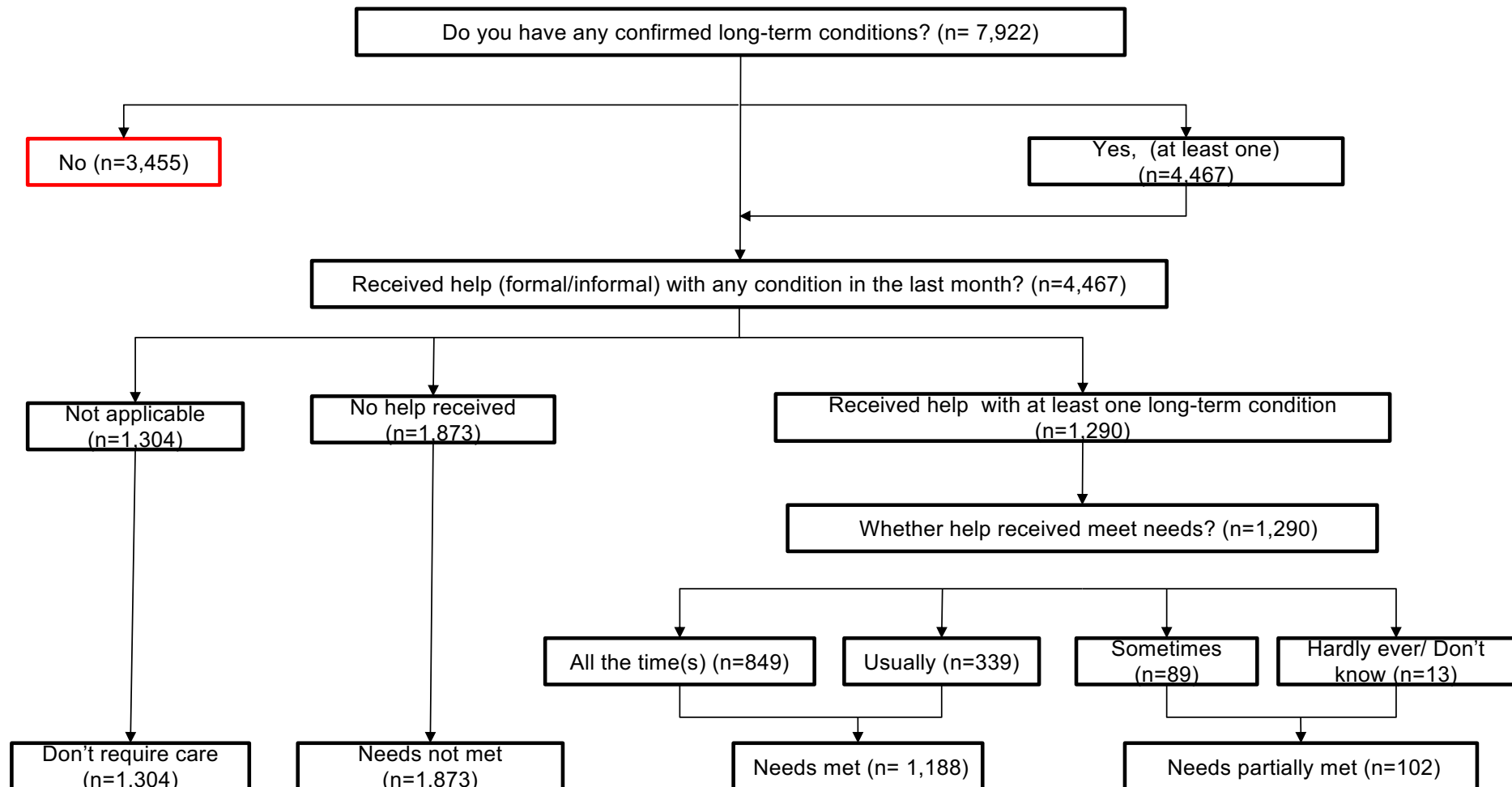
Individuals with Alzheimer's and mental health are most likely to require care (21% and 16% respectively)

High blood pressure being the least likely (-2%) compared to those reporting no condition.

