# Health Survey for England 2016
# Social care for older adults

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This report examines the need for and receipt of social care among adults aged 65 and over in England in 2016. It compares different population groups by age, sex, region, household income and area deprivation.

## Key findings

Among adults aged 65 and over in England:

- 24% of men and 31% of women needed help with at least one Activity of Daily Living (ADL), and 22% and 32% respectively needed help with at least one Instrumental Activity of Daily Living (IADL).
- 20% of men and 27% of women had some unmet need with at least one ADL, and 12% and 16% respectively had some unmet need with at least one IADL.
- Men (33%) and women (42%) in the most deprived areas were around twice as likely to have unmet need for at least one ADL compared with men and women in the least deprived areas (15% of men and 22% of women).
- Most adults who had received help for ADLs in the past month, had received this from unpaid helpers only (65%). Three quarters of adults had received help with IADLs from unpaid helpers only (74%).
- Among adults with some need for help and support with ADLs and/or IADLs, a minority (19%) had received a local authority assessment of care needs in the last 12 months.

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This report may be of interest to members of the public, policy officials, people working in public health and to providers and commissioners of health and care services to older adults with an interest in the need for and receipt of social care in England.

# Introduction

## Contents

Since 2011, the Health Survey for England (HSE) has included questions on adult social care each year. Adults aged 65 and over are asked about their need for social care, whether they receive it, and, if so, how it is provided. This report presents analysis by age, sex, region, income, and area deprivation.

## Background

Social care is the provision of help with personal care and domestic tasks to help people live as independently as possible. It affects the daily lives of several million people in England. While those who need care and support are of all ages, many are older people needing help because of problems associated with long-term physical or mental ill-health, disability or problems relating to old age.[1] In 2016/17, local authorities received 1.8 million new requests for social care and support; of these, 1.3 million (72%) were for adults aged 65 and over.[2] This age group accounted for two thirds (67%) of all adults accessing long term support.[2]

A number of factors are expected to increase the demand for care services. These include the ageing population, other demographic changes such as changes in the birth rate, changes in family structures, and migration between urban and rural areas, as well as changes in expectations.[3] In particular, the growth in the number of people living with dementia is expected to exert substantial pressure on care services.[1,4]

A central aspect of the policies of recent governments has been to help people maintain their independence in their own homes for as long as possible. There has been emphasis on the personalisation of services, to help people take greater choice and control over the services they receive.[1,4,5] The availability of early, preventative interventions has been seen as a means of helping to reduce the need for more intensive levels of support or crisis interventions at a later stage.[1,6] However, policy makers have identified a range of long-standing issues related to the provision of social care, including a greater focus on reactive rather than preventative services; variations in levels and the quality of services; a lack of good information and advice; and a lack of coordination between health, housing and social care agencies.[1,4]

The Care Act 2014 implemented several national strategies to improve care and support in the UK.[7,8] National eligibility criteria have been introduced to set a standard for local councils to follow; local councils now have a duty to provide deferred payment agreements; carers now have the same right to assessment and support as

[1] HM Government. *Caring for our future: reforming care and support*. Cm 8378, The Stationery Office, Norwich, 2012. https://www.gov.uk/government/publications/caring-for-our-future-reforming-care-and-support
[2] NHS Digital. *Adult social care activity and finance report: detailed analysis, England 2016-17. https://digital.nhs.uk/catalogue/PUB30121*
[3] Department of Health. *Independence, Well-being and Choice: Our vision for the Future of Social Care for Adults in England*. Cm 6499. The Stationery Office, London, 2005.
[4] Department for Communities and Local Government. *Lifetime Homes, Lifetime Neighbourhoods. A National Strategy for Housing in an Ageing Society.* DCLG, London, 2008.
[5] HM Government. *The Coalition: Our Programme for Government*. Cabinet Office, London, 2010.
[6] Department of Health. *Modernising Social Services: Promoting Independence, Improving Protection, Raising Standards*. Cm 4169, The Stationery Office, London, 1998.
[7] The Care Act 2014. http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted
[8] Department of Health. *Guidance: Care and support: what's changing?* DH, London, 2014.

the individuals they care for; and individuals paying for their own care have the right to access information and advice on the care system.

The Care and Support (Eligibility Criteria) Regulations 2014 defined outcomes that adults should be able to achieve.[9] These cover basic personal care, family and social relationships and access to community activities and services.

The specified outcomes are:

- Managing and maintaining nutrition
- Maintaining personal hygiene
- Managing toilet needs
- Being appropriately clothed
- Being able to make use of [their] home safely
- Maintaining a habitable home environment
- Developing and maintaining family or other personal relationships
- Accessing and engaging in work, training, education or volunteering
- Making use of necessary facilities or services in the local community, including public transport and recreational facilities or services
- Carrying out any caring responsibilities […] for a child.

# Methods and definitions

## Methods

The current module of social care questions was developed in 2009 and 2010 and first used in the HSE 2011. The aim of the module is to deliver robust data on the need for, receipt and provision of social care services, the characteristics of people providing and receiving unpaid care, and on people receiving formal care and support. More detailed information about the module can be found in the 2011 report.[10]

The module was intended to provide information on need for, receipt and provision of social care services among the population aged 65 and over in private households; it does not cover those living in care institutions. It focuses on older people, who constitute by far the largest group receiving care.[11] The full module is asked every other year, and a shorter version asked in the alternate years.

[9] The Care and Support (Eligibility Criteria) Regulations 2014. http://www.legislation.gov.uk/ukdsi/2014/9780111124185

[10] Craig R, Mindell J (eds). *Health Survey for England 2011: Volume 1 Health, Social Care and Lifestyles*. Health and Social Care Information Centre, Leeds, 2012. http://digital.nhs.uk/catalogue/PUB09300

[11] While social care may be needed by and provided for people of any age, the sample size for the HSE (and most general population surveys) does not deliver sufficient numbers of social care recipients in children and adults aged under 65 for robust analyses of the patterns of need and receipt of care among different groups.

HSE 2016 included the full version of the social care questions. The questionnaire was revised to take account of changes to social care provision and payment included in the Care Act 2014 and introduced from April 2016. A question was also included about whether older adults with care and support needs had received an assessment or review of their care needs in the last 12 months.

## Definitions

### Measuring need for and receipt of social care: ADLs and IADLs

The need for and receipt of social care is measured using a number of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). ADLs are activities relating to personal care and mobility about the home that are basic to daily living. IADLs are activities which, while not fundamental to functioning, are important aspects of living independently. The ADLs and IADLs used in the HSE and shown in Table A were carefully selected to represent a full range of key activities.[12]

### Table A: Summary of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)

| ADLs | IADLs |
|---|---|
| Having a bath or shower | Doing routine housework or laundry |
| Using the toilet | Shopping for food |
| Getting up and down stairs | Getting out of the house |
| Getting around indoors | Doing paperwork or paying bills |
| Dressing or undressing | |
| Getting in and out of bed | |
| Washing face and hands | |
| Eating, including cutting up food | |
| Taking medicine | |

### Need for help and unmet need

For each ADL and IADL, participants aged 65 and over were asked whether they could carry out the activity on their own, manage on their own with difficulty, only do the activity with help, or could not do at all. Where ‘need’ for help is discussed in the report, it refers to people in the last three categories.

