

Unmet health care needs during the COVID-19 pandemic among adults: a prospective cohort study in the Canadian Longitudinal Study on Aging

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Abstract

Background: The COVID-19 pandemic affected access to health care services in Canada; however, limited research examines the influence of the social determinants of health on unmet health care needs during the first year of the pandemic. The objectives of this study were to describe unmet health care needs during the first year of the pandemic and to investigate the association of unmet needs with the social determinants of health.

Methods: We conducted a prospective cohort study of 23 972 adults participating in the Canadian Longitudinal Study on Aging (CLSA) COVID-19 Study (April–December 2020) to identify the social determinants of health associated with unmet health care needs during the pandemic. Using logistic regression, we assessed the association between several social determinants of health on the following 3 outcomes (separately): experiencing any challenges in accessing health care services, not going to a hospital or seeing a doctor when needed, and experiencing barriers to accessing testing for SARS-CoV-2 infection.

Results: From September to December 2020, 25% of participants experienced challenges accessing health care services, 8% did not go to a hospital or see a doctor when needed and 4% faced barriers accessing testing for SARS-CoV-2 infection. The prevalence of all 3 unmet need outcomes was lower among older age groups. Differences were observed by sex, region, education, income and racial background. Immigrants (odds ratio [OR] 1.18, 95% confidence interval [CI] 1.09–1.27) or people with chronic conditions (OR 1.35, 95% CI 1.27–1.43) had higher odds of experiencing challenges accessing health care services and had higher odds of not going to a hospital or seeing a doctor (immigrants OR 1.26, 95% CI 1.11–1.43; chronic conditions OR 1.45, 95% CI 1.31–1.61). Prepandemic unmet health care needs were strongly associated with all 3 outcomes.

Interpretation: Substantial unmet health care needs were reported by Canadian adults during the first year of the pandemic. The results of this study have important implications for health equity.

The first Canadian case of COVID-19 was detected in January 2020. By March 2020, all provinces and territories adopted public health restrictions, such as school and business closures and limits on gatherings, to mitigate its spread.¹ Public health measures have continued to varying degrees across Canada.¹ The spread of SARS-CoV-2 and the adoption of public health restrictions in Canada affected access to health care services. To adapt to the strain of patients with COVID-19, health care systems cancelled elective surgeries and in-person appointments, and reliance on virtual visits increased.^{2,3} Nationally, emergency department visits and inpatient admission levels declined by 24% and 10%, respectively, in 2020.^{4,5} Home care and primary care services were disrupted.^{6,7}

Self-perceived unmet needs are a reflection of access to, and performance of, a health care system.⁸ Unmet needs are

dependent not only on the use of services but also their accessibility and acceptability. Unmet health care needs during the COVID-19 pandemic may have serious implications on patient care and potentially enduring consequences.⁹ Patients have reported limitations of virtual visits.^{10–13} Independent of the COVID-19 pandemic, it is well known that the social

Competing interests: Lauren Griffith reports her salary was supported by the McLaughlin Foundation Professorship in Population and Public Health and that this support had no impact on what or where she publishes. No other competing interests were declared.

This article has been peer reviewed.

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CMAJ Open 2023 February 14. DOI:10.9778/cmajo.20210320

determinants of health affect unmet health care needs.^{14,15} However, the effect of the social determinants of health on unmet health care needs during the pandemic are not yet understood in Canada. Disruptions to services may have deepened access concerns for vulnerable groups, potentially having implications for health equity. We describe the experience of unmet health care needs, including access to SARS-CoV-2 testing, and evaluate the association between the social determinants of health and other predictors (prepandemic unmet health care needs and chronic conditions) with unmet health care needs among adults in Canada during the first year of the COVID-19 pandemic.

Methods

We conducted a prospective cohort study using participants in the Canadian Longitudinal Study on Aging (CLSA). The CLSA is a national long-term study of community-dwelling adults aged 45 to 85 years at the time of recruitment (2010–2015).^{16,17} Participants were recruited across the 10 provinces and are followed-up every 3 years for at least 20 years or until death or loss to follow-up. Residents of the 3 territories or First Nations reserves, members of the Canadian Armed Forces and people who were living in institutions were excluded. Participants were required to participate in English or French and complete the survey independently. At baseline, 51 338 people participated in the CLSA (2011–2015) and 44 817 went on to complete first follow-up (2015–2018).

In response to the COVID-19 pandemic, the CLSA COVID-19 Questionnaire Study was developed by the CLSA COVID-19 team and launched to collect longitudinal data over a 9-month period with participants completing a 30-minute baseline survey (Apr. 15–May 30, 2020); 10-minute weekly, biweekly and monthly surveys; and a 30-minute exit survey (Sept. 29–Dec. 29, 2020). Detailed information about the surveys and their administration is available on the CLSA website (<https://www.clsa-elcv.ca/researchers/data-collection>). All eligible members of the CLSA cohort (i.e., alive, with known contact information and able to independently complete the survey) were invited to participate ($n = 42\ 511$) by way of email ($n = 34\ 428$) or telephone ($n = 8083$), if email information was not available. From the invited members, 28 559 completed the baseline survey (response = 67%), with 23 832 completing it online and 4727 by telephone.

