

IFS Briefing note BN309

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COVID-19 and disruptions to the health and social care of older people in England

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Executive summary

The COVID-19 pandemic has led to dramatic changes in the delivery of routine health care in England. To prioritise access to hospital beds, staff and ventilators for COVID-19 patients, and to minimise the risk of infection for other patients, much routine health care was postponed or replaced with online or phone consultations. In addition, many would-be patients declined to seek care in the first place. In this briefing note, we use novel data to quantify these disruptions to care among older people in England in the early stages of the pandemic, and to examine who was most affected.

Widespread disruption of health care during the pandemic

Newly available data from the English Longitudinal Study of Ageing show that many of the over-50 population were unable to access health care services during the early stages of the COVID-19 pandemic in England. A sixth of older people report having hospital treatment cancelled, with an additional one in ten unable to visit or speak to their GP. Access to community health and social care has also been severely disrupted.

Poorer and sicker individuals worst affected

The burden of disruptions to health care services has disproportionately fallen on those living in the most deprived areas and those with worse underlying health. These individuals are most likely to require care in the first place, and least likely to be able to substitute temporarily for other types of care, or to forgo care entirely for a period of time. With routine services only slowly returning to their pre-pandemic capacity, and a large backlog of care to be worked through, long-standing health inequalities are likely to be exacerbated for years to come. These findings underline the importance of boosting capacity to address care backlogs as soon as possible.

Key findings

- 1 Disruptions to hospital care were widespread during the early stages of the pandemic. A sixth of the over-50 population in England – that is 3.6 million individuals – had hospital treatment or an operation cancelled.
- 2 Hospital cancellations were most common for heavy users of hospital services. Older people, those living in more deprived areas and those with worse self-reported health were most likely to experience a disruption to their hospital care.
- 3 Disruptions to the use of GP and community health and social care services were also widespread. Almost a quarter of those reporting that they needed to speak to a GP did not, while almost three-quarters of those reporting that they needed community health and social care services did not use these.
- 4 Much more impressively, access to prescription medication continued largely unaffected. Less than 1% of the population reported that they could not access their regular medication.
- 5 Individuals previously reporting a worse health status were more than twice as likely not to see or talk to a GP when they sought one than those previously reporting an excellent general health status. 12.8% of those who reported 'poor' or 'fair' health failed to see a GP when attempting to do so, compared with just 5.8% among those with 'excellent' health.
- 6 Those living in the most deprived areas were most affected by disruptions to community services. 37% of those living in the least deprived areas did not access these services even after attempting to do so, increasing to 46% among those living in the most deprived areas.
- 7 Care-seeking behaviour changed radically in the early stages of the pandemic, with a significant proportion of patients with care needs not

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actively seeking help. 14% of those requiring GP care, and more than a third of those reporting that they needed community care services, did not contact these services.

1. Introduction

The COVID-19 pandemic has led to enormous changes in the provision of health and social care across the UK. In order to focus resources on treating patients suffering from the acute effects of the virus, and to minimise the risk of infection during treatment, hospitals were asked to suspend non-urgent surgery and GPs replaced face-to-face appointments with online and phone consultations. At the same time, patients also sought less care from hospitals, with, for example, large drops in the number of attendances at A&E (Kelly and Firth, 2020). As a result, the amount and type of care received by the population have changed dramatically as a result of the crisis. With performance against legal elective waiting time targets at its worst recorded level since records began in 2007 (Royal College of Surgeons of England, 2020), the consequences of the pandemic will affect the delivery of health care for years to come. However, currently, little is known about whose care has been affected and, consequently, which groups should be targeted by policies to avoid introducing or exacerbating health inequalities in the longer term.

In this briefing note, we use newly available survey data to examine how health care has been disrupted among the older population in England in the early stages of the COVID-19 pandemic. We provide evidence of how widespread were the disruptions to the use of hospitals, GPs and community care services, and access to prescription medication, from February 2020 to May 2020.

We also examine who has been most affected by these changes by documenting how disruptions to care varied across age, sex, household composition, local area deprivation and self-reported health status.

To do this, we use new data from the English Longitudinal Study of Ageing (ELSA). ELSA has interviewed a representative sample of the English household population aged 50 years and older since 2002–03, with participants interviewed every two years about their health, economic and social circumstances. A special module was fielded in June 2020 to collect information on the experiences of these participants in the early stages of the pandemic (February–May 2020), including their need for and use of different types of health and social care. This collected a

full set of responses from 6,615 participants concerning their use of health and social care. Combining these responses with data previously collected as part of the main survey allows us to examine in detail how disruptions to health care varied across different population groups. All figures are weighted to ensure that the results are representative of the over-50 household population in England.

2. Disruptions to hospital care

Much of the initial focus of the NHS was to create additional capacity for patients who were acutely ill as a result of COVID-19. To do this, existing resources (including staff, beds and ventilators) were directed away from more routine services. In addition, in order to reduce the threat of infecting patients who use other hospital services, non-emergency care was mostly cancelled. As a result, many hospital services were disrupted.