If participants indicated that they needed help for any ADL or IADL, they were then asked whether they had received any help in the last month. For the IADLs relating to shopping, housework and paperwork, participants were asked to exclude help which was provided simply because of the way household responsibilities were divided.

[12] The ADLs and IADLs included in the social care module allow an approximation of the Barthel Index, a measure of ability to live independently at home for older people. For further details see Craig R, Mindell J (eds). Health Survey for England 2011; full reference in note 10.

Unmet need has been identified where participants indicated that they needed help with a particular ADL or IADL, but had not received any help with it in the last month.[13]

## Formal and unpaid help

Participants who had received help in the last month with ADLs or IADLs were asked who had provided help; the ADLs and IADLs were grouped, as described above. Table B shows the people who provided help which were listed on two show cards. In previous HSE reports, unpaid carers have been referred to as 'informal' carers to make the distinction from formal carers. However, the term 'unpaid' carer is preferred to avoid any implication that these carers provide more or less important care.

### Table B: Formal and unpaid carers

| Formal carers | Unpaid carers |
|---|---|
| Home care worker/home help/personal assistant | Husband/wife/partner |
| Member of the reablement/intermediate care staff team | Son/son-in-law |
| Occupational Therapist / Physiotherapist | Daughter/daughter-in-law |
| Voluntary helper | Grandchild/great grandchild |
| Warden/ Sheltered housing manager | Brother/sister (including in-laws) |
| Cleaner | Niece/nephew |
| Council's handyman | Mother/father |
| Other | Other family member |
| | Friend |
| | Neighbour |

## Age-standardisation

Age-standardised data are presented in this report for most analyses shown in the text, tables and charts. Age-standardisation allows comparisons between groups, such as regions, after adjusting for the effects of any differences in age distributions between regions.

For regions, both observed and age-standardised data are provided. Those wishing to ascertain the actual levels of need for and receipt of help in each region should use the observed data, while those making comparisons between regions should use the age-standardised data. The comments on region in this report are based on age-standardised results.

## Equivalised household income

Equivalised household income was derived as the annual household income divided by a score based on the number and ages of all household members. This equivalised annual household income was attributed to all members of the household,

[13] There was a change to the routing of these questions from 2013 onwards; see note 4 to Table 4. This change has had a negligible impact on results.

including children. Households were ranked by equivalised income, and tertiles (thirds) were identified.

All individuals in each household were allocated to the equivalised household income tertile to which their household had been allocated.[14]

### Index of Multiple Deprivation (IMD)

The English Indices of Deprivation 2015, which measure and rank local levels of deprivation, are calculated by the Department for Communities and Local Government. The indices are based on 37 indicators, across seven domains of deprivation.[15] The Index of Multiple Deprivation (IMD) is a measure of the overall deprivation experienced by people living in a neighbourhood.[16]

In this publication IMD rankings have been split into quintiles. The lowest quintile indicates the lowest levels of deprivation; the highest quintile indicates that the neighbourhood experiences the highest levels of deprivation. Not everyone who lives in a deprived neighbourhood will be deprived themselves.

## About the survey estimates

The Health Survey for England, in common with other surveys, collects information from a sample of the population. The sample is designed to represent the whole population as accurately as possible within practical constraints, such as time and cost. Consequently, statistics based on the survey are estimates, rather than precise figures, and are subject to a margin of error, also known as a 95% confidence interval. For example the survey estimate might be 24% with a 95% confidence interval of 22% to 26%. A different sample might have given a different estimate, but we expect that the true value of the statistic in the population would be within the range given by the 95% confidence interval in 95 cases out of 100.

Where differences are commented on in this report, these reflect the same degree of certainty that these differences are real, and not just within the margins of sampling error. These differences can be described as statistically significant.[17]

Confidence intervals are quoted for key statistics within this report and are also shown in more detail in the Excel tables accompanying the Methods report. Confidence intervals are affected by the size of the sample on which the estimate is based. Generally, the larger the sample, the smaller the confidence interval, and hence the more precise the estimate.

[14] For further information about the method for calculating equivalised household income, see the HSE 2016 Methods report at https://digital.nhs.uk/pubs/hse2016.

[15] The seven domains used to calculate IMD are: income deprivation; employment deprivation; health deprivation and disability; education; skills and training deprivation; crime; barriers to housing and services; and living environment deprivation.

[16] Department for Communities and Local Government. *The English Indices of Deprivation 2015,* London, 2015. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/465791/English_Indices_of_Deprivation_2015_-_Statistical_Release.pdf

[17] Statistical significance does not imply substantive importance; differences that are statistically significant are not necessarily meaningful or relevant.

# Need for and receipt of care among older adults

## Ability to perform ADLs and IADLs in the last month, by sex and age

Participants aged 65 and over were asked whether they needed help with a list of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). The majority reported that they were able to complete all of the ADLs and IADLs on their own without help. Where people did have some problems, they were most likely to say that they could manage on their own with difficulty. Much smaller proportions said that they could only do these activities with help, or could not do them at all. These three groups have been combined to form a group who have at least some difficulty, and therefore at least potentially need help.

Figures 1 and 2, Table 1

A quarter of men and one third of women aged 65 and over needed help with at least one ADL (24% and 31% respectively). Similar proportions, 22% of men and 32% of women, said that they needed help with at least one IADL.