Measurement of unmet health care needs

Unmet health care needs were measured using 3 questions in the COVID-19 exit survey: “Since the beginning of the COVID-19 pandemic have you experienced any challenges in accessing health care?”, “Since March 1, 2020 were there times when you did not go to the hospital or to see a doctor even though you needed to?” and “Since the beginning of the COVID-19 pandemic have you experienced barriers to accessing testing for COVID-19?” The response options for each question were yes, no, don’t know, or no answer and prefer not to answer. Less than 2% of participants responded with don’t know or no answer for the first 2 outcomes and these responses were grouped together with the no responses.

Nearly 12% of the respondents answered with don’t know or no answer to the third question; thus, a sensitivity analysis was conducted to determine if the categorization of the outcomes as no compared with those missing affected the results, and no differences were observed. Therefore, the don’t know or no answer responses were also combined with no for the third outcome. These questions were not formally validated but are similar to questions asked in the Canadian Community Health Survey (CCHS), European Union Statistics on Income and Living Conditions and the Survey of Health, Aging and Retirement in Europe.^{18–20} The questions did not differentiate between virtual and in-person care.

Participants who answered yes to the 3 unmet health care questions were asked follow-up questions clarifying the health care services they had challenges accessing, the reasons they did not visit the hospital or see a doctor and the barriers they faced when accessing testing for SARS-CoV-2 infection. The frequency of the follow-up questions will be reported, stratified by age and province.

Measurement of the social determinants of health and other predictors

Information on the social determinants of health were extracted from the CLSA surveys, across different time points. Sex, racial background, education and immigrant status were extracted from the CLSA baseline (2011–2015). Household income, dwelling type and marital status were extracted from first follow-up (2015–2018). Age, region (Atlantic: Newfoundland and Labrador, Nova Scotia, Prince Edward Island, New Brunswick; Quebec; Ontario; Prairies: Alberta, Saskatchewan, Manitoba; British Columbia), urban or rural status and work status were extracted from the COVID-19 baseline survey. Urban or rural status was measured by linking the participants’ postal codes to the Statistics Canada postal code conversion file.²¹ Work status was determined by asking participants if they usually worked outside of their residence, regardless of whether they were an essential worker. Dwelling type was measured by asking if they lived in a house, apartment or condominium, or other residence type (seniors’ housing, institution or mobile home). In addition to the social determinants of health, prepandemic unmet needs were extracted from the first follow-up when participants were asked, “During the past 12 months, was there ever a time when you felt that you needed health care but you didn’t receive it?” The presence of chronic conditions was measured in the COVID-19 baseline survey by inquiring about the lifetime occurrence of asthma; chronic obstructive pulmonary disease; other chronic lung diseases; diabetes; high blood pressure; heart disease; cancer; heart, lung, kidney, liver, or pancreas failure; autoimmune disorder; pneumonia and human immunodeficiency virus.

Statistical analysis

We described and compared the characteristics of the study’s participants who completed the first follow-up or who did not complete the COVID-19 exit survey. We considered how results of our study might differ if all participants from the first

follow-up had completed the COVID-19 exit survey. Participants had a unique study identifier, which allowed for linkage of their data across time. Although sampling weights are available for the larger CLSA cohort, they were not available for the subsample of participants who completed COVID-19 surveys, and therefore were not applied for this analysis. Proportions of participants who reported the unmet health care needs outcomes along with 95% confidence intervals (CIs) were computed overall and by the social determinants of health.

The magnitude of the association between the social determinants of health and the 3 unmet health care outcomes was estimated using logistic regression. Odds ratios (ORs) and CIs were estimated individually for unadjusted models with each predictor variable. Then, an adjusted model that included the following variables was estimated: sex, age, province, urban or rural, racial background, immigrant status, household income, education, marital status, dwelling type, work status, chronic condition status and pre-pandemic unmet needs. The adjusted

risk differences were estimated. Variance inflation factors for the adjusted models were estimated in a linear regression model to assess multicollinearity.²²

Ethics approval

This study has been approved by the Hamilton Integrated Research Ethics Board.

Results

Among the 28 559 people who completed the COVID-19 baseline survey, information on 23 975 people was available at CLSA baseline, first follow-up and the CLSA COVID-19 study (at both baseline and exit). Three people were excluded as they resided in the territories in 2020, resulting in a sample size of 23 972 (response = 56%; Figure 1). The sociodemographic characteristics of the participants are presented in Table 1. Appendix 1 (available at www.cmajopen.ca/content/11/1/E140/)