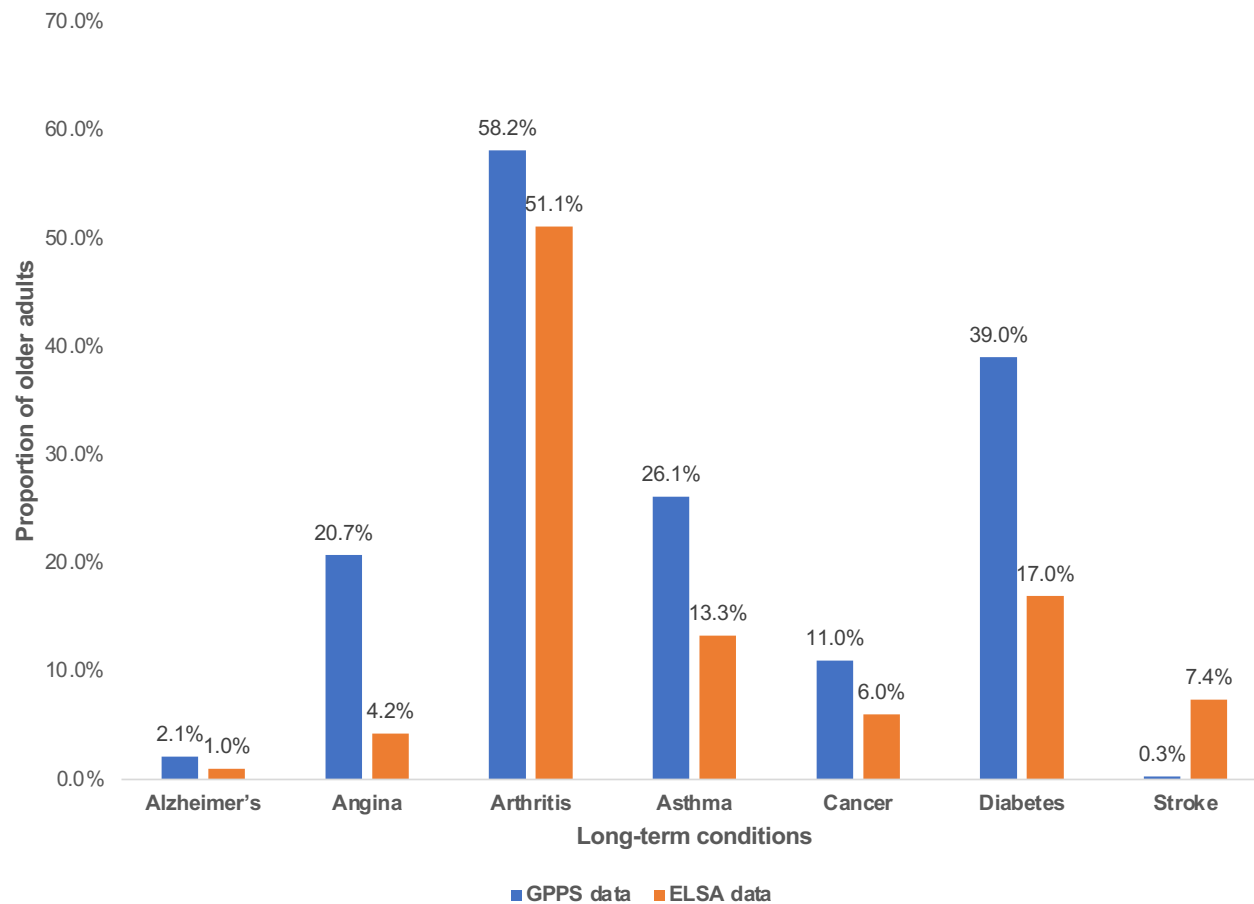
Respondents with arthritis and mental health are most likely to have needs that are not met, 17% and 14%, respectively.

Notes: : Coefficient plot from a linear probability model. Standard errors clustered at the GP practice. 95% confidence intervals are displayed. The full model also contains all variables, as shown in Figure 1. The number of respondents for the "requires care" model is 409,118, the number of respondents for the "needs not met" model is 186,438. Conditions in bold are conditions that can be referred to community services. The base category is patients that have long-term health conditions that did not report.

