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Full Report

Which unmet social care needs have the biggest impact on healthy ageing?

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Key messages

- An unmet care need arises when people could benefit from help with their daily lives, but do not receive support.

- Having an unmet care need has previously been linked to poor health and greater healthcare utilisation.

- Evidence is needed to understand which care needs, when unmet, are likely to have the *biggest* impact on healthy ageing.

- Our analysis aimed to explore this using data from Wave 9 of the English Longitudinal Study of Ageing (ELSA).

- Our findings do not support a clear link between individual unmet needs and poor self-rated health.

- Whilst unmet need for support with each of managing money, managing medication, getting in and out of bed, bathing and showering, and shopping was linked to poor health, only one of these associations was statistically significant (managing money).

- Other unmet care needs were linked to a lower risk of poor health, but these associations were not statistically significant.

- This pattern of findings may be explained by the binary measure of disability available in ELSA, which we used in our analysis.

- Our analysis highlights the importance of data on the level of need for support to better understand the link between unmet care needs and healthy ageing.

- The absence of support for managing money, managing medication, getting in and out of bed, bathing and showering, and shopping may adversely impact on health. Further research, using more detailed data about the level of need for support, will help to understand the independent contributions of each to healthy ageing.

Background and aim

An unmet care need arises when people could benefit from help with their daily lives, but do not receive support. Such needs may include, for example, help with activities of daily living (ADLs), instrumental activities of daily living (IADLs) and mobility. Needs may be considered unmet when no help is received (absolute unmet need) or when help received is judged to be insufficient or inadequate (relative unmet need).

Unmet needs are linked to poor health outcomes. Discomfort, weight loss, dehydration, falls, burns,[1] a greater risk of using emergency care (particularly for falls and injuries)[2] an increased risk of hospital admission and readmission,[3,4] and an increased risk of mortality[5] are all observed consequences of unmet need for help with ADLs, IADLs and mobility limitations. This evidence is not surprising: ADLs, IADLs and mobility are underpinned by physical activity, cognitive stimulation and social interactions, all of which are integral to healthy ageing.[6-8] A lack of support with such needs will thus inevitably lead to a decline in health.

Although unmet need for support with ADLs, IADLs and mobility are linked to poor health, our understanding of this remains superficial. Needs relating to ADLs, IADLs and mobility are diverse, and so therefore is the potential range of unmet needs an older person might face. Feasibly, all difficulties with ADLs, IADLs and mobility, which are not countered with support, are likely to have an adverse impact on the health of older people. However, it is unclear which unmet support needs are likely to have the *biggest* impact on healthy ageing. This is important as it may not be feasible for all needs to be addressed by resource-stretched care services. However, if there are a subset of needs that have a bigger adverse impact on health than others, there may be argument to prioritise and target such needs in policy and practice.

To address this gap in evidence, we aimed to explore the nature and size of the relationship between individual unmet ADL, IADL and mobility needs and healthy ageing.

Methods

To address the aims of this work, we undertook a cross-sectional analysis of data from the English Longitudinal Study of Ageing (ELSA), an ongoing population-based study of adults aged 50 and over in England.[9]

Population

Using data from the most recent study wave (Wave 9, 2019), 6,109 (unweighted) people aged 50 or over, with complete data items, formed the basis for this analysis. With weighting, the final sample was 6,136 participants.

Measures

A measure of absolute unmet need was created for each self-reported ADL, IADL, and mobility need available in ELSA. Absolute unmet need describes the number of people who have difficulty, but receive no help, with an ADL/IADL/mobility limitation. Unmet need may also be operationalised as a relative measure, which quantifies the number of people who report that the support they receive is inadequate or insufficient. However, data are not available in ELSA to support this approach for individual ADL, IADL and mobility need items.

The measures of individual unmet need were created in two steps. First, we selected the needs relevant to this analysis. These were self-reported difficulties with: walking 100 yards, climbing one flight of steps (mobility); managing money, managing medication, doing housework, and shopping for groceries (IADLs); dressing, walking across a room, bathing or showering, eating, using the toilet, and getting in and out of bed (ADLs). These twelve needs were selected as ELSA also records whether help is received, which enables us to quantified unmet need.[1]

Second, for each need, we determined whether help was received and used this to create three response categories: (i) no self-reported difficulty (no need), (ii) self-reported difficulty and receives help from a person (met need), (iii) self-reported difficulty and no help from a person (unmet need). Our measures of unmet need included a 'no need' category; this was because not all participants would report difficulty with all ADLs, IADLs and mobility limitations, but all were included in the model (see analysis, below).