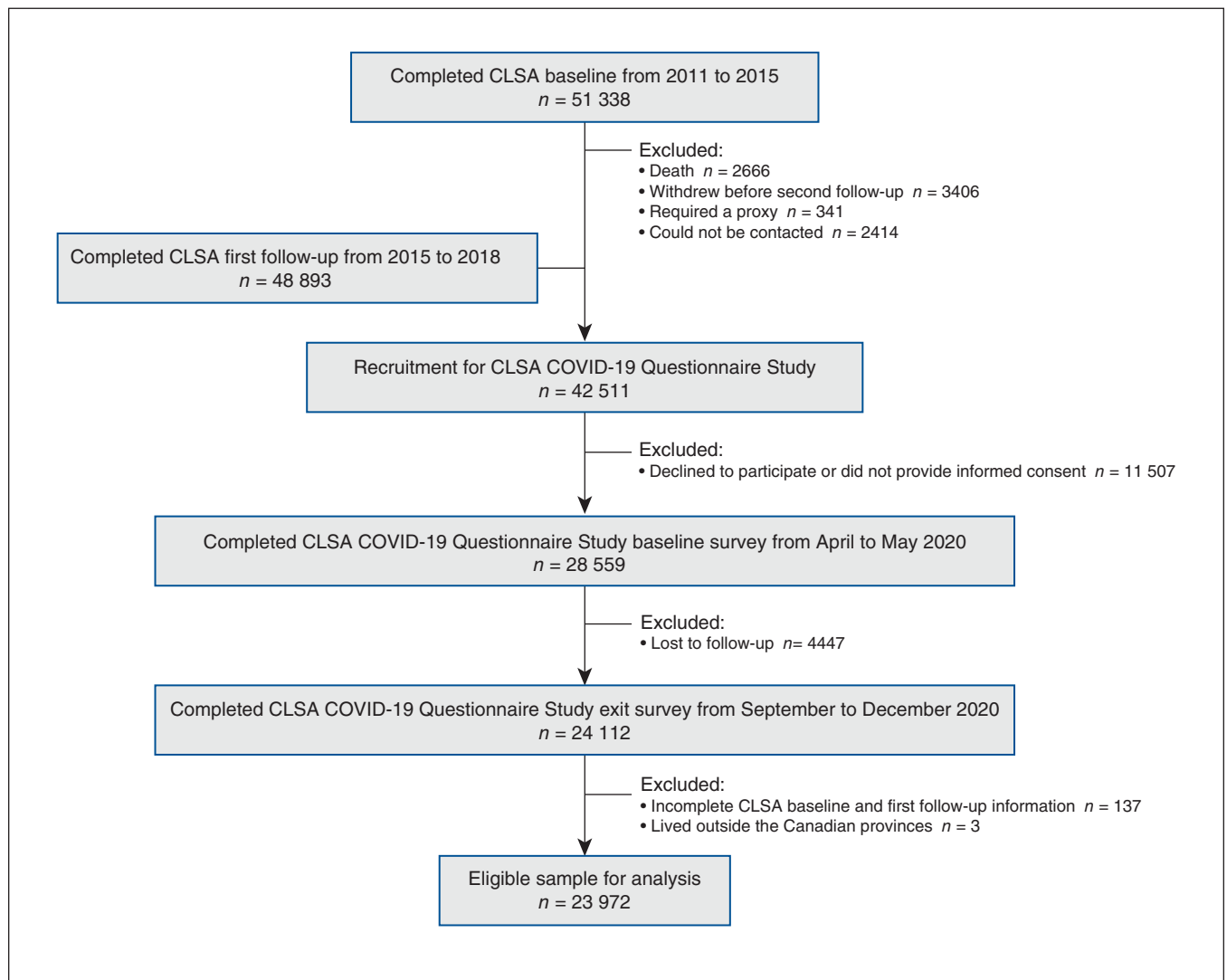


Figure 1: Canadian Longitudinal Study on Aging participant flow throughout baseline (2011–2015), first follow-up (2015–2018) and COVID-19 (2020) data collection. Note: CLSA = Canadian Longitudinal Study on Aging.

Table 1 (part 1 of 2): Descriptive characteristics of CLSA participants who completed the COVID-19 exit survey (September–December 2020)

Characteristic	No. (%) of participants <i>n</i> = 23 972
Measured at baseline (2011–2015)	
Sex	
Female	12 743 (53.2)
Male	11 229 (46.8)
Racial background	
White	23 273 (97.2)
Not white	673 (2.8)
Missing	26
Immigrant status	
Immigrant	3789 (15.8)
Nonimmigrant	20 173 (84.2)
Missing	10
Education	
< Secondary school	1101 (4.6)
Secondary school	2349 (9.8)
Some postsecondary	1719 (7.2)
Postsecondary degree or diploma	18 756 (78.4)
Missing	47
Measured at first follow-up (2015–2018)	
Household income, \$	
< 20 000	861 (3.8)
20 000–49 999	4855 (21.4)
50 000–99 999	8569 (37.9)
100 000–149 999	4589 (20.3)
≥ 150 000	3758 (16.6)
Missing	1340
Marital status	
Single, never married or never lived with a partner	2007 (8.4)
Married or living with a partner	16 833 (70.3)
Widowed	2332 (9.7)
Divorced or separated	2785 (11.6)
Missing	15
Unmet needs (prepandemic)	
Yes	1874 (7.8)
No	22 060 (92.2)
Missing	38
Measured at COVID-19 baseline (April–May 2020)	
Age, yr	
< 50	0 (0.0)
50–54	1097 (4.6)
55–64	7250 (30.2)
65–74	8759 (36.5)
75–84	5145 (21.5)
85–96	1721 (7.2)