When surveyed in June 2020, ELSA participants were asked whether they had had a hospital operation or treatment cancelled since the start of the outbreak. A sixth (16.8%) of participants – equivalent to 3.6 million individuals in England – reported that their operation or treatment had been cancelled. A large part of the older population in England therefore experienced disruptions to their planned hospital care, despite many people in this age group having no hospital treatment planned over this period. The survey does not record how many participants had such treatment scheduled. As a result, we cannot examine what proportion of patients with planned treatment or operations experienced a cancellation. However, data collected in May 2020 as part of the Understanding Society COVID-19 study suggest that 23.5% of participants aged 50 years and older had hospital treatment planned in the month before the interview, with 57.4% of these participants who had planned treatment either experiencing a cancellation, or postponing their treatment themselves.¹

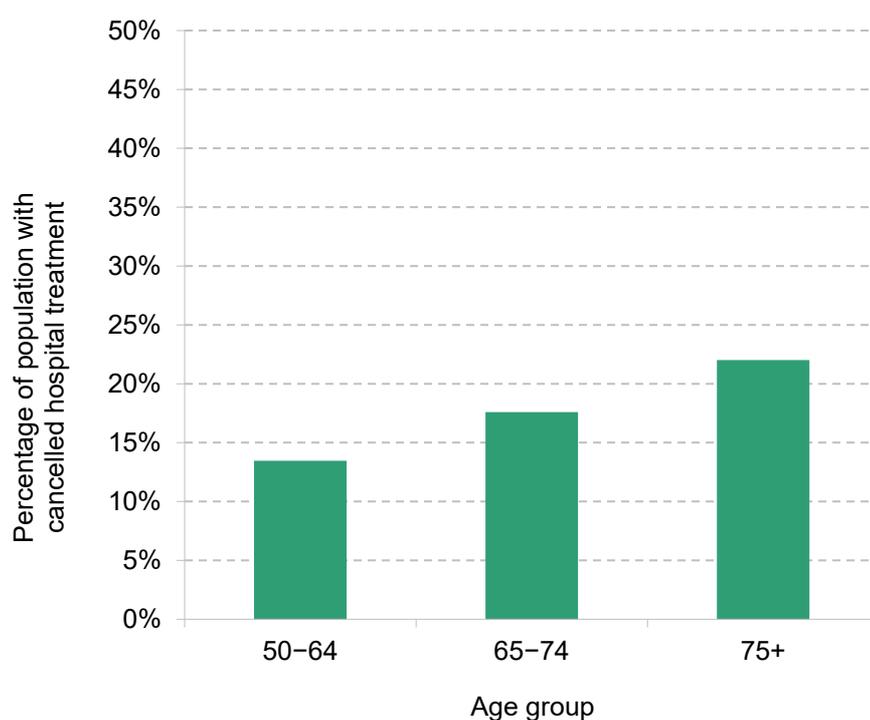
We also use these data to examine how the percentage of people with cancelled hospital treatment varies across different population groups. Given that we do not have information on how many participants had treatment scheduled, all figures reported in this section show the proportion of the over-50 population in England

¹ For more information on use of care during April 2020 across the UK population, see Benzeval et al. (2020).

who were affected by these disruptions (as opposed to the proportion of this population with planned hospital care). This means that variation across groups will in part simply reflect differences in the need for care. However, this still reveals important variation in the groups most affected by these cancellations.

Figure 2.1 shows how the percentage of people with cancelled hospital treatment varies across age groups. It shows that older individuals were more likely to have some hospital treatment cancelled: 22.0% of those aged 75 and older had treatment cancelled, compared to 13.5% for those aged between 50 and 64, and 17.6% for those aged between 65 and 74. This pattern is likely to reflect, in part, that older

Figure 2.1. Percentage of the English over-50 population with cancelled hospital treatment or operations, by age group



Note: Sample = 6,615. Figures are weighted to ensure national representativeness. We omit any responses for individual questions that are noted as 'prefer not to say' or 'doesn't know'.

Source: Authors' calculations using ELSA data.

people are more likely to use hospital care in general: for example, in 2015, the over-75s were more than twice as likely to have an elective hospital admission than those in their 50s (Lee and Stoye, 2018). The relative differences in cancellations

across age groups may therefore suggest that, if anything, hospital treatment was less likely to be cancelled for the oldest patients if it was already planned.

Cancellation rates varied a little across sex and household composition, with women somewhat more likely to have their care cancelled than men (18.0% for women relative to 15.4% for men), as were those living without a partner (19.7% relative to those living as part of a couple (15.4%).