To examine impact on healthy ageing, we used self-rated health as our outcome measure. Self-rated health was selected as it is a strong indicator of health and mortality in older populations.[10] A binary version of this variable was created to differentiate populations with poor self-rated health and excellent/very good/good/fair self-rated health.

Covariates selected for this analysis included: age, sex, total net non-pension wealth as an indicator on socioeconomic status, and disease count. Total net non-pension wealth was selected as this is a robust indicator of socioeconomic status in older populations.[11,12] This measure combines net housing wealth, net non-housing wealth, and net financial wealth. In ELSA, this measure is available as quintiles. For this analysis, we merged quintiles 2-4 to create three categories: low, medium and high wealth. Disease count was used as an indicator of multimorbidity: diseases were selected based on those used in previous research.[13]

Analysis

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[1] Another mobility variable (*difficulty climbing several flights of steps*) was also available but not selected due to the risk of collinearity with the included variable *difficulty climbing one flight of steps*.

Logistic regression was used to model the association between all twelve individual unmet needs and the outcome poor self-rated health. This model was adjusted for age, sex, total net non-pension wealth and disease count. To further understand the pattern of findings observed, we compared the health profiles of populations across the three categories of need (no need, met need and unmet need). All analyses were weighted by the cross-sectional weight using the survey package[14] in R version 3.6.0.

Results

Table 1 summarises the characteristics of the study population. Just over half of participants were female (51.4%), and a majority were aged 50-59 years (36.6.%). Almost half of participants reported two or more long-term conditions (46.6%). Difficulties with ADLs, IADLs and mobility were rare: for most needs, difficulties were reported by less than 10% of participants.

Table 2 presents the model exploring the association between unmet needs and poor health, adjusting for covariates. Compared to populations with met needs, poor self-rated health was more likely for those with unmet need for support with managing money, managing medication, getting in and out of bed, bathing and showering, and shopping. Only one of these associations was statistically significant at the 95% confidence interval (managing money). For the remaining need variables, populations with unmet needs were less likely to be in poor health compared to populations whose needs were met on these measures; all of these associations were not statistically significant at the 95% confidence interval.

Table 1. Characteristics of the study sample (weighted N=6,136)

Characteristic		Percentage (count)
Sex	Male	48.6 (2983)
	Female	51.4 (3153)
Age group	50-59	36.6 (2243)
	50-69	30.5 (1870)
	70-79	22.1 (1354)
	80+	10.9 (668)
Wealth group	Poorest group	18.5 (1136)
	Middle group	60.8 (3733)
	Richest group	20.6 (1267)
Disease groups	0	21.4 (1312)
	1	32.0 (1962)
	2+	46.6 (2862)
Self-rated health	Poor	6.1 (372)
	Excellent/very good/good/fair	93.9 (5763)
Need: managing money	No needs	97.8 (5999)
	Met need	1.7 (105)
	Unmet need	0.5 (32)
Need: taking medication	No needs	98.3 (6030)
	Met need	1.2 (71)
	Unmet need	0.6 (35)
Need: walking 100 yards	No needs	91.7 (5627)
	Met need	1.8 (113)
	Unmet need	6.4 (396)
Need: walking across a room	No needs	97.9 (6005)
	Met need	0.5 (30)
	Unmet need	1.7 (101)
Need: Getting in/out of bed	No needs	96.0 (5888)
	Met need	0.7 (46)
	Unmet need	3.3 (202)
Need: Climbing one flight of steps	No needs	90.4 (5546)
	Met need	1.0 (63)
	Unmet need	8.6 (526)
Need: Bathing or showering	No needs	94.3 (5784)
	Met need	2.2 (133)
	Unmet need	3.6 (219)
Need: Using the toilet	No needs	97.5 (5983)
	Met need	0.4 (25)
	Unmet need	2.1 (127)
Need: Eating	No needs	98.5 (6045)
	Met need	0.7 (45)

	Unmet need	0.7 (45)
Need: Work around house/garden	No needs	89.4 (5486)
	Met need	6.6 (405)
	Unmet need	4.0 (244)
Need: Dressing	No needs	90.7 (5564)
	Met need	3.1 (192)
	Unmet need	6.2 (379)
Need: Shopping	No needs	93.7 (5749)
	Met need	5.1 (311)
	Unmet need	1.2 (75)

Numbers are weighted and rounded.