Table 1 (part 2 of 2): Descriptive characteristics of CLSA participants who completed the COVID-19 exit survey (September–December 2020)

Characteristic	No. (%) of participants <i>n</i> = 23 972
Region*	
Atlantic	4334 (18.0)
Prairies	5130 (21.4)
Ontario	5554 (23.2)
Quebec	4336 (18.1)
British Columbia	4618 (19.3)
Urban or rural	
Rural area	4245 (17.8)
Urban area	19 602 (82.2)
Missing	125
Dwelling type	
House	18 625 (77.8)
Apartment or condominium	4410 (18.4)
Other	907 (3.8)
Missing	30
Chronic conditions	
Present	14 235 (59.7)
Absent	9594 (40.3)
Missing	143
Work status	
Usually work outside the home	6273 (26.6)
Do not work outside the home	17 357 (73.4)
Missing	342
Measured at COVID-19 exit survey (September–December 2020)	
Any challenges in accessing health care	
Yes	5992 (25.3)
No	17 759 (74.7)
Missing	221
Did not go to the hospital or to see a doctor even though they needed to	
Yes	1776 (7.5)
No	21 989 (92.5)
Missing	207
Experienced barriers to accessing testing for COVID-19	
Yes	917 (3.9)
No	22 828 (96.1)
Missing	227

Note: CLSA = Canadian Longitudinal Study on Aging.
*Atlantic: Newfoundland and Labrador, Nova Scotia, Prince Edward Island, New Brunswick; Prairies: Alberta, Saskatchewan, Manitoba.

suppl/DC1) describes how the characteristics of people at the first follow-up who did or did not complete the COVID-19 exit survey are fairly similar, as has been previously shown.²³ Notably, prepandemic unmet needs are slightly higher in the group who did not complete the COVID-19 exit survey.

Overall, 25% of the participants indicated facing challenges accessing health care and 8% of the participants indicated they did not go to a hospital or see a doctor, even though they needed to. In addition, 4% of participants indicated facing barriers accessing testing for SARS-CoV-2 infection. The percentage of participants who reported the 3 outcomes, stratified by key characteristics, are shown in Figure 2, Figure 3 and Figure 4.

Table 2 reports the logistic regression results examining the associations between each of the social determinants of health, other predictors and the unmet needs outcomes. Notably, older age was associated with lower odds of reporting all 3 outcomes. Immigrants had higher odds of reporting challenges accessing health care (OR 1.18, 95% CI 1.09–1.27), as well as not visiting a hospital or seeing a doctor when needed (OR 1.26, 95% CI 1.11–1.43). Higher education levels were associated with higher odds of indicating challenges accessing health care and barriers to COVID-19 testing. Whereas lower income was associated with increased odds of not visiting the hospital or seeing a doctor when needed, higher income was associated with increased odds of challenges accessing health care and barriers to testing for

SARS-CoV-2 infection. Females (OR 1.20, 95% CI 1.09–1.32) and participants who were not white (OR 1.37, 95% CI 1.06–1.78) had higher odds of reporting not visiting the hospital or seeing a doctor when needed, relative to males and white participants, respectively. Ontario residents had the highest odds of reporting challenges accessing health care and barriers to SARS-CoV-2 testing. Quebec residents were most likely to not visit a hospital or doctor and were the least likely to indicate the other 2 outcomes. Prepandemic unmet needs were strongly associated with higher odds of all 3 outcomes. Chronic conditions were associated with the first 2 outcomes, but not the SARS-CoV-2 testing outcome. The results of fully adjusted models, adjusted for all variables simultaneously, revealed similar associations, with few exceptions (e.g., the association between racial background and barriers to testing changes direction but is not significant in the adjusted or unadjusted models) (Appendix 2, available at www.cmajopen.ca/content/11/1/E140/suppl/DC1). The adjusted risk differences are reported in Appendix 3 (available at www.cmajopen.ca/content/11/1/E140/suppl/DC1).

Participants were most likely to report difficulties accessing primary care and specialist care (Appendix 4, available at