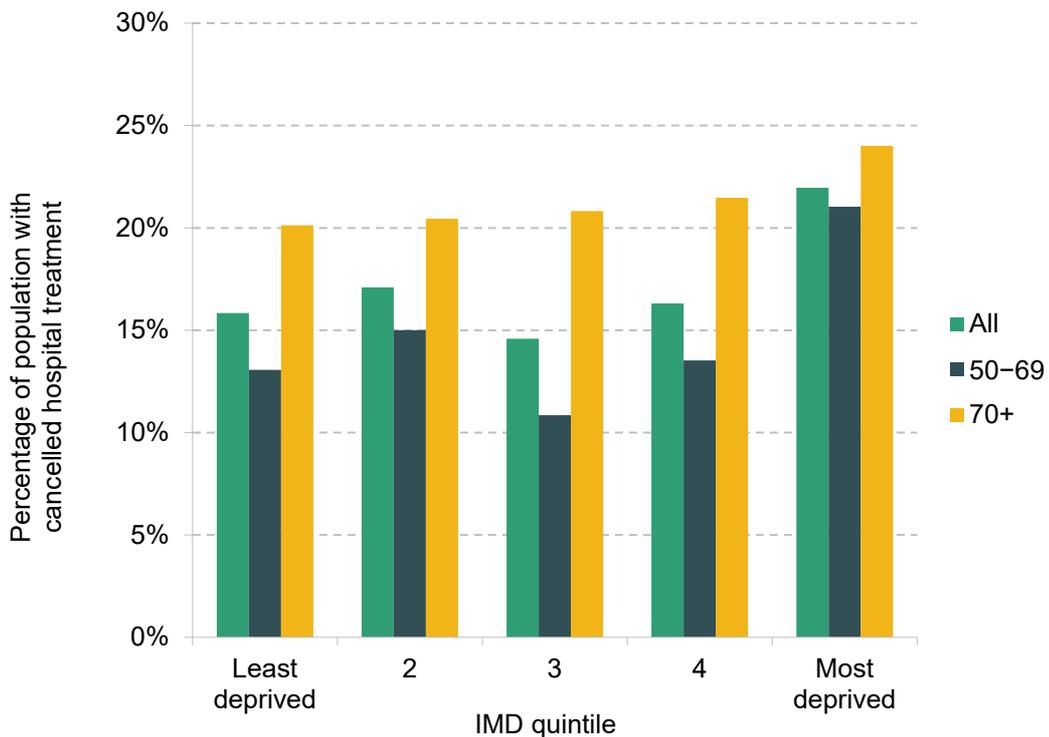
Figure 2.2 shows that there are clear differences in the proportion of individuals whose care was cancelled by the deprivation level of the local area in which they live. Splitting individuals into five groups based on their 2015 index of multiple deprivation (IMD) score, those living in the most deprived fifth of areas were more likely to have hospital treatment cancelled (22.0%) than those living in the least deprived fifth of areas (15.8%). Noticeably, these differences only really emerge between the most deprived fifth of areas and all others, with only small differences in cancellation rates across all other areas. This will again somewhat reflect differences in the need for care: for example, between 2010–11 and 2014–15, annual hospital spending for the over-65 population in England was 35% higher in the most deprived fifth of areas compared with the least deprived fifth of areas (Kelly, Stoye and Vera-Hernández, 2016). However, the differences in care use between all other deprivation quintiles is much more gradual than the pattern observed in cancellations, suggesting that differences in the need for care are unlikely to explain the entire difference.

Figure 2.2 also shows how cancellations varied across deprivation level for two age groups: those aged between 50 and 69 years old (blue-grey bars), and those aged 70 and older (gold bars). This shows that the stark differences between those living in the most deprived fifth of areas and all other areas is driven by the relatively younger group: for example, cancellations were 55.0% more common in the most deprived fifth of areas than in the second most deprived fifth of areas among those aged 50–69 (21.0% compared with 13.1%), but only 11.8% more common among those aged 70 and older (24.0% compared with 20.1%).

The fact that those who were more likely to require treatment were most affected by hospital cancellations is clearly shown by comparing cancellation rates across individuals with different health needs. Figure 2.3 shows the percentage of the population with cancelled treatment according to the self-reported health status of individuals recorded at the time of their previous ELSA interview (June 2018 to

July 2019). 8.0% of participants who previously rated their health as ‘excellent’ reported having hospital treatment cancelled. This increased to 14.0% for those who rated their health as ‘very good’ or ‘good’, and to 28.4% among those who rated their health as ‘fair’ or ‘poor’.

Figure 2.2. Percentage of the English over-50 population with cancelled hospital treatment or operation, by local area deprivation



Note: Sample = 6,615. Figures are weighted to ensure national representativeness. We omit any responses for individual questions that are noted as ‘prefer not to say’ or ‘doesn’t know’. IMD quintiles are calculated using the lower super output area (LSOA) of residents at the time of their wave 9 interview, and we use the 2015 IMD estimates for these areas.