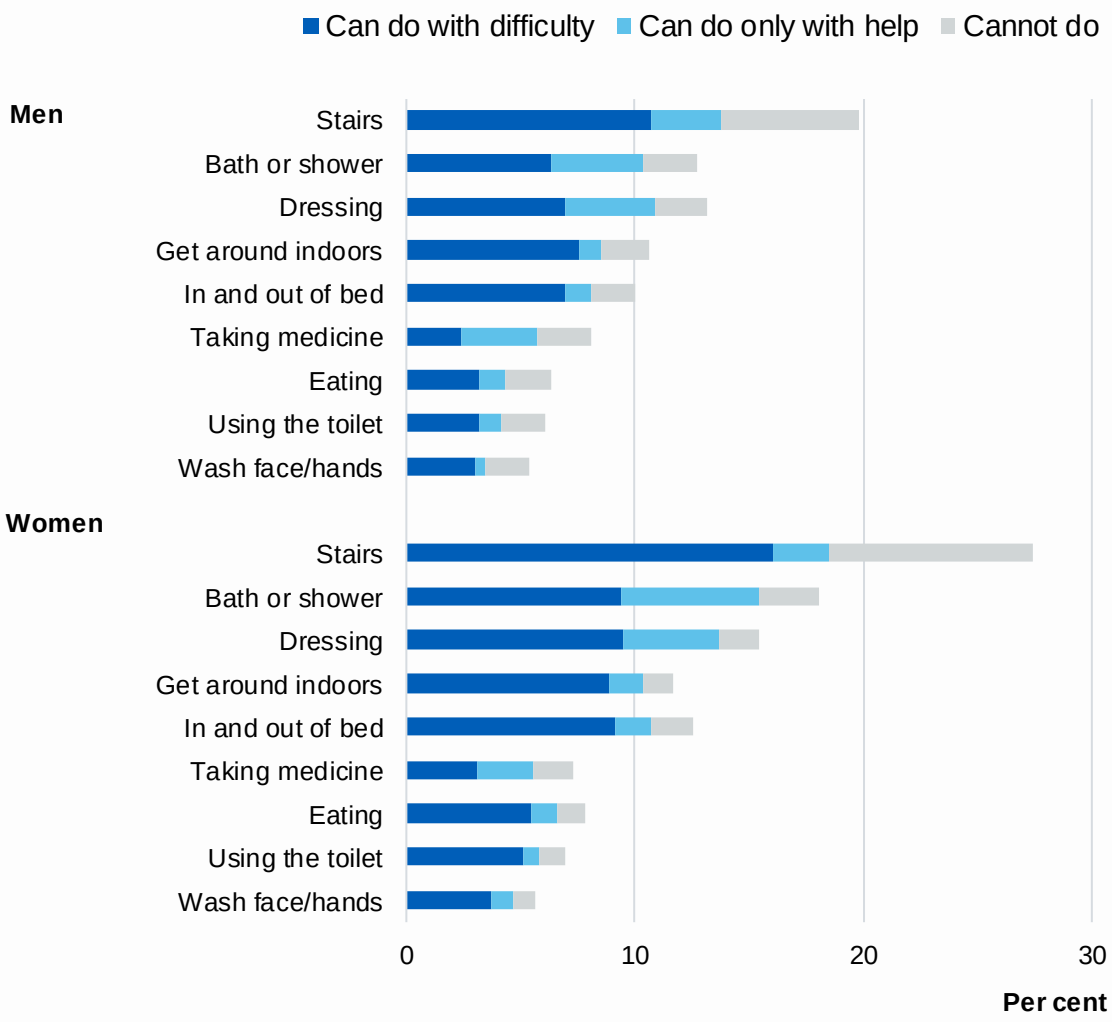
Table 4

People aged 65 and over most commonly needed help with getting up and down the stairs, followed by having a bath or shower, and dressing and undressing. They were least likely to need help with washing face and hands, eating (including cutting up food), or using the toilet. Women were more likely than men to report needing help with having a bath or shower and getting up and down stairs.

Figure 1, Table 1

**Figure 1: Ability to perform ADLs in the last month, by sex**

Base: Aged 65 and over



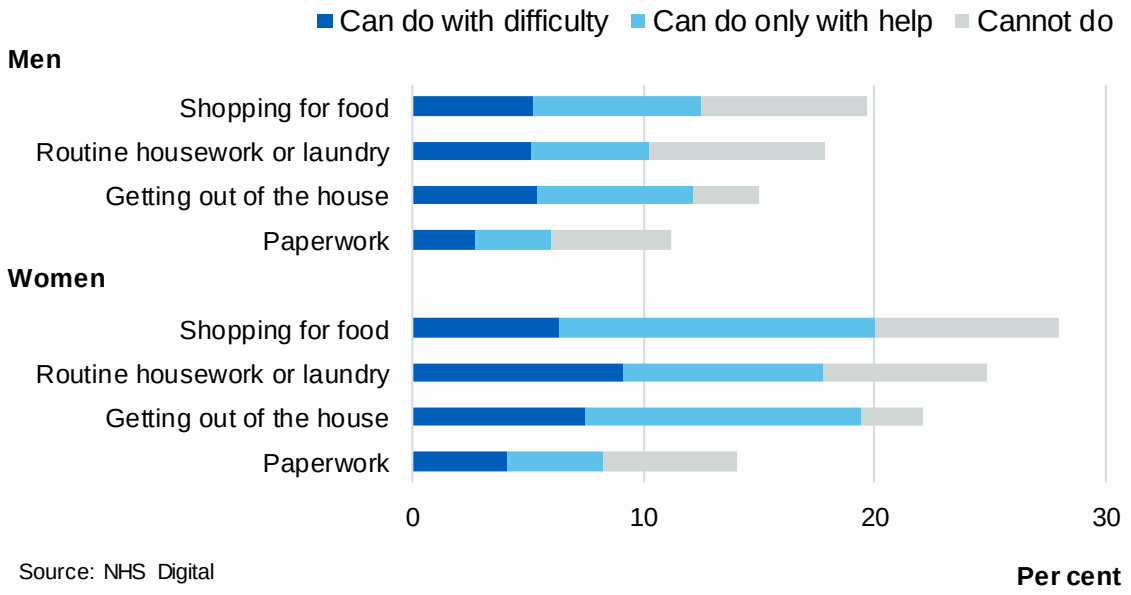

Source: NHS Digital

Women were more likely than men to need help with all IADLs, except doing paperwork or paying bills.

Figure 2, Table 2

**Figure 2: Ability to perform IADLs in the last month, by sex**

Base: Aged 65 and over



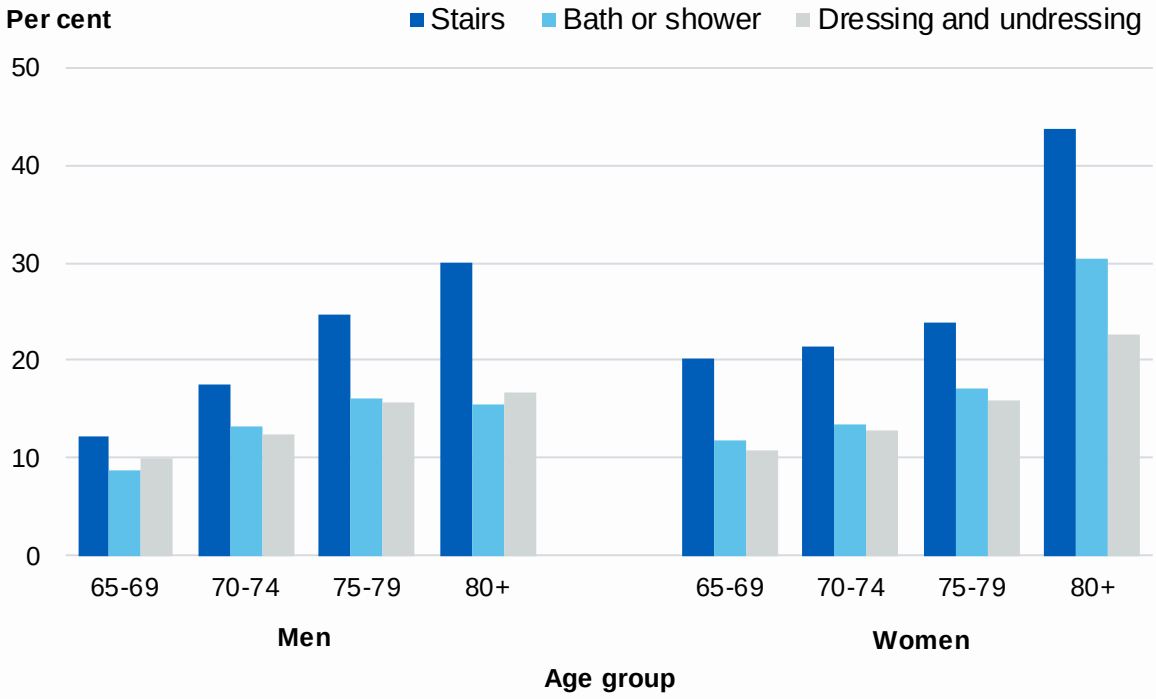

Source: NHS Digital

The proportions of men and women who needed help with ADLs and IADLs increased with age. Among all adults, the increases across age groups were particularly marked for the ADLs that people were more likely to need help with; using the stairs, having a bath or shower, dressing and undressing and getting around indoors. The ADLs with which men and women were most likely to need help are shown in Figure 3.