Table 2. Odds ratio of poor self-rated health for populations with unmet need or no need; met need is the referent. 95% Confidence Intervals in parentheses.

Self-reported difficulties	No need	Unmet need
Managing money	1.59 (0.66-3.84)	9.23 (2.12-40.23)
Managing medication	0.78 (0.26-2.34)	4.14 (0.78-21.98)
Walking 100 yards	0.23 (0.11-0.50)	0.73 (0.36-1.47)
Walking across a room	0.73 (0.20-2.62)	0.68 (0.19-2.38)
Getting in/out of bed	1.51 (0.49-4.69)	2.82 (0.88-9.01)
Climbing one flight of steps	0.54 (0.20-1.46)	0.90 (0.35-2.28)
Bathing and showering	0.67 (0.32-1.42)	1.21 (0.55-2.66)
Using the toilet	1.19 (0.27-5.17)	0.73 (0.16-3.32)
Eating	1.01 (0.26-3.96)	0.64 (0.12-3.29)
Gardening and housework	0.22 (0.12-0.39)	0.67 (0.36-1.26)
Dressing	0.60 (0.30-1.18)	0.81 (0.40-1.63)
Shopping	1.11 (0.58-2.11)	1.18 (0.46-3.00)

Model adjusted for age, sex, disease count, total net non-pension wealth, and all needs, with met need as the referent.

Due to the risk of overfitting, we repeated this analysis adjusting for fewer covariates for a more parsimonious model. Appendix Table A presents this analysis adjusted for all needs and: age; age and sex; and age, sex and disease count. Across these iterations, a similar pattern was observed. That is, poor self-rated health was more likely for those with unmet need for support with managing money, managing medication, getting in and out of bed, bathing and showering, and shopping (compared to those with met need on these measures). However, the statistical significance and effect size of these associations varied by model, and for most, wide confidence intervals indicated imprecise estimates. We opted therefore not to include any further covariates to minimise the risk of overfitting the model.

Additional analysis

Contrary to previous evidence, most unmet ADL, IADL and mobility needs were linked to a lower likelihood to poor health in these data. To further explore this pattern of findings, we hypothesised that the populations with met and unmet need in our analysis did not have equivalent levels of help needed for each ADL, IADL and mobility limitation. If people with the greatest need for support with ADL and IADL are the most likely to access support, that may explain why people with met needs were more likely to be in poor health compared to those with unmet needs.

To explore this, we compared the health profiles for the populations with met and unmet need. Overall, participants with met needs used more aids and adaptations than those with unmet needs (Appendix Table B). Multimorbidity presents a more complex picture (Appendix Table C). For some ADLs, IADLs and mobility difficulties, the proportions of people with met and unmet needs were similar across levels of multimorbidity. For other difficulties, the figures indicated that people living with a higher number of conditions were more likely to have met needs.

This analysis tends to support our hypothesis that individuals with met needs had a greater level of dependency than those with unmet needs.

Discussion

Previous research supports a clear link between unmet need for social care and poor health.[1,2,4,5,15] Our analysis suggests that the contribution of individual unmet care needs to healthy ageing is more challenging to elucidate and understand.

Poor health was more likely amongst older people with unmet needs for support with managing money, managing medication, getting in and out of bed, bathing and showering, and shopping. Only one of these associations was statistically significant: unmet need for help managing money. This suggests that support for managing money may be especially important for older people's health. This is reasonable, as difficulties managing money will limit many other crucial aspects of day-to-day life, such as traveling to and from appointments, buying food, and heating homes. However, an unmet need for support with managing money is unlikely to be the *only* unmet need implicated in healthy ageing.

An important consideration to these findings concerns the nature of the data. Our findings may stem from the use of binary disability variables in ELSA. That is, participants respond yes or no when asked if they have difficulty with a particular ADL, IADL or mobility activity. Such a binary response provides no information on the level of severity of difficulty that participants experience. This means that study participants reporting difficulty with an activity may be heterogeneous in their need for support with that activity. When we added information on whether help was received, in order to define unmet need (e.g. does anyone help you with this activity, yes or no), this appeared to have had the unintended effect of differentiating people with dependency from those with disability. This explanation is supported by the greater use of aids and adaptations among those with met needs in our study population.