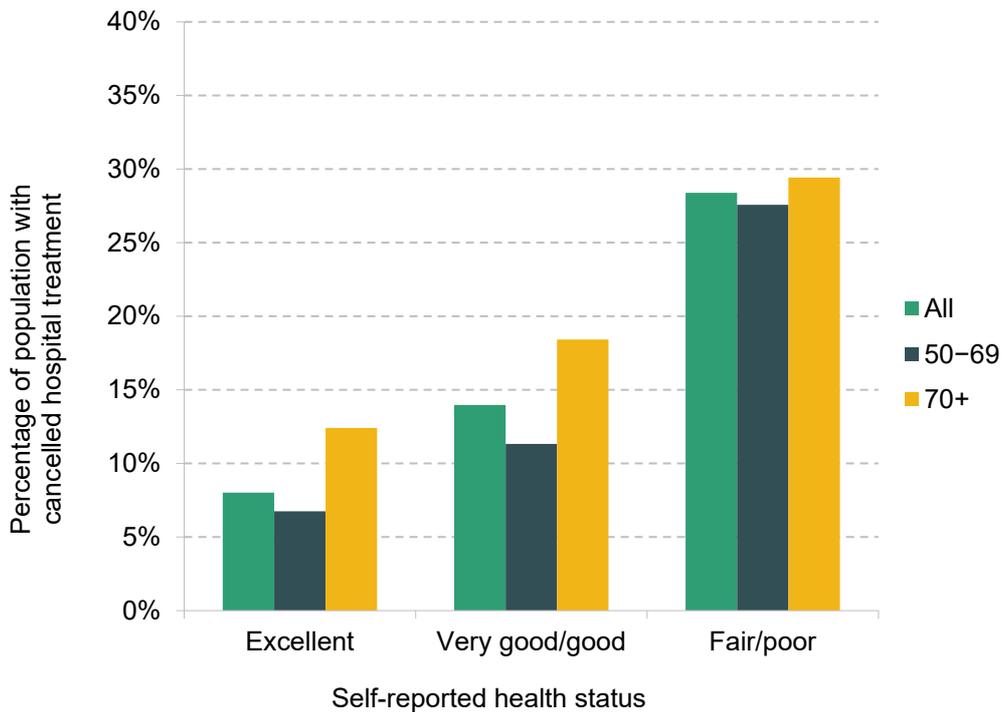
Source: Authors’ calculations using ELSA and Office for National Statistics 2015 IMD data.

Distinguishing between those aged younger and older than 70 again suggests that the greatest differences across groups are within the younger age groups. Individuals aged between 50 and 69 were more than four times more likely to have hospital treatment cancelled if they previously reported fair or poor health rather than excellent health. In the older category, those reporting fair or poor health were around two and a half times more likely to experience a cancellation. This may reflect changes in the relative needs of individuals with different self-reported

health status at different ages, with hospital treatment more likely to be required at older ages even if an individual considers themselves to be in excellent health.

Figure 2.3. Percentage of the over-50 population with cancelled hospital treatment or operations, by self-reported health status

Note: Sample = 6,615. Figures are weighted to ensure national representativeness. We omit any responses for individual questions that are noted as ‘prefer not to say’ or ‘doesn’t know’. Self-reported health status is taken from wave 9 interview responses.



Source: Authors' calculations using ELSA data.

Taken together, these statistics show that disruptions to hospital care as a result of the pandemic affected a large share of the older population. Unsurprisingly, the greatest impacts were on groups who were most likely to need such care, including the oldest, those living in more deprived areas and those with worse underlying health. This is likely to exacerbate existing health inequalities between these groups, and highlights the needs for additional resources to be made available to provide treatment in order to offset these widening health inequalities.

3. Access to primary and community care

All parts of the health system – not just hospitals – have been affected by the pandemic. The survey also collected information on the need for GP services, prescription medication and community health and social care services (including a dentist, podiatrist, nurse, counselling or personal care), and the ability of individuals to access these services.

Figure 3.1 shows the percentage of individuals who could access each of the three types of service. One-third (34.0%) of individuals reported that they have wanted to see or talk to a GP since the start of the outbreak. One-quarter (25.9%) of all participants reported that they could access these services. However, the remainder reported that they had not spoken to a GP, affecting almost one in eleven of the over-50 population (and about a quarter of those patients who reported that they required care). This was either because they had not sought care (4.7% of participants and 57.3% of those who required care and did not receive it) or because they did seek care but could not access it (3.5% of all participants and 42.7% of those who required care and did not receive it). This suggests both that some individuals were not able to access the services they required, and that others altered their care-seeking behaviour. Both of these effects may lead to worse health outcomes now and in future (if health worsens without appropriate and timely treatment).

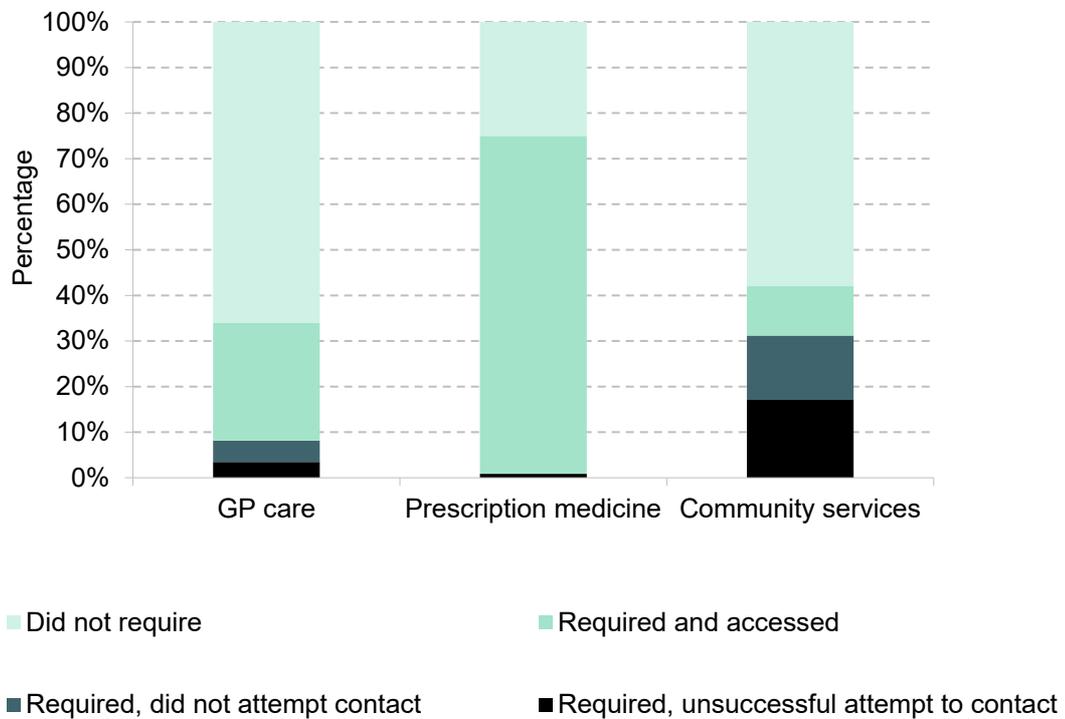
Almost three-quarters (74.1%) of the over-50 population reported that they required regular medication. Among those who required regular medication, almost everyone reported that they had been able to maintain access to this medication, with less than 1% of the population reporting that they had not had access.