Figure 3, Table 2

**Figure 3: ADLs for which help was most commonly needed in the last month, by age and sex**

Base: Aged 65 and over




Source: NHS Digital

## Receipt of help, by age and sex

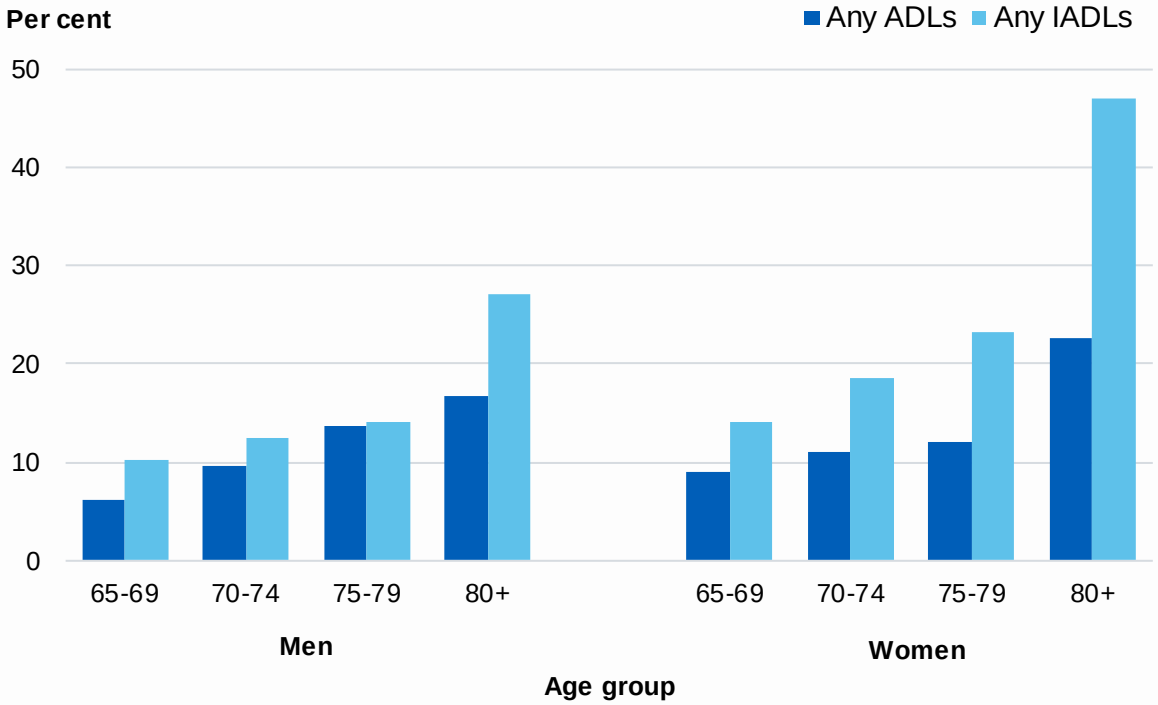
Adults who said that they needed help with any task were asked whether they received help. Similar proportions of men and women had received help with at least one ADL in the last month (11% and 14% respectively). Women were more likely to have received help with IADLs; 15% of men and 26% of women had received help with at least one IADL.

As with need, the proportions receiving help with ADLs increased with age. There was a similar pattern for IADLs.

Figure 4, Table 2

**Figure 4: Receipt of help with ADLs and IADLs in last month, by age and sex**

Base: Aged 65 and over




Source: NHS Digital

Because these questions were asked of everyone who had reported any need at all, there was a minority of those who received help in the last month for a particular activity for which they did not feel that they needed help.[18] Unmet need, the difference between the proportions needing help and those receiving it, is discussed below.

## Prevalence of unmet need, by sex and age

Unmet need has been defined as being able to manage a particular ADL or IADL with difficulty, only with help, or not at all, but not receiving help with that activity in the last month. The assumption is that those who have at least some difficulty with an activity may need help.

20% of men and 27% of women aged 65 and over had some unmet need with at least one ADL. 12% and 16% respectively had some unmet need with at least one IADL. Women were more likely than men to have needed help with at least one ADL or IADL in the last month but to have received no help.

Table 3

Unmet need with ADLs increased with age. 14% of men and 19% of women aged between 65 and 69 had some unmet need for help with ADLs, compared with 30% of men and 42% of women aged 80 and over. For IADLs the pattern was less clear-cut,

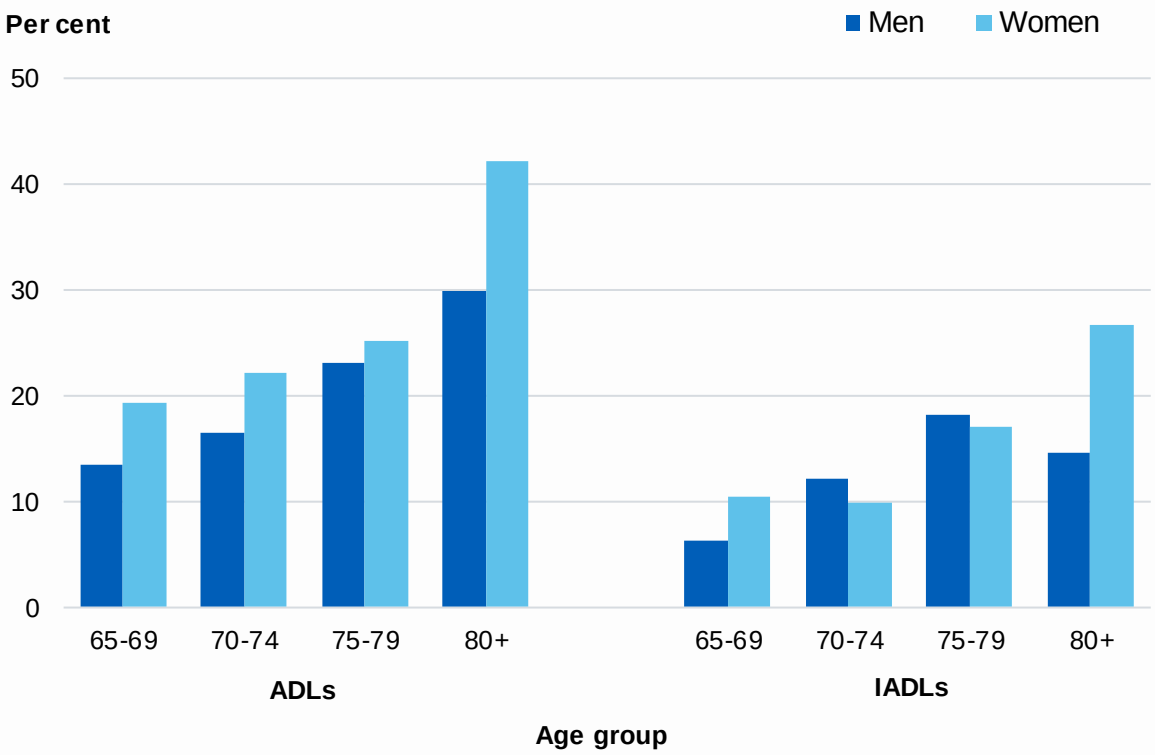
[18] The absolute numbers of adults receiving help for each activity were generally low, so it is not possible to draw reliable conclusions about the proportions of older adults receiving help that they may not have needed.

although overall older men and women were more likely to have some unmet need for help with IADLs.