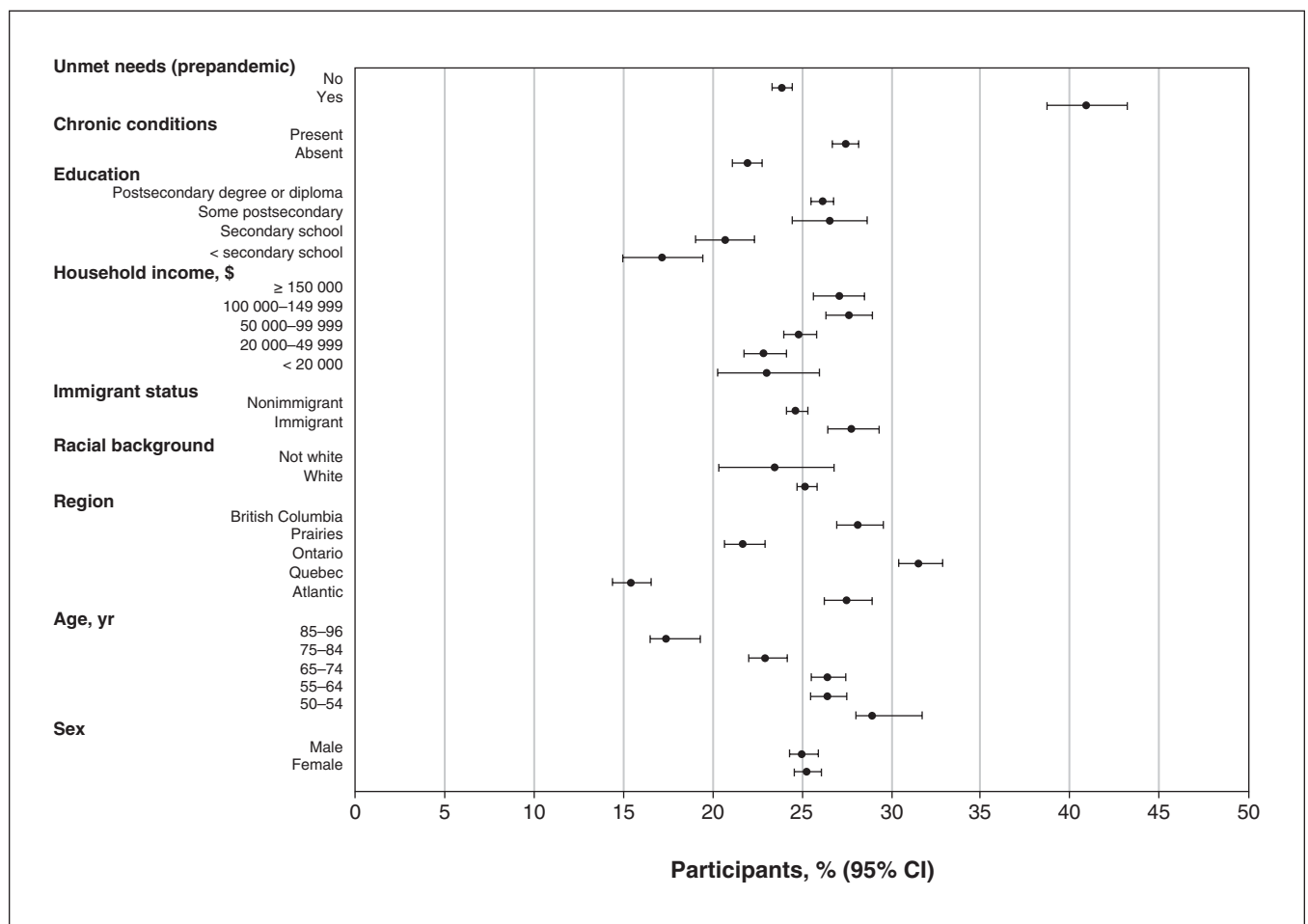


Figure 2: Prevalence of any challenges in accessing health care during the COVID-19 pandemic as reported by participants during the Canadian Longitudinal Study on Aging COVID-19 exit survey (September–December 2020), according to select sociodemographic characteristics. Note: CI = confidence interval.