In contrast, a large proportion of people who reported requiring community health and social care services did not use this care as usual. 42.0% of participants reported requiring such services since the start of the outbreak. 10.8% of all people reported receiving this care. This means that only around a quarter (25.7%) of those

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reporting that they required these services actually received such care. This suggests that access to community services was particularly disrupted as a result of the crisis. 14.1% of all people reported not seeking care at this time, while 17.1% reported seeking care but not receiving it. This means that of those who reported needing these services but did not receive them, 54.8% reported not seeking them at all while the remaining 45.2% did unsuccessfully seek them.

Figure 3.1. Access to GP services, prescription medication, and community health and social care services among the over-50 population in April 2020



Note: Sample = 6,615. Figures are weighted to ensure national representativeness. We omit any responses for individual questions that are noted as 'prefer not to say' or 'doesn't know'. 'Required, unsuccessful attempt to contact' records individuals who sought care but did not receive it. 'Required, did not attempt contact' records individuals who report that they required the respective care service but did not attempt to contact this service.

Source: Authors' calculations using ELSA data.

Variation in access to GP services

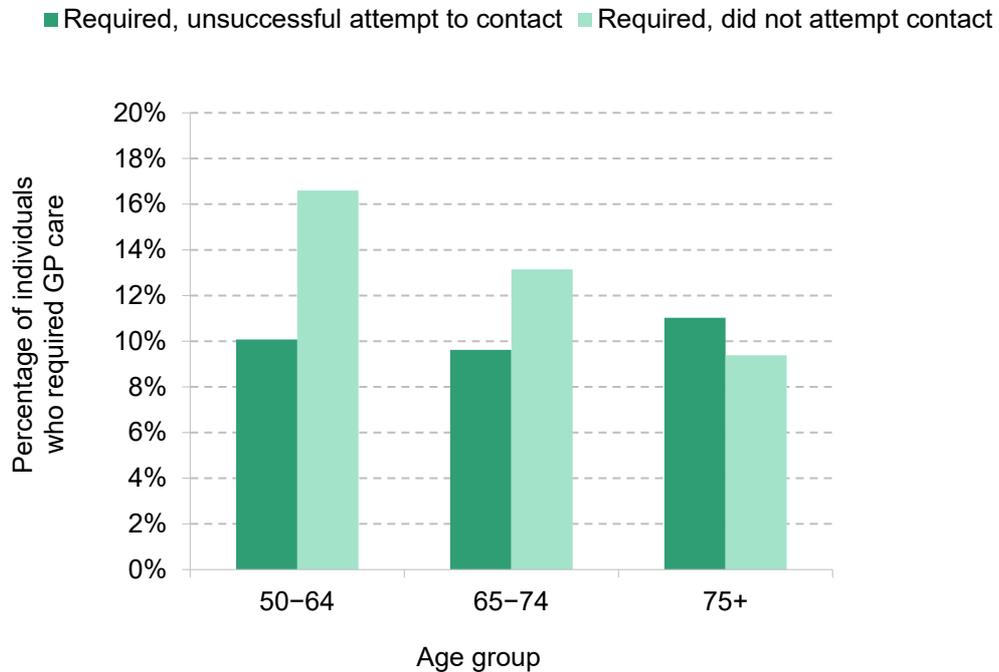
For GP and community services, the survey collects information both on the need for, and receipt of, these care types. We can therefore examine how access to these services varied across population types among patients who reported that they required this care. While this will not perfectly allow for differences in the need for care across these groups (for example, it does not distinguish more or less urgent, or more or less severe, health care needs), it should provide a clearer picture of which groups have had the most difficulty in accessing health and social care than simply looking at differences in the use of these services across the whole population (as was only possible for hospital care).

Among all of those who reported that they wished to speak to or see a GP since the COVID-19 outbreak began, almost a quarter (23.9%) reported that they had not seen a GP during this period. Of this group, 42.7% sought access to a GP but were not successful ('no access', 10.2% of all those who wished to speak to or see a GP), while 57.3% said that they did not attempt to contact a GP ('did not contact', 13.7% of all those who wished to speak to or see a GP). However, these figures do vary across different groups of the population.