# ELSA Wave 8 (2018) sample

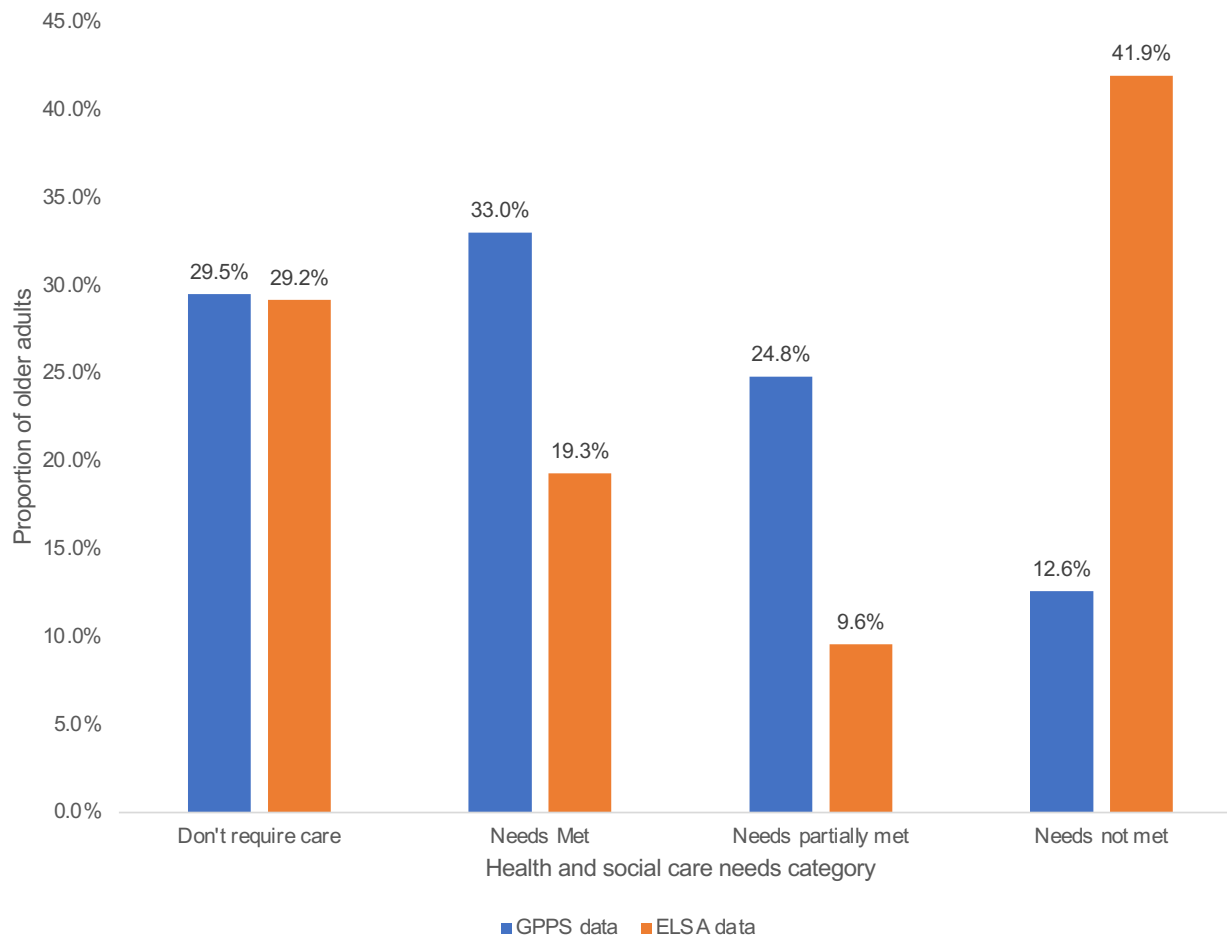


# ELSA-GPPS comparison: distribution of LT conditions



- Overall, fairly similar spread of long-term conditions in both data set
- Similarities, Arthritis, Diabetes, Asthma
- Differences: Angina was forth in GPPS data, but Stroke was forth in ELSA data