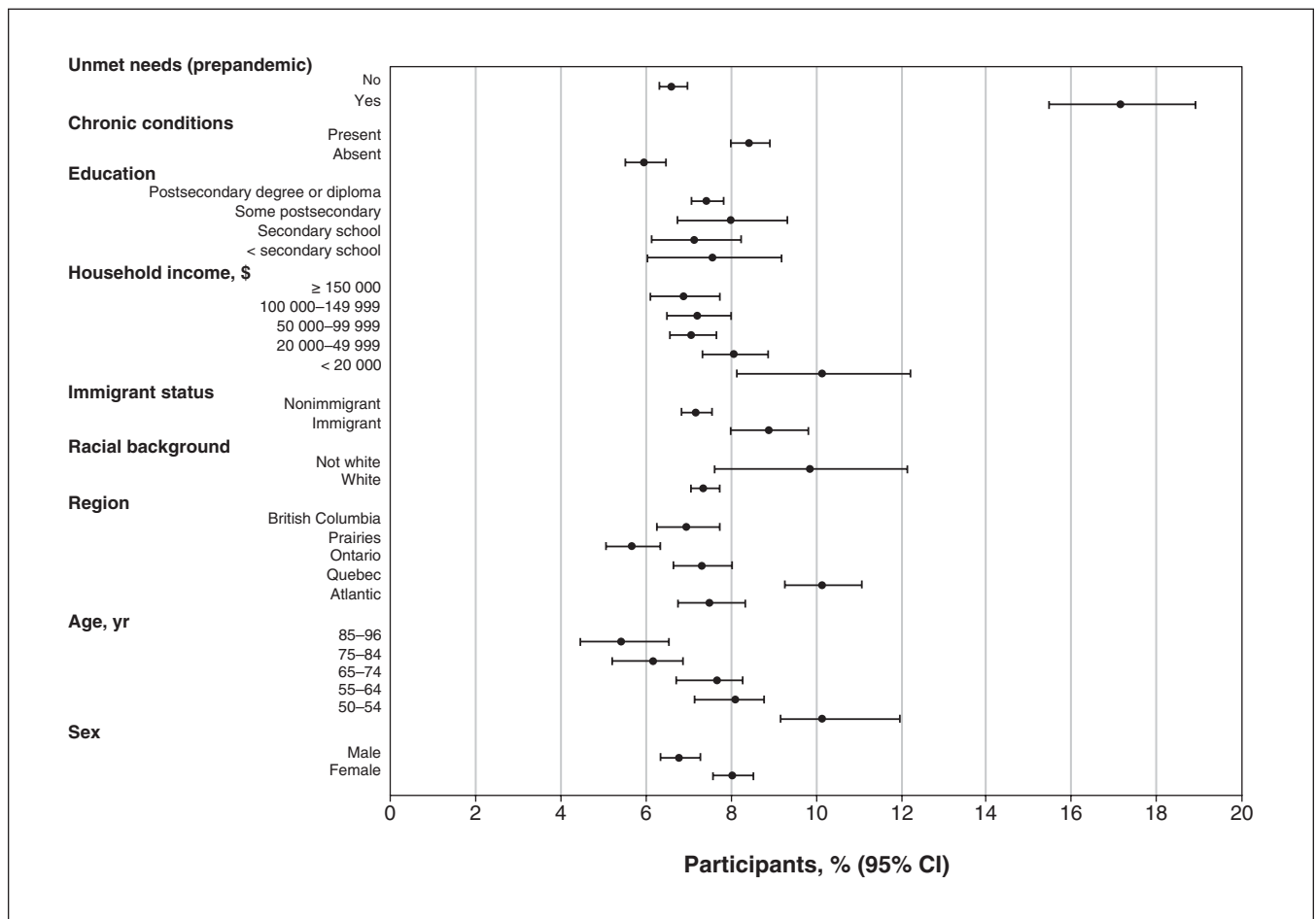


Figure 3: Prevalence of not visiting the hospital or seeing a doctor while needing to during the COVID-19 pandemic as reported by participants during the Canadian Longitudinal Study on Aging COVID-19 exit survey (September–December 2020), according to select sociodemographic characteristics. Note: CI = confidence interval.

www.cmajopen.ca/content/11/1/E140/suppl/DC1). The most common reasons for not visiting the hospital or doctor were redirection of services to priority groups and fear of SARS-CoV-2 contact (Appendix 5, available at www.cmajopen.ca/content/11/1/E140/suppl/DC1). The most commonly reported barrier to SARS-CoV-2 testing was not being eligible (Appendix 6, available at www.cmajopen.ca/content/11/1/E140/suppl/DC1). Redirection of services was of greater concern to adults aged 50 to 54 years than to those aged 85 to 96 years (Figure 5). The most common barrier to testing for SARS-CoV-2 infection was not being eligible, which was most commonly reported by adults aged 50 to 54 years (Figure 6). The responses to the other follow-up questions, stratified by age and province, have been included in Appendices 7, 8, 9 and 10 (available at www.cmajopen.ca/content/11/1/E140/suppl/DC1).

Interpretation

One-quarter of adults surveyed (25%) faced challenges accessing health care services, and 8% did not go to the hospital or see a doctor even though they needed to during the first

9 months of the pandemic in Canada. About 4% of adults experienced barriers accessing testing for SARS-CoV-2 infection. Regional differences in the level of unmet health care needs were noted.

Reporting of all 3 outcomes decreased with older age. This is consistent with analysis of CCHS data on unmet health care needs of Canadians from 2001 to 2014, as well as pandemic data from Europe and Korea.^{19,24,25} Older adults may have experienced relatively smaller interruption to care. We found that services being redirected to priority groups was a primary concern for adults aged 50 to 54 years, but not adults aged 85 to 96 years. In Ontario, the lowest decline in primary care visits was observed in older adults, who were also more likely to use virtual visits.^{6,26} Furthermore, we found that not being eligible for SARS-CoV-2 testing was of greater concern to adults aged 50 to 54 years than to those aged 85 to 96 years, which may be consistent with provincial testing restrictions that may have prioritized older symptomatic adults.²⁷ Statistics Canada reported that younger adults (aged 25–44 yr) were more likely to indicate that they would seek testing than older adults (aged > 65 yr).²⁸ Thus, they may be more likely to report barriers attaining the service. In addition, older