Figure 5, Table 3

**Figure 5: Unmet need in the last month, by age and sex**

Base: Aged 65 and over




Source: NHS Digital

The activity with the highest level of unmet need among older people was getting up and down stairs (15% of men and 23% of women overall, including 24% and 36% respectively aged 80 and over).

Table 3

## Need for and receipt of help and unmet need, 2011 to 2016

In 2016, adults aged 65 and over were less likely to report that they needed help with ADLs or IADLs than in 2011. In 2011, 32% of adults needed help with ADLs and 33% with IADLs; in 2016 the proportion was 28% for both. Similarly, the proportions of adults who received help with either ADLs or IADLs were also lower in 2016 (12% and 21%) than in 2011 (15% and 27%). Unmet need has remained at similar levels over this period; 26% had some unmet need with ADLs and 15% with IADLs in 2011, compared with 24% and 14% in 2016.

Table 4

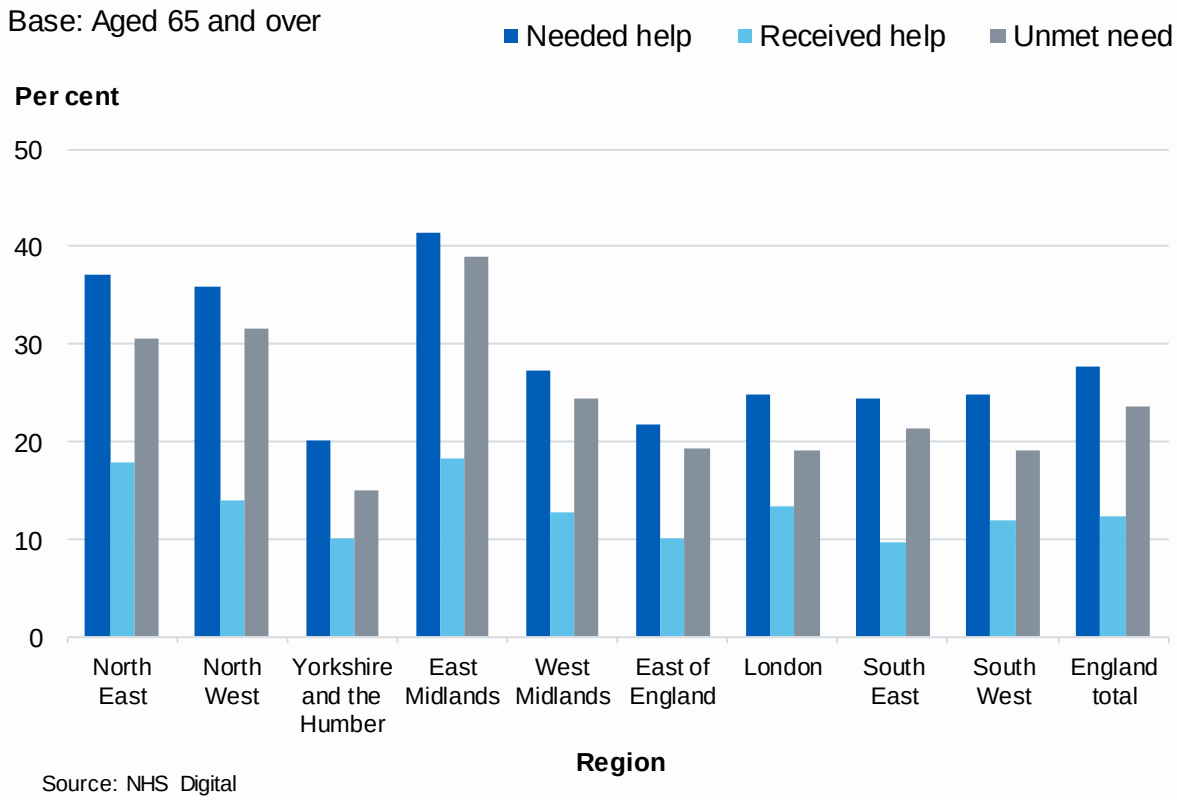
## Need for and receipt of help, by region and sex

Data for region are shown in the tables both as observed and age-standardised estimates to account for the different age profiles across different regions. The following commentary is based on age-standardised results.

The need for and receipt of help with ADLs and IADLs varied by region. The need for and receipt of help, as well as unmet need, with ADLs was generally more prevalent in the East Midlands, North East and North West than in the South East, East of England and Yorkshire and the Humber. There was a similar pattern for IADLs.

Figures 6 and 7, Table 5

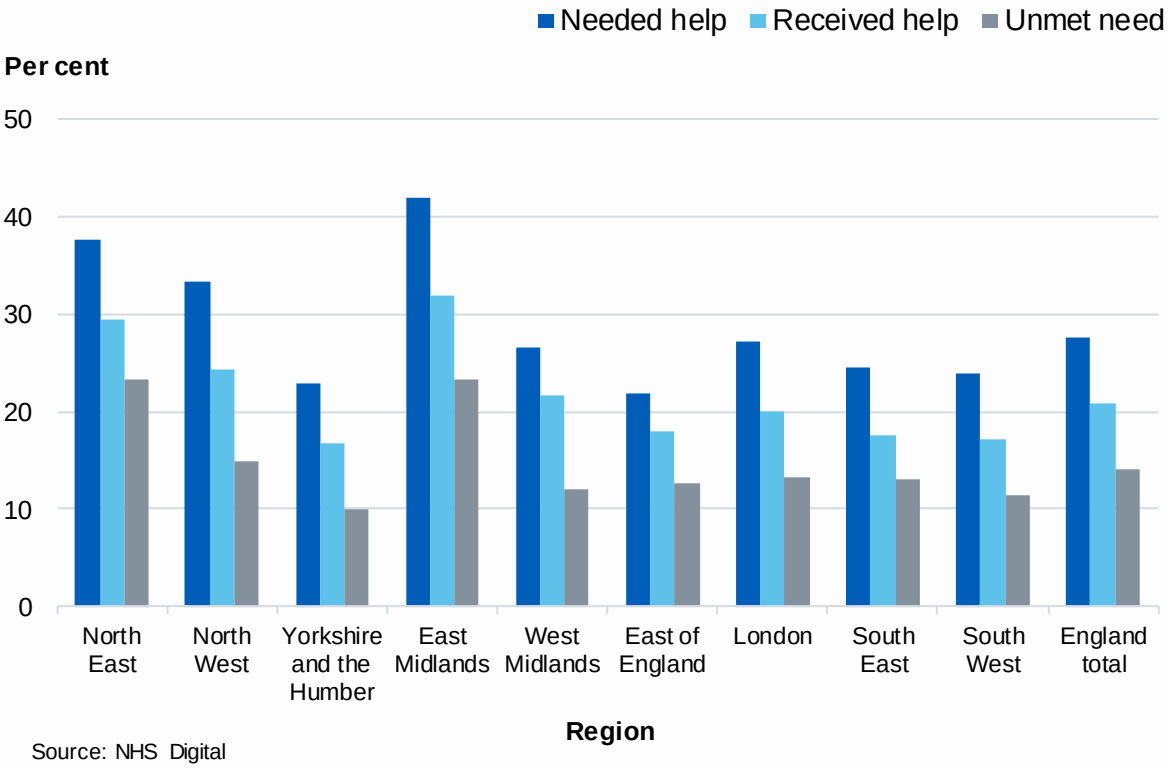
**Figure 6: Need for, receipt of help, and unmet need with ADLs in the last month (age-standardised), by region**