# ELSA-GPPS comparison: met & unmet needs



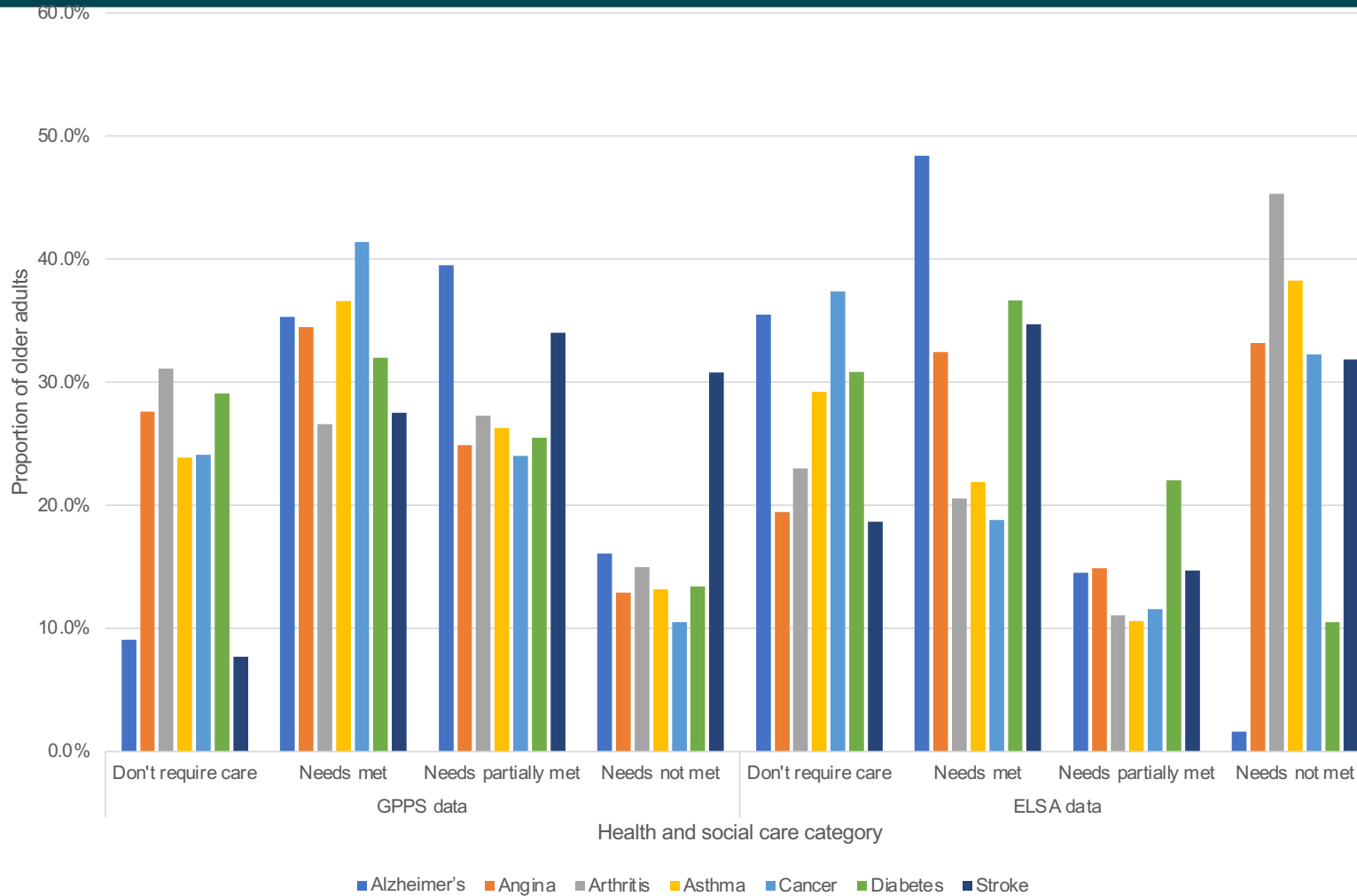
## Similarities:

- The proportion that don't require care match

## Differences:

- Higher proportion with unmet needs in ELSA data compared to GPPS data
- Higher proportion with care needs met in GPPS data compared to ELSA data

# ELSA-GPPS comparison: met & unmet needs by condition



## Needs not met (top 3 conditions):

- **GPPS data:** Stroke, Alzheimer's, Angina with the least been cancer patients
- **ELSA data :** Arthritis, Asthma, Angina, with the least been those with Alzheimer's
- The proportion with long-term conditions and needs partially met were higher in all cases in GPPS data compared to ELSA data



# Reflections on the two sets of results

- ❖ Unmet need is a significant health metric;
- ❖ Population datasets are crucial.
  - ❖ ELSA trend analysis shows **overall decreasing** trends in the prevalence of unmet needs
    - ❖ However, the prevalence of unmet needs with **mobility** and **IADL** has increased over time.
    - ❖ Highlight the effectiveness of some policies and interventions
  - ❖ Data sources and definitions matter
    - ❖ A mix of similar and different results in the distribution of unmet health and social care needs, long-term health conditions, and demographic characteristics
  - ❖ Detailed questions and answers provide helpful, nuanced insights related to socio-economic and local area characteristics.