Figure 3.2 shows that among those who required GP care and who did attempt to contact their GP, older individuals were slightly less likely to be successful than younger individuals. 11.0% of those aged 75 and older who required GP care failed to see a GP after attempting to do so, compared with 9.6% among those aged 65–74. In contrast, among those who required GP care, it was younger individuals who were more likely not to attempt to contact their GP at all: this group accounts for 16.6% of those in the youngest age group compared with just 9.4% in the oldest age group.

There was little difference in the percentage of patients who were able to access care across sex, household composition or local area deprivation. However, Figure 3.3 shows a clear gradient in GP access across self-reported health status, with those previously reporting a worse health status more than twice as likely not to see or talk to a GP when they sought one than those previously reporting an excellent general health status: 12.8% of those who reported 'poor' or 'fair' health failed to see a GP when attempting to do so, compared with just 5.8% among those with 'excellent' health. There was little meaningful difference in the share of people who did not attempt to contact a GP across these groups.

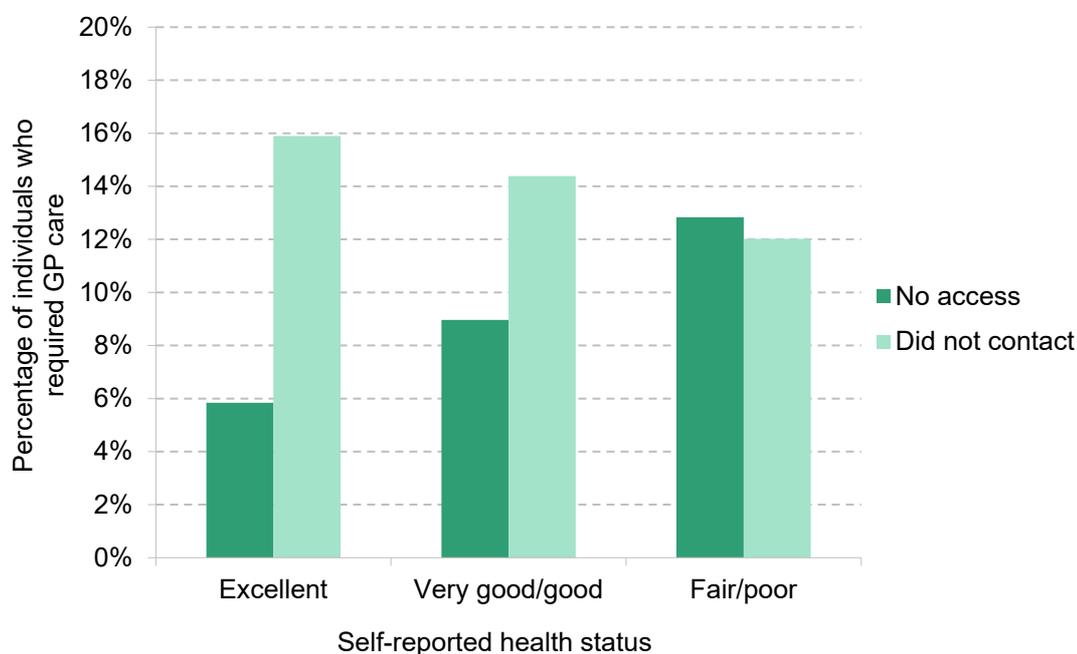
Figure 3.2. Access to GP care among individuals who required GP care since the start of the COVID-19 pandemic, by age group



Note: Sample = 6,615. Figures are weighted to ensure national representativeness. We omit any responses for individual questions that are noted as 'prefer not to say' or 'doesn't know'. 'Required, unsuccessful attempt to contact' records individuals who sought care but did not receive it. 'Required, did not attempt contact' records individuals who report that they required the respective care service but did not attempt to contact this service.

Source: Authors' calculations using ELSA data.

Figure 3.3. Access to GP care among individuals who required GP care since the start of the COVID-19 pandemic, by self-reported health status



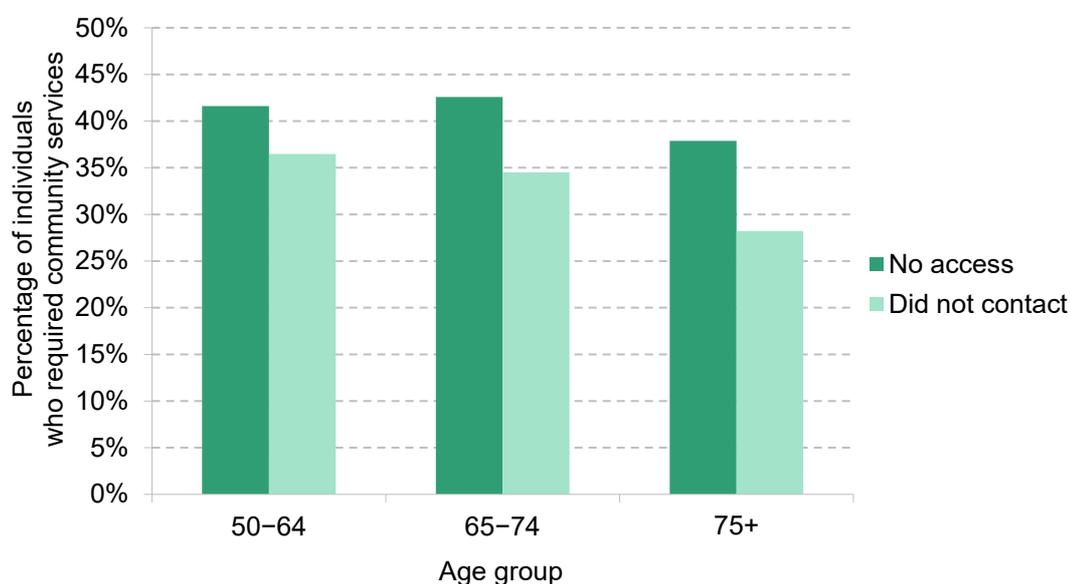
Note: Sample = 6,615. Figures are weighted to ensure national representativeness. We omit any responses for individual questions that are noted as 'prefer not to say' or 'doesn't know'. 'No access' records individuals who sought care but did not receive it. 'Did not contact' records individuals who report that they required the respective care service but did not attempt to contact this service. Self-reported health status is taken from wave 9 interview responses.