Source: NHS Digital

**Figure 7: Need for, receipt of help, and unmet need with IADLs in the last month (age-standardised), by region**

Base: Aged 65 and over




Source: NHS Digital

## Need for and receipt of help in the last month, by equivalised household income and sex

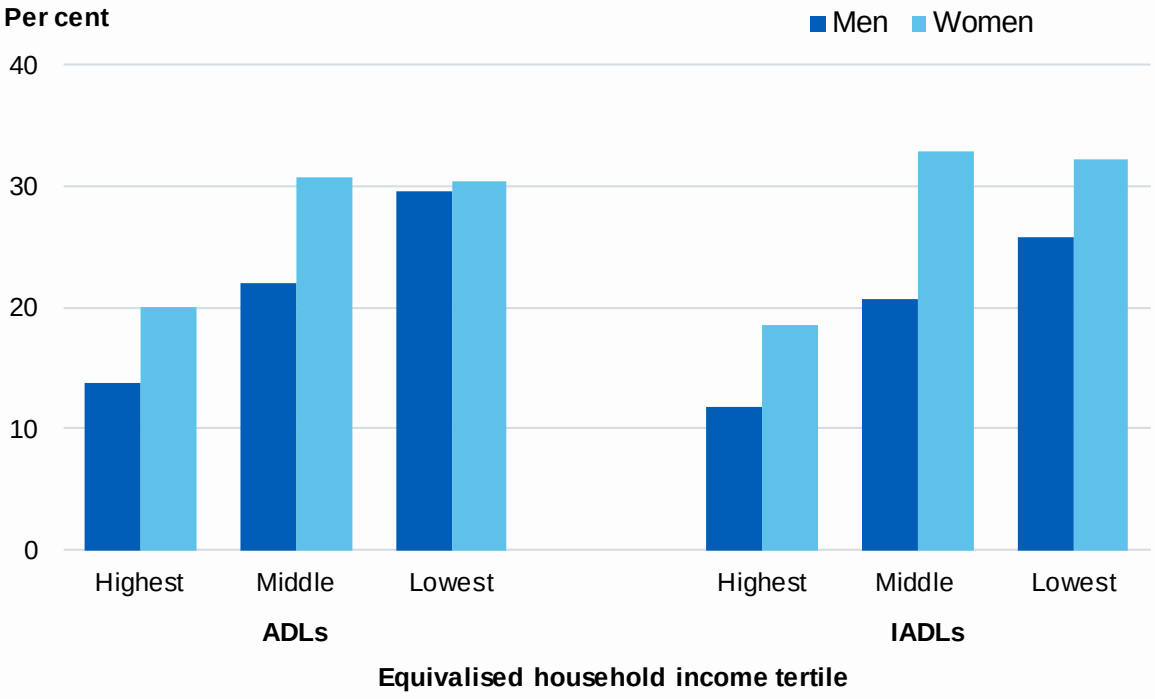
Equivalised income compares household incomes by taking into account the number of people living in each household, as well as their combined income.[19] Equivalised household income data are shown in the tables as age-standardised estimates to account for the different age profiles across household incomes.

The proportion of adults aged 65 and over who needed help with at least one ADL or IADL varied by household income. Among men, 30% in the lowest household income group needed help with ADLs, compared with 14% in the highest household income group. Among women, the need for help with ADLs was similar in the lower two income tertiles (30% to 31%) and lower in the highest income tertile (20%). Need for help with IADLs followed a similar pattern for both men and women.

Figure 8, Table 6

**Figure 8: Need for help with ADLs and IADLs (age-standardised), by income and sex**

Base: Aged 65 and over




Source: NHS Digital

The proportion of men and women receiving help with ADLs and/or IADLs also increased as household income decreased.

Figure 9 shows unmet need for ADLs and IADLs among men and women aged 65 and over. Unmet need was lower in the highest income households and higher in

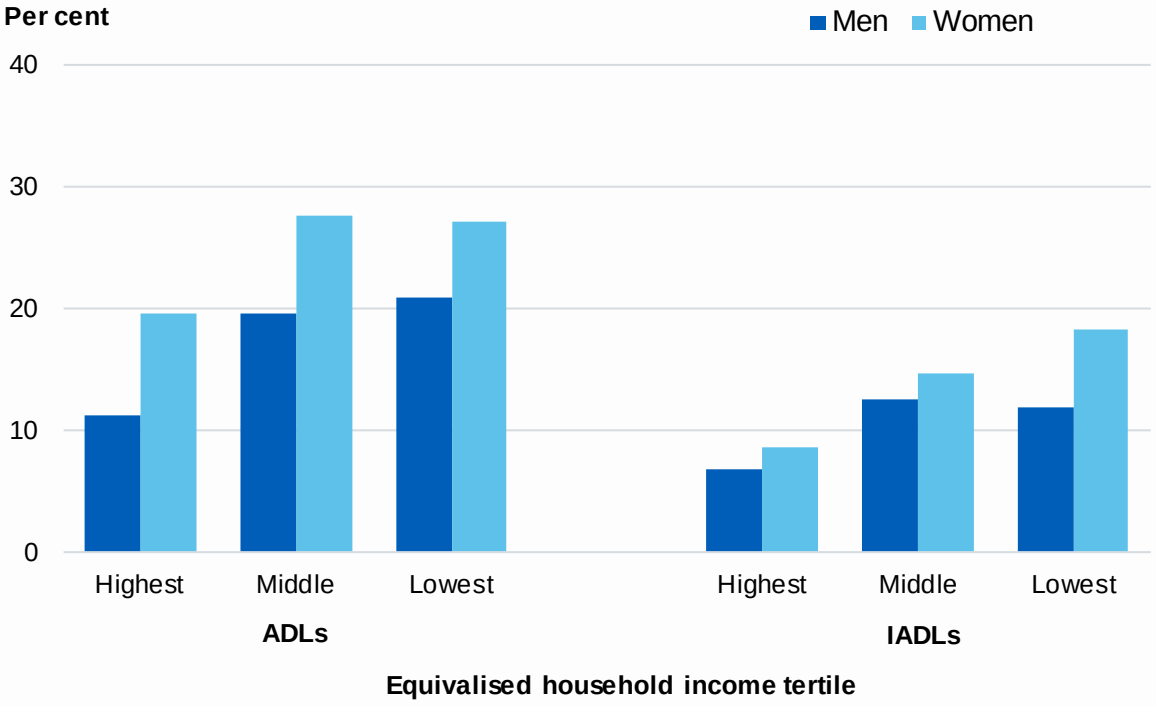
[19] The method for calculating equivalised income is explained in detail in the HSE Methods report.

households with lower incomes. For ADLs, 20% to 21% of men and 27% to 28% of women in the two lower household income groups had unmet need for help, compared with 11% of men and 20% of women in the highest household income group. Unmet need for help with IADLs followed a similar pattern.

Figure 9, Table 6

**Figure 9: Unmet need for help with ADLs and IADLs (age-standardised), by income and sex**

Base: Aged 65 and over




Source: NHS Digital

## Need for and receipt of help in the last month, by Index of Multiple Deprivation and sex

Data for Index of Multiple Deprivation (IMD) are shown in the tables as age-standardised estimates to account for the different age profiles across areas of deprivation.