A second explanation is that isolated unmet ADL, IADL and mobility needs may be less consequential for health than a combination of unmet needs. Specifically, when certain needs go unmet, this is likely to impact on a person's ability to carry out other ADLs and IADLs. Any interaction between multiple unmet needs would not be accounted for, in our attempt to quantify the independent contributions of individual unmet needs.

Our analysis also made use of cross-sectional data. This approach may not be ideal to examine the potential impact of individual unmet care needs on health, especially where such impact may be manifest over time. Longitudinal study of health trajectories and changing support for daily living may offer greater insights.

In summary, we would expect that most, if not all, of these unmet needs to have consequences for healthy ageing. However, more reliable data is needed to confidently understand the independent impact of each type of unmet need on older people's health.

Strengths and limitations

Our analysis makes use of contemporary data collected in 2019 using a representative sample. We adjusted for key confounders, including age, sex, wealth and disease count. Changes in the estimates between models indicated a risk of the model being overfitted, thus potentially reducing the reliability of the findings. We chose therefore not to explore any additional confounding variables in the analysis (for example, ethnicity, area deprivation). Whilst this is a limitation of the study, it is not a major shortcoming given the other, more critical limitations of the data described earlier.

Finally, the proportion of participants reporting difficulties with each ADL, IADL and mobility limitation (with either met or unmet need) was small. This is not uncommon and mirrors similarly small proportions of participants reporting ADL, IADL and mobility difficulties in other studies (e.g.[16,17]). Such small proportions may partly account for the imprecision in confidence intervals observed in this analysis, which limits the conclusions we can draw.

Implications for policy and research

Managing money, managing medication, getting in and out of bed, bathing and showering, and shopping are important needs that likely contribute to healthy ageing. Our findings suggest that the absence of support for these needs may adversely impact on health. However, more comprehensive data about need for help will allow us to offer a more confident picture of this dynamic.

Unmet needs are an important part of understanding healthy ageing, especially when care provision is not universal. Previous evidence also highlights the impact of unmet needs on health, and the link between the two is not without a rational foundation. Our attempt to understand the independent contribution of *individual* unmet needs to heathy ageing was novel but challenged by limitations in our dataset.

Quantifying unmet care needs is complex. Different ways of identifying need (perceived or assumed), the support received or not (paid, unpaid, both) and whether such need is unmet (absolute, relative) highlight the myriad of ways the concept can be operationalised.

Further challenges arise when attempting to align existing data on needs to social care eligibility thresholds. For example, eligibility for care in England is determined by being unable to carry out two or more designated activities, which impact on a person's wellbeing. However, it is challenging to mirror this in existing data, because it requires some indication of the severity of difficulty. Current datasets do not typically offer this.

Our analysis points to a third challenge: a binary measure of disability may group together people with heterogeneous needs for support. Satisfying an assumption of equivalence in need is important as it allows a fair comparison of the health consequences when some people do not receive support.

Going forward, there is a need to optimise nationally representative data to be able to answer questions about healthy ageing and unmet care needs. We propose three areas where data could be improved. First, data that describes the degree of difficulty with ADLs, IADLs and mobility activities are critical. Such data can offer a proxy for the level of need for support with individual activities. This will enable us to compare the health outcomes of populations with equivalent levels of need for support, where that need is either met or unmet.

Second, data about whether people perceived their needs to be met or unmet could offer greater granularity in understanding the link between unmet need and healthy ageing. At present, ELSA allows researchers to quantify an absolute measure of unmet need for individual ADL, IADL and mobility limitations. A relative measure of unmet need is available only as a broad, generic question and not linked to specific difficulties. Expanding these data to identify whether people judge their own individual needs to be met or unmet can account for different (and subjective) expectations of care. This subjective judgement may help to further expand our understanding of the health consequences when people do not get the help they need.

Finally, detail of the quantity and quality of any social care support received would be beneficial. Receipt of help is necessary to quantify absolute unmet need. However, without accounting for the quantity and quality of that help, we risk not being able to control for these important confounders.

As yet, no dataset is available that satisfies each of these three requirements. The Cognitive Function and Ageing Study II records level of difficulties with ADLs and IADLs, but does not contain data on help received to quantify unmet need for individual activities. The Newcastle 85+ Study offers a comprehensive set of questions to identify the level of difficulty with ADLs, IADLs and mobility, alongside questions about help received for most ADLs and IADLs (but not mobility items) to quantify unmet need. Whilst promising, this regional dataset suffers the limitation of a much smaller participant sample that is not necessarily representative of the national population.