Source: Authors' calculations using ELSA data.

Variation in access to community health and social care services

Among all of those who reported that they needed to use community health and social care services since the COVID-19 outbreak began, almost three-quarters (74.3%) of people reported that they had not accessed these services. Of this group, 55% tried to access these services but were unsuccessful, while 45% did not attempt to contact these services.

Figure 3.4. Access to community health and social care services among individuals who required such services since the start of the COVID-19 pandemic, by age group



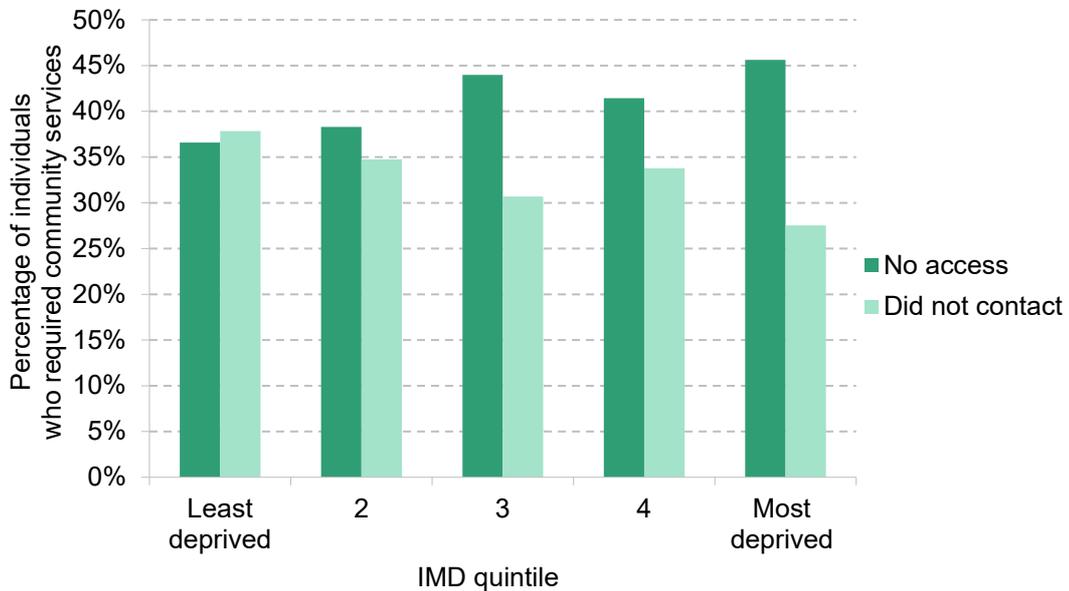
Note: Sample = 6,615. Figures are weighted to ensure national representativeness. We omit any responses for individual questions that are noted as 'prefer not to say' or 'doesn't know'. 'No access' records individuals who sought care but did not receive it. 'Did not contact' records individuals who report that they required the respective care service but did not attempt to contact this service.

Source: Authors' calculations using ELSA data.

Figure 3.4 shows the percentage of people in different age groups who were not able to access community services, or did not attempt to contact these services, after reporting that in the survey that they required such care. Those in the youngest age group were slightly more likely to fail to access care after seeking it than the oldest, but the differences are not very large. However, younger individuals were much more likely not to seek care in the first place: 36.5% of those aged 50–64 who required community care reported not contacting these services compared with only 28.2% among those aged 75 and older.

Figure 3.5 shows variation in access across different levels of local area deprivation. 36.6% of those living in the least deprived areas did not access these services even after attempting to do so. This increases to 45.6% among those living in the most deprived areas. This suggests that those living in the most deprived areas were most affected by disruptions to community services.

Figure 3.5. Access to community health and social care services among individuals who required such services since the start of the COVID-19 pandemic, by local area deprivation



Note: Sample = 6,615. Figures are weighted to ensure national representativeness. We omit any responses for individual questions that are noted as 'prefer not to say' or 'doesn't know'. 'No access' records individuals who sought care but did not receive it. 'Did not contact' records individuals who report that they required the respective care service but did not attempt to contact this service. IMD quintiles are calculated using the lower super output area (LSOA) of residents at the time of their wave 9 interview, and we use the 2015 IMD estimates for these areas.