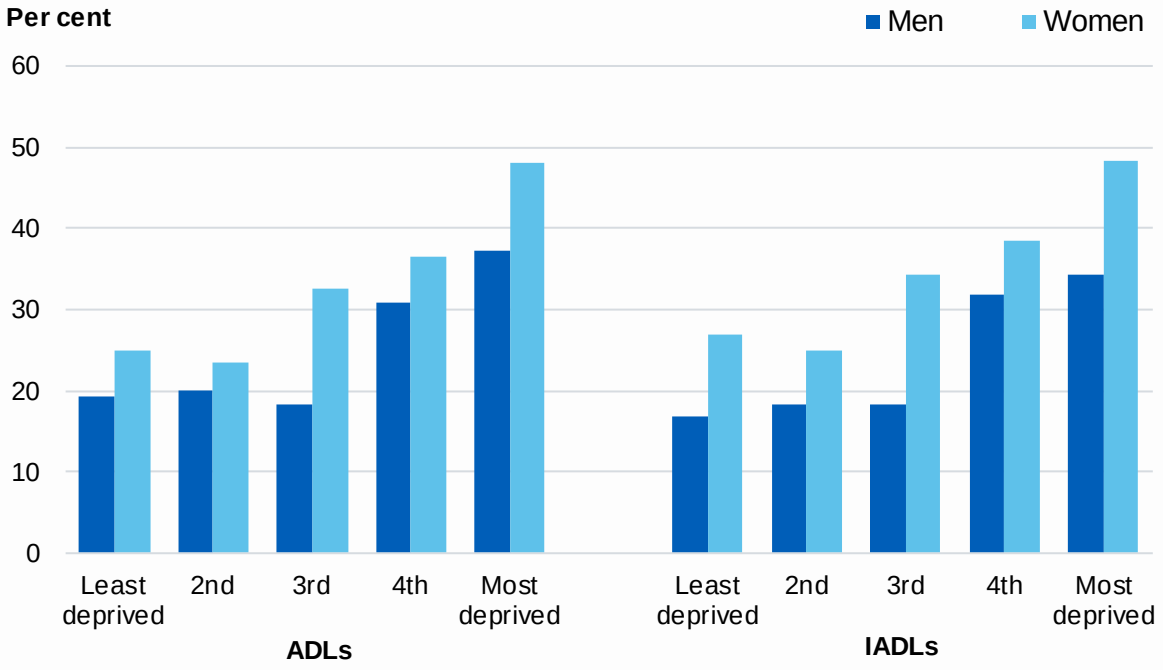
Need for help varied by area deprivation among adults aged 65 and over, Overall, the need for help with ADLs and IADLs was higher in more deprived areas, and lower in less deprived ones, but the pattern was not clear-cut, for example there was very little difference in the need for help among men in the three least deprived quintiles, or among women in the two least deprived quintiles.

Figure 10, Table 7

**Figure 10: Need for help with ADLs and IADLs (age-standardised), by Index of Multiple Deprivation (IMD) and sex**

Base: Aged 65 and over




Source: NHS Digital

Generally speaking, the proportion of adults aged 65 and over receiving help with ADLs also increased with area deprivation. The pattern differed between men and women; receipt of help with ADLs was lowest among women in the two least deprived areas (8% to 10%), increasing to 20% of women in the most deprived areas. The pattern for men was less clear however, with similar proportions receiving help with ADLs in four out of five quintiles, including the most and least deprived. Receipt of help for IADLs was also higher in the most deprived areas (24% of men and 39% of women) than the least deprived areas (11% of men and 23% of women), but again the pattern for men was not clear-cut.

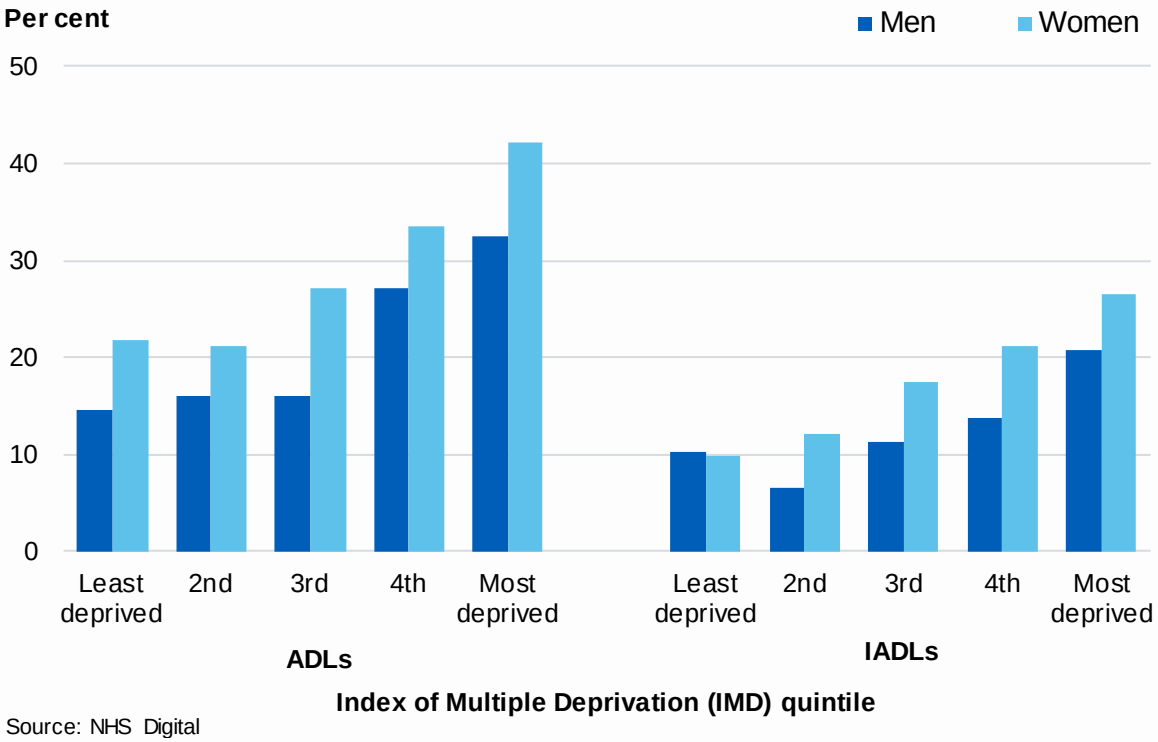
Table 7

There was also variation in unmet need by area deprivation, as Figure 11 shows. Men and women in the most deprived areas were around twice as likely to have unmet need for at least one ADL (33% and 42% respectively), compared with men and women in the least deprived areas (15% and 22% respectively). Unmet need for help with IADLs followed a similar pattern, although proportions were lower than for ADLs.