Conclusion

Understanding which unmet ADL, IADL and mobility needs have the biggest impact on healthy ageing is important. Some unmet needs (managing money, managing medication, getting in and out of bed, bathing and showering, and shopping) may be especially consequential for older people's health. However, shortcomings to current data limit a clear and confident assessment of this. Our analysis highlights the importance of data on the level of need to better understand the link between unmet care needs and healthy ageing.

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Appendix A: Additional models reporting odds ratio of poor self-rated health by need item (met need as the referent). 95% Confidence Intervals in parentheses.

	Adjusted for age and all needs	Adjusted for age, sex and all needs	Adjusted for age, sex, disease count and all needs	Adjusted for age, sex, disease count, wealth and all needs
	Unmet need	Unmet need	Unmet need	Unmet need
Managing money	10.10 (2.27-44.92)	9.59 (2.17-42.42)	10.38 (2.41-44.73)	9.23 (2.12-40.23)
Managing medication	4.90 (0.73-32.70)	4.97 (0.80-30.69)	3.50 (0.64-18.99)	4.14 (0.78-21.98)
Walking 100 yards	0.81 (0.42-1.56)	0.77 (0.40-1.49)	0.78 (0.39-1.57)	0.73 (0.36-1.47)
Walking across a room	0.86 (0.25-2.90)	0.85 (0.25-2.95)	0.61 (0.17-2.12)	0.68 (0.19-2.38)
Getting in and out of bed	3.39 (1.11-10.33)	3.35 (1.09-10.31)	3.12 (0.97-10.08)	2.82 (0.88-9.01)
Climbing one flight of steps	0.91 (0.39-2.13)	0.96 (0.41-2.24)	0.96 (0.38-2.45)	0.90 (0.35-2.28)
Bathing and showering	1.17 (0.57-2.41)	1.15 (0.55-2.39)	1.33 (0.60-2.92)	1.21 (0.55-2.66)
Using the toilet	0.50 (0.12-2.15)	0.56 (0.13-2.44)	0.60 (0.13-2.75)	0.73 (0.16-3.32)
Eating	0.75 (0.18-3.23)	0.74 (0.17-3.19)	0.72 (0.15-3.44)	0.64 (0.12-3.29)
Doing garden and housework	0.60 (0.32-1.10)	0.58 (0.31-1.07)	0.67 (0.35-1.27)	0.67 (0.36-1.26)
Dressing	0.98 (0.49-1.98)	1.02 (0.50-2.05)	0.86 (0.43-1.72)	0.81 (0.40-1.63)
Shopping	1.74 (0.68-4.43)	1.61 (0.63-4.11)	1.18 (0.46-3.04)	1.18 (0.46-3.00)

Note: estimates for 'no need' not shown.

Appendix Table B. Proportion of participants using each number of aids and adaptations by need response, for each ADL, IADL and mobility difficulty

ADL/IADL/Mobility limitation and category of need		Number of aids/adaptations, prevalence (%)			
		0	*1*	*2*	*3+*
Managing money	No need	88.4	8.0	2.3	1.2
	Met	20.4	28.6	28.7	22.3
	Unmet	65.4	30.6	0.0	4.0
Taking medication	No need	88.3	8.1	2.4	1.2
	Met	17.7	29.5	25.4	27.5
	Unmet	31.6	27.2	22.0	19.2
Walking 100 yards	No need	92.8	6.0	0.9	0.3
	Met	8.9	31.7	34.7	24.7
	Unmet	28.4	38.0	20.1	13.5
Walking across a room	No need	88.8	8.1	2.1	0.9
	Met	2.7	27.0	38.9	31.4
	Unmet	9.8	27.0	30.1	33.0
Getting in/out of bed	No need	89.3	7.6	2.0	1.0
	Met	9.9	28.4	39.1	22.5
	Unmet	39.6	30.3	15.5	14.6
Climbing one flight of steps	No need	92.8	5.9	1.0	0.3
	Met	11.4	41.9	27.7	19.1
	Unmet	36.3	32.1	18.1	13.5
Bathing or showering	No need	90.7	7.0	1.7	0.6
	Met	10.8	35.2	27.3	26.7
	Unmet	38.9	33.1	16.0	12.1
Using the toilet	No need	88.7	7.9	2.2	1.2
	Met	0.0	18.7	53.7	27.6
	Unmet	30.2	33.2	19.0	17.6
Eating	No need	87.9	8.3	2.4	1.4
	Met	19.3	23.7	33.1	23.9
	Unmet	46.0	16.0	25.4	12.7
Doing work around house/garden	No need	93.4	5.5	0.8	0.3
	Met	23.6	34.0	25.9	16.6
	Unmet	51.6	33.5	8.5	6.4
Dressing	No need	91.6	6.2	1.5	0.7
	Met	22.2	35.1	25.3	17.4
	Unmet	54.3	28.5	10.6	6.7
Shopping	No need	91.2	7.0	1.2	0.5
	Met	22.7	29.4	28.5	19.4
	Unmet	39.4	35.7	14.1	10.8

