**AMLC Assessment of Unmet Need: update March 2015**

1. The NRAC formula relines on health service activity data as the basic proxy for the need for health services. It is therefore important to check for the existence and extent of any unmet need and, where appropriate, to adjust the formula to reflect such unmet need.
2. The sub-group most recently discussed unmet need at its meeting on 2nd October 2014 (paper TAMLC 15 ‘Assessing Unmet Need’, and associated presentation).
3. Since that meeting we have had a discussion with Matt Sutton (who had been unable to attend the October meeting). That discussion confirmed that the most useful approach is to re-run the analysis reported in McConnachie and Sutton (2004)[[1]](#footnote-1) with up-to-date Scottish Health Survey (SHeS) data. We also noted that there is an on-going research project on unmet need in England, which may be useful if the analysis becomes available within the time frame of the AMLC.
4. We have also obtained SHeS data and undertaken some preliminary analysis. The survey covers the period 2008 to 2011 and contains around 37,000 respondents. The data are coded by ICD(10) which allows a reasonable fit with four acute diagnostic groups: cancer, heart, respiratory and digestive. Positive responses to the survey question are highest for heart, for which around 10% of responses are positive. Around 95% of data zones have respondents and around 40% of data zones had a positive response coded to the heart diagnostic group.
5. Initial examination of the data has included a comparison of the gradient of the positive survey responses, by diagnostic group, with the related MLC weights. This shows a, broadly, similar gradient across deciles of MLC weights except in the case of the respiratory diagnostic group, the group for which there is currently an adjustment for unmet need in the formula.
6. The next phase of the work will be to undertake the detailed statistical analysis. Broadly, this involves a two-step process. The first step is to regress the SHeS morbidity prevalence data (by diagnostic group) on indicators of need (i.e. estimate the relationship between prevalence and ION) and thereby calculate predicted prevalence for all data zones. In the second step the utilisation data are regressed on the predicted prevalence along with upper and lower splines for deprivation. The spline parameters can then be used to test for under or over utilisation at both ends of the deprivation spectrum.
7. We are aiming to have the results of this analysis for the meeting of the sub-group in August 2015.
1. McConnachie and Sutton (2004) ‘Derivation of an Adjustment to the Arbuthnott Formula for Socio-economic Inequities in Health Care’. [↑](#footnote-ref-1)