Figure 11, Table 7

**Figure 11: Unmet need with ADLs/IADLs in the last month (age-standardised), by Index of Multiple Deprivation (IMD) and sex**

Base: Aged 65 and over




Source: NHS Digital

# Sources of care

## Unpaid and formal helpers, by sex

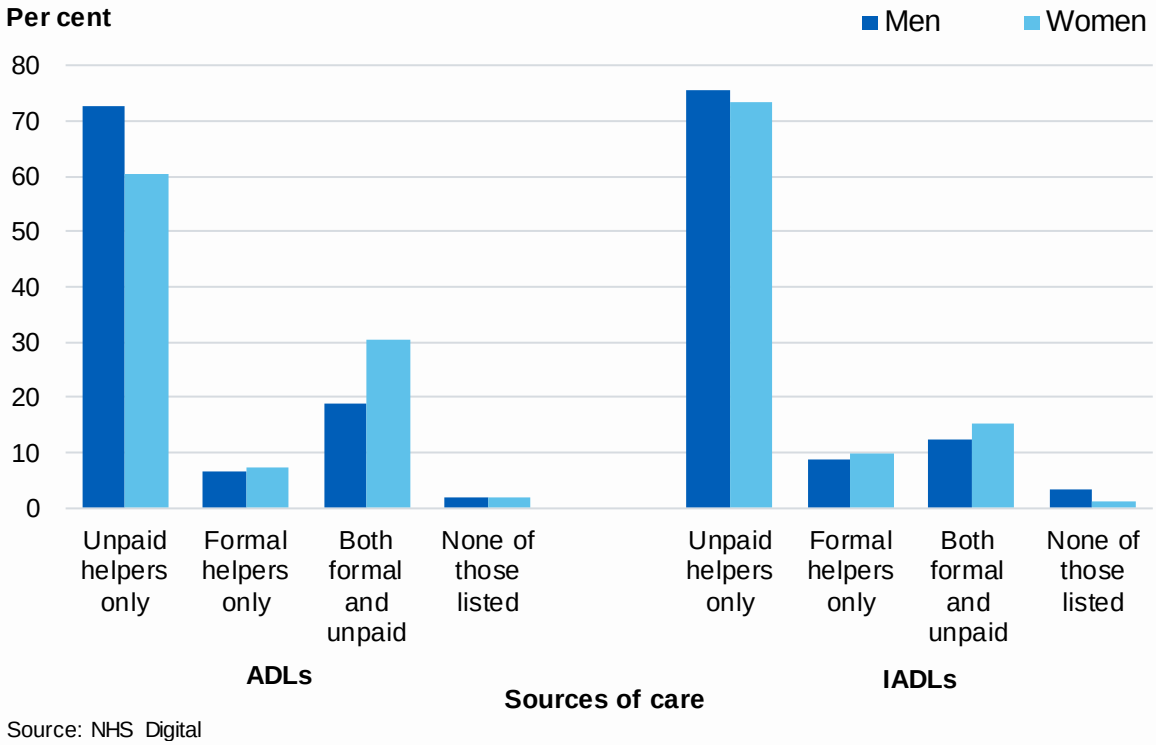
Around two thirds of adults aged 65 and over who had received help for ADLs in the past month, had received this from unpaid helpers only (65%). Men were more likely than women to receive only unpaid help (73% and 61% respectively). A higher proportion of women received both unpaid and formal help for ADLs than men (30% of women and 19% of men).

For IADLs, almost three quarters (74%) of adults received only unpaid help. The proportions of men and women receiving this form of help for IADLs were similar (76% and 74% respectively), as were the proportions who received both unpaid and formal help with IADLs (15% of women and 12% of men).

Figure 12, Table 8

**Figure 12: Summary of who provided help with ADLs/IADLs in the last month, by sex**

Base: Aged 65 and over




Source: NHS Digital

# Assessment of care

## Local authority assessment of care needs in the last 12 months, by age

A fifth (19%) of adults aged 65 and over with any need for help with ADLs or IADLs had received a local authority assessment of their care needs within the last 12 months; however the majority of these adults with some care needs had not (81%).

This proportion was similar for adults aged between 65 and 79 and for those aged 80 and over.

Table 9

# Discussion

HSE 2016 is the first full survey year since the Care Act 2014 came into force in April 2015.[20] The Act lays out local authorities' duties in relation to assessing people's needs. This includes the requirement to carry out an assessment of any adult who may require care. The majority of adults who needed help with ADLs and/or IADLs in 2016 had not received an assessment in the last 12 months (81%).

The Care Act 2014 also outlines the eligibility criteria for accessing adult care and support under The Care and Support (Eligibility Criteria) Regulations 2014.[21] Under these guidelines, a person is eligible for care if they cannot achieve two or more specified outcomes in their day-to-day life, and as a result experience significant impact on their well-being. This criterion differs to the HSE definition of need which defines adults aged 65 and over to be in need of care and support if they said there was at least one ADL or IADL that they could manage on their own with difficulty, could only do with help, or could not do at all.

Although the national eligibility criteria threshold appears to be higher, there are differences between the outcomes it uses and the ADLs and IADLs measured in the HSE. In some ways the outcomes in the eligibility criteria are broader and they do not distinguish between types of activity as the HSE does for ADLs and IADLs. An instrumental activity such as getting around in the community safely and being able to use facilities such as public transport, is one outcome alongside others focused on more personal activities, such as being able to dress and being appropriately dressed. Table C compares the national eligibility criteria with the ADLs and IADLs where there is an obvious correspondence.

[20] The Care Act 2014. http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

[21] The Care and Support (Eligibility Criteria) Regulations 2014. https://www.legislation.gov.uk/ukdsi/2014/9780111124185

## Table C: Comparison between national eligibility criteria, ADLs and IADLs

| National eligibility criterion | ADL | IADL |
|---|---|---|
| Managing and maintaining nutrition | Eating, including cutting up food. | Shopping for food. |
| Maintaining personal hygiene | Having a bath or shower. Washing face and hands. | |
| Managing toilet needs | Using the toilet. | |
| Being appropriately clothed | Dressing and undressing. | |
| Being able to make use of [their] home safely | Getting up and down stairs. Getting around indoors. Getting in or out of bed. | |
| Maintaining a habitable home environment | | Doing routine housework or laundry. |
| Making use of necessary facilities or services in the local community, including public transport and recreational facilities or services | | Getting out of the house |

There are no direct equivalents among the eligibility criteria for the ADL ‘taking medicine’ or the IADL ’doing paperwork and paying bills’. Similarly, several of the national eligibility criteria – developing and maintaining family or other personal relationships; accessing and engaging in work, training, education or volunteering; and carrying out childcare responsibilities – have no equivalent ADLs or IADLs. Some of the ADLs and IADLs affect more than one criterion, for example being able to get in or out of bed, get up and down stairs and get around indoors all have an impact on most of those eligibility criteria concerned with daily home life, for example maintaining personal hygiene and managing toilet needs.

Although the two measures are not directly comparable, as Table D shows, 19% of adults aged 65 and over in the HSE 2016 needed help with two or more ADLS, and 22% needed help with two or more IADLs. There may be some overlap between these two groups of older people because some may need help with both ADLS and IADLS. Table D data suggest that some older adults have multiple needs for help and support with ADLs and/or IADLs. Although the eligibility criteria and the ADLs and IADLs are differently defined, the data suggest that applying the national eligibility criteria would identify a sizeable minority within this age group as qualifying for support.

## Table D: Number of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) needed help with, aged 65 and over

| | Men % | Women % | All adults % |
|---|---|---|---|
| **Number of ADLs need help with** | | | |
| 0 | 76 | 69 | 72 |
| 1 | 7 | 10 | 8 |
| 2+ | 17 | 21 | 19 |
| **Number of IADLs need help with** | | | |
| 0 | 78 | 68 | 72 |
| 1 | 4 | 7 | 5 |
| 2+ | 19 | 26 | 22 |

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