Rows may not sum to 100% due to rounding.

Appendix Table C. Proportion of participants with each number of long-term conditions by need response, for each ADL, IADL and mobility need

		Number of long-term conditions (%)							
		0	1	2	3	4	5	6	7
Managing money	No need	21.9	32.4	24.7	13.9	5.4	1.6	0.2	0.0
	Met	0.7	14.2	20.9	24.4	26.6	6.4	5.6	1.1
	Unmet	2.8	12.3	23.9	48.3	5.2	3.6	0.0	4.0
Managing medication	No need	21.8	32.4	24.7	14.0	5.4	1.5	0.2	0.0
	Met	1.0	9.7	24.7	22.5	24.9	10.5	6.6	0.0
	Unmet	0.0	6.7	6.1	46.1	27.8	2.4	5.2	5.8
Walking 100 yards	No need	23.1	34.0	24.6	12.9	4.4	1.0	0.1	0.0
	Met	0.6	6.0	22.1	30.0	25.1	10.8	3.1	2.2
	Unmet	3.2	10.7	25.8	29.3	19.5	8.9	2.2	0.5
Walking across room	No need	21.8	32.5	24.6	13.9	5.4	1.5	0.2	0.0
	Met	5.5	5.4	26.5	13.5	35.6	9.5	5.1	0.0
	Unmet	0.0	8.2	26.2	33.7	16.4	7.4	4.0	3.1
Getting in and out of bed	No need	22.2	33.0	24.5	13.7	5.0	1.4	0.2	0.0
	Met	3.6	3.7	26.4	28.2	24.9	9.1	4.1	0.0
	Unmet	1.2	9.2	28.8	27.3	22.5	7.1	2.4	1.6
Climbing one flight of steps	No need	23.3	34.4	24.6	12.7	3.9	1.0	0.1	0.0
	Met	3.5	0.8	28.6	29.1	22.6	12.3	1.1	1.9
	Unmet	3.7	9.7	24.5	28.7	23.1	7.5	2.1	0.6
Bathing and showering	No need	22.5	33.3	24.7	13.5	4.7	1.1	0.2	0.0
	Met	1.1	7.2	26.1	22.3	26.5	11.7	1.8	3.3
	Unmet	4.8	11.3	22.7	28.6	21.2	10.2	1.2	0.0
Using the toilet	No need	21.9	32.6	24.7	13.9	5.4	1.4	0.2	0.0
	Met	3.5	4.1	26.7	26.0	23.8	11.1	4.7	0.0
	Unmet	3.3	9.1	20.9	29.3	20.3	12.3	1.4	3.5
Eating	No need	21.7	32.3	24.7	14.0	5.4	1.5	0.2	0.1
	Met	0.0	7.9	22.6	21.4	38.1	4.4	2.7	2.8
	Unmet	3.9	7.4	16.3	35.4	20.8	13.5	2.6	0.0
Housework and gardening	No need	23.5	34.4	24.6	12.5	3.9	0.9	0.1	0.0
	Met	2.3	10.7	22.1	28.2	24.4	8.9	2.7	0.8
	Unmet	4.8	13.0	29.2	30.3	15.9	5.4	0.9	0.5
Dressing	No need	23.1	33.9	24.0	12.9	4.4	1.1	0.2	0.0
	Met	1.2	9.2	27.0	30.3	22.5	6.7	1.5	1.7
	Unmet	6.0	14.7	27.1	26.7	16.7	7.9	0.7	0.3
Shopping	No need	22.7	33.6	24.7	13.2	4.6	1.1	0.1	0.0
	Met	2.5	9.4	23.8	28.3	22.8	9.4	2.6	1.2
	Unmet	0.0	4.1	20.6	38.0	19.1	13.4	3.8	1.0

Rows may not sum to 100% due to rounding.

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