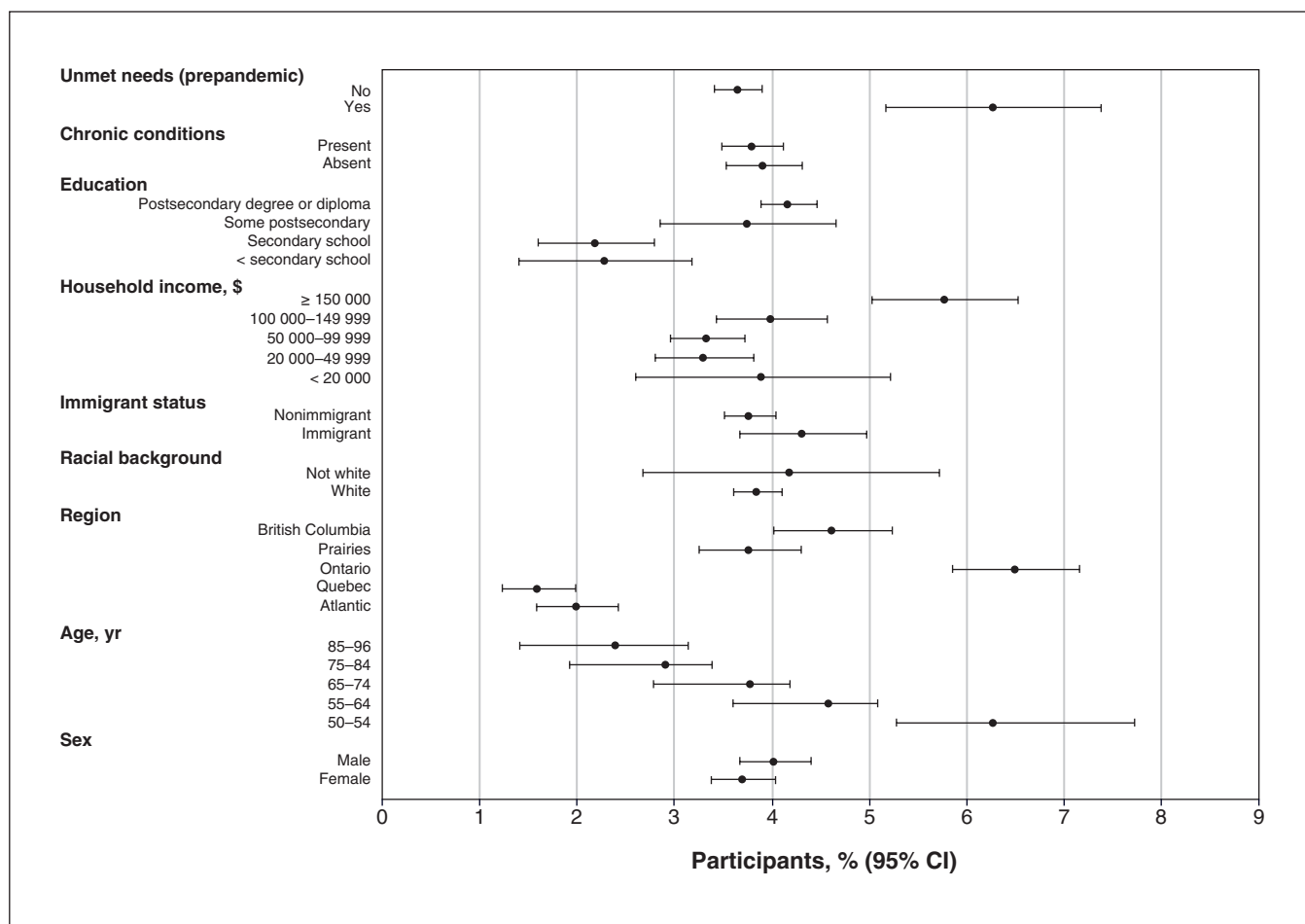


Figure 4: Prevalence of barriers to accessing testing for SARS-CoV-2 infection during the COVID-19 pandemic as reported by participants during the Canadian Longitudinal Study on Aging COVID-19 exit survey (September–December 2020), according to select sociodemographic characteristics. Note: CI = confidence interval.

participants may have experienced a smaller decline in mental health, relative to younger participants, possibly enabling them to continue to seek services.²⁹

Immigrants were significantly more likely to indicate challenges accessing health care services and not visiting a hospital or doctor. The literature has established that immigrants face unique difficulties accessing health care.^{15,30–32} Participants who were not white were more likely to report not visiting a hospital or seeing a doctor than white participants. Canadians who were not white are less likely to have a regular physician.³³ Consistent with other national data for this time period, we found minimal evidence of differences in SARS-CoV-2 testing access by racial background, but it is a major limitation that only 3% of the participants sampled were not white.³⁴ Females were 13% more likely to indicate not seeking hospital or doctor attention, as has been found in previous studies.²⁴

Participants with higher education levels had higher odds of indicating challenges accessing health care, consistent with prepandemic CCHS research, possibly owing to perceiving greater disruption as they typically had higher levels of health care utilization before the pandemic.^{24,35} People with higher

education levels also had higher odds of reporting barriers accessing SARS-CoV-2 testing, given they were more likely to report seeking testing according to Statistics Canada.²⁸ Although participants with higher levels of income were more likely to report challenges accessing health care and barriers to SARS-CoV-2 testing, they were less likely to report not visiting a hospital or seeing a doctor. People with higher levels of income tend to be less likely to forgo care, as has been noted even during the pandemic, meaning they may have greater expectations for accessibility of services.^{36–38}

Regional differences in unmet health care needs were not uniform across outcomes. Whereas Quebec residents had higher odds of not visiting a hospital or doctor, Ontario residents had higher odds of facing challenges accessing health care and barriers to SARS-CoV-2 testing. We explored whether these differences were due to the language of survey administration (French v. English). It was difficult to distinguish language and regional effects as most French surveys were completed in Quebec. Quebec residents are more likely to lack access to a family physician.³⁹ Residents of the Prairies did not report higher levels of unmet need, in spite of high case incidence.⁴⁰