# Care Workforce Policies and Unmet Needs

*Tensions & Synergies*



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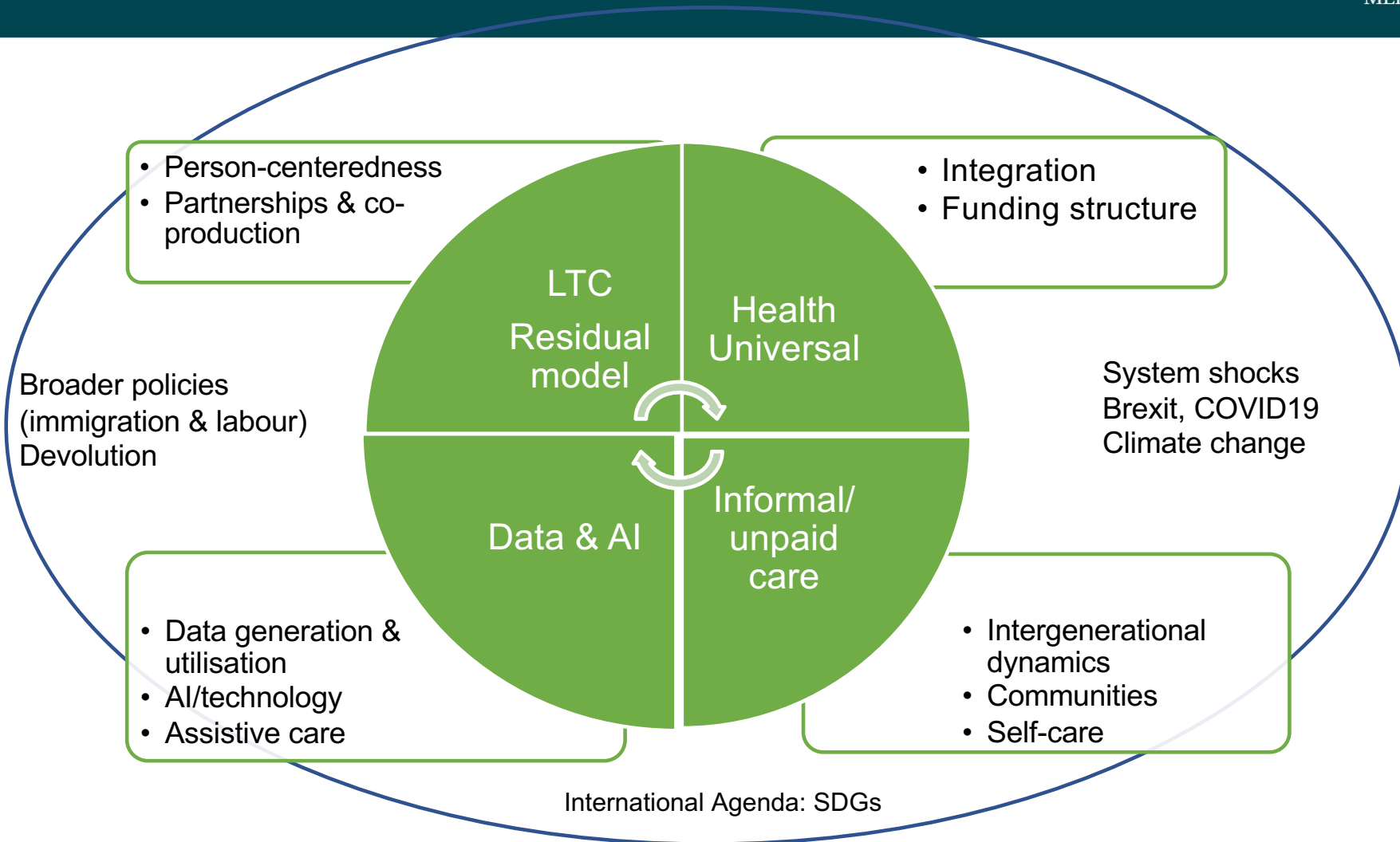
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Research Council