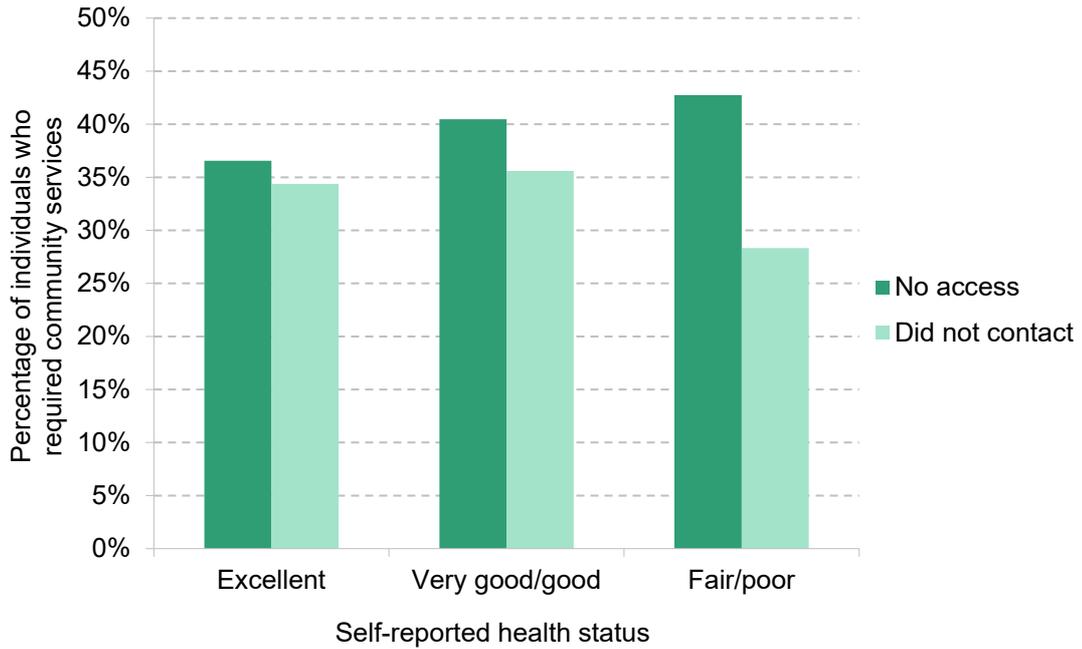
Source: Authors' calculations using ELSA and Office for National Statistics 2015 IMD data.

The opposite pattern is shown for those who did not attempt to contact these services despite reporting that they needed such care: 37.9% in the least deprived fifth of areas compared with just 27.5% among those living in the most deprived fifth of areas. This suggests that those living in the most deprived areas are more reliant on these community services – and potentially less able to substitute to alternative sources of care or less able to forgo care temporarily.

A similar pattern is observed across health status, as shown by Figure 3.6. 42.7% of those reporting 'fair/poor' health could not access the service despite trying, compared with 36.6% among those reporting 'excellent' health. 28.3% of those in the worst self-rated health reported not contacting community services, rising to 34.4% of those with the best health. This suggests that those with the worst health

status were most affected by reduced access to these services and the least able to seek alternative (or no) help instead.

Figure 3.6. Access to community health and social care services among individuals who required such services since the start of the COVID-19 pandemic, by self-reported health status



Note: Sample = 6,615. Figures are weighted to ensure national representativeness. We omit any responses for individual questions that are noted as ‘prefer not to say’ or ‘doesn’t know’. ‘No access’ records individuals who sought care but did not receive it. ‘Did not contact’ records individuals who report that they required the respective care service but did not attempt to contact this service. Self-reported health status is taken from wave 9 interview responses.

Source: Authors’ calculations using ELSA data.

4. Conclusions

Prioritisation of COVID-19 patients has led to widespread disruptions of health care for the over-50 population in England. Our analysis shows that almost one in six individuals in this group – implying a total of 3.6 million older individuals in England – have had some hospital treatment cancelled in the early stages of the pandemic.

Older individuals, those in worse health and those who live in more deprived areas are more likely to require hospital care and have consequently been more affected by cancellations. Policies to catch up on missed care should prioritise these vulnerable patients to avoid disruptions during the pandemic exacerbating long-standing health inequalities.

Disruptions to health care during the pandemic have not been limited to hospital services. In addition to cancelled hospital treatment, more than one in ten individuals have been unable to access GP care during the survey period in spring 2020. Worryingly, among those who needed to see or speak to their GP and tried to do so, individuals previously reporting worse overall health were twice as likely to be unsuccessful in their efforts to see a GP than those previously reporting excellent general health. Access to community health and social care services has been even more severely affected, with three-quarters of individuals who required such services either unable to access them or deciding not to contact them in the first place. The impact of this disruption has disproportionately fallen on those living in the most deprived areas, and those in worst health. These groups are likely either to struggle most to access alternative forms of care, or to forgo care entirely.

In addition to experiencing cancellations and postponements by the NHS and community providers, large shares of individuals opted not to contact the services they needed in the first place during this period. This may stem from a concern about overburdening services already under pressure, or about the risk of infection with COVID-19 in health care settings. These changes in care-seeking behaviour, combined with widespread cancellations, are likely to store up health problems for the future if individuals do not receive appropriate and timely care.

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