Table 2 (part 1 of 2): Logistic regression models assessing the association between sociodemographic characteristics and unmet health care needs during the COVID-19 pandemic as reported by participants during the CLSA COVID-19 exit survey (September–December 2020)

Characteristic	OR (95% CI)		
	Any challenges in accessing health care	Did not go to the hospital or to see a doctor even though they needed to	Experienced barriers to accessing testing for SARS-CoV-2
Sex			
Male	Ref.	Ref.	Ref.
Female	1.01 (0.95–1.07)	1.20 (1.09–1.32)	0.92 (0.80–1.05)
Age, yr			
50–55	Ref.	Ref.	Ref.
55–64	0.88 (0.77–1.02)	0.78 (0.63–0.97)	0.72 (0.55–0.94)
65–74	0.88 (0.77–1.02)	0.74 (0.60–0.91)	0.59 (0.45–0.77)
75–84	0.73 (0.63–0.85)	0.59 (0.47–0.74)	0.45 (0.34–0.60)
85–96	0.52 (0.43–0.62)	0.51 (0.36–0.68)	0.37 (0.25–0.55)
Region			
Atlantic	Ref.	Ref.	Ref.
Quebec	0.48 (0.43–0.54)	1.38 (1.19–1.61)	0.80 (0.58–1.10)
Ontario	1.22 (1.11–1.33)	0.97 (0.83–1.13)	3.40 (2.68–4.32)
Prairies	0.73 (0.67–0.80)	0.74 (0.63–0.87)	1.92 (1.48–2.48)
British Columbia	1.03 (0.94–1.13)	0.92 (0.79–1.08)	2.37 (1.84–3.06)
Urban or rural			
Urban	Ref.	Ref.	Ref.
Rural	0.93 (0.86–1.00)	1.06 (0.93–1.20)	0.79 (0.65–0.95)
Racial background			
White	Ref.	Ref.	Ref.
Not white	0.91 (0.76–1.10)	1.37 (1.06–1.78)	1.09 (0.74–1.60)
Immigrant status			
Nonimmigrant	Ref.	Ref.	Ref.
Immigrant	1.18 (1.09–1.27)	1.26 (1.11–1.43)	1.15 (0.97–1.37)
Household income, \$			
< 20 000	0.81 (0.68–0.97)	1.52 (1.18–1.97)	0.66 (0.46–0.97)
20 000–49 999	0.80 (0.73–0.89)	1.19 (1.01–1.40)	0.56 (0.45–0.69)
50 000–99 999	0.89 (0.82–0.98)	1.03 (0.89–1.20)	0.56 (0.47–0.68)
100 000–149 999	1.03 (0.93–1.13)	1.05 (0.89–1.24)	0.68 (0.56–0.83)
≥ 150 000	Ref.	Ref.	Ref.
Education			
< Secondary school	0.58 (0.50–0.69)	1.02 (0.81–1.29)	0.54 (0.36–0.81)
Secondary school	0.74 (0.66–0.82)	0.96 (0.81–1.14)	0.52 (0.39–0.67)
Some postsecondary	1.02 (0.91–1.14)	1.09 (0.90–1.30)	0.90 (0.70–1.16)
≥ Postsecondary diploma	Ref.	Ref.	Ref.
Marital status			
Married or living with a partner	Ref.	Ref.	Ref.
Single, never married or never lived with a partner	1.02 (0.92–1.14)	1.16 (0.98–1.38)	1.15 (0.92–1.45)
Widowed	0.76 (0.70–0.84)	1.02 (0.87–1.21)	0.72 (0.56–0.94)
Divorced or separated	1.03 (0.94–1.13)	1.40 (1.21–1.61)	1.13 (0.92–1.38)

Table 2 (part 2 of 2): Logistic regression models assessing the association between sociodemographic characteristics and unmet health care needs during the COVID-19 pandemic as reported by participants during the CLSA COVID-19 exit survey (September–December 2020)

Characteristic	OR (95% CI)		
	Any challenges in accessing health care	Did not go to the hospital or to see a doctor even though they needed to	Experienced barriers to accessing testing for SARS-CoV-2
Chronic conditions			
Absent	Ref.	Ref.	Ref.
Present	1.35 (1.27–1.43)	1.45 (1.31–1.61)	0.97 (0.85–1.11)
Dwelling type			
House	Ref.	Ref.	Ref.
Apartment	0.90 (0.83–0.97)	1.09 (0.97–1.23)	1.01 (0.85–1.19)
Other	0.74 (0.63–0.88)	1.08 (0.84–1.38)	0.59 (0.38–0.92)
Work status			
Do not work outside the home	Ref.	Ref.	Ref.
Usually work outside the home	1.07 (1.01–1.15)	1.05 (0.94–1.17)	1.43 (1.24–1.65)
Unmet needs (prepandemic)			
Yes	2.21 (2.00–2.44)	2.91 (2.55–3.33)	1.77 (1.45–2.16)
No	Ref.	Ref.	Ref.

Note: CI = confidence interval, OR = odds ratio, Ref. = reference category.