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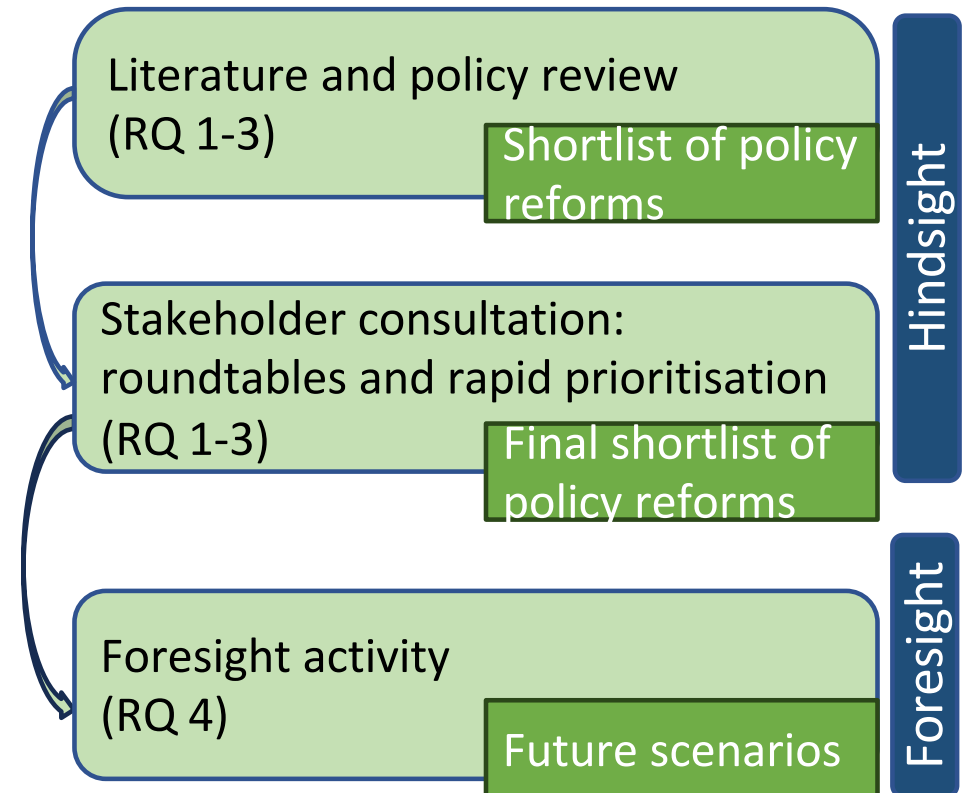
National Institute for  
Health and Care Research

# Context: Health & Social Care in the UK



# Health & Social Care Workforce & unmet needs

- ❖ One of the drivers of unmet needs is long waiting lists due to staff shortages
- ❖ Chronic shortages of health & social care personnel
- ❖ Policy direction towards integration and task shifting & delegation from health to social care
- ❖ Different policies require different things from the social care workforce
- ❖ Lack of parity in working conditions and status across health and social care
- ❖ We consider care workforce policy tensions related explicitly to personalisation and professionalisation



# Key Policies: Integration, Professionalisation and Personalisation



## Integration

England: Health and Care Act 2022 (Integrated Care Systems)

Scotland: Public Bodies (Joint Working) (Scotland) Act 2014

## Professionalisation

England: Care Certificate; Delegation principles; digital skills passport; care pathways.

Scotland, Wales and Northern Ireland: Compulsory registration; minimum level of training/certification; national induction framework; continuous development

## Personalisation

UK: Policy aspiration

Person-centred care

Choice & control

Facilitated through personal budget and marketisation

Variably defined

# Policy Tensions

## Integration & Personalisation

- Policy focus on systems integration/structural change rather than on service integration – leading to gaps & misconceptions of the specific role of staff across health & social care sectors
- Lack of parity across H&SC → reduced the autonomy of SC staff – questions the viability of task shifting/delegation

## Professionalisation & Personalisation

- Compulsory registration limits the pool of potential care workers
- Individuals drawing on care argued to want ‘soft skills’ rather than technical skills.
- Different needs and wants of different individuals, e.g., those with complex medical needs vs. those who do not need specialist support.

# Implications

## The policy landscape

- Policy fragmentation and tensions
- System-level AND practice-level alignments, coordination and integration
- Task delegation can only work with adequate training AND ensuring parity across workforce groups.
- Economic and societal cost implications

## Data and evidence-informed policies

- More attention to integrated health and social care research
- Feedback mechanisms from research into the policy decision-making processes

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Thank you for listening  
Happy to respond to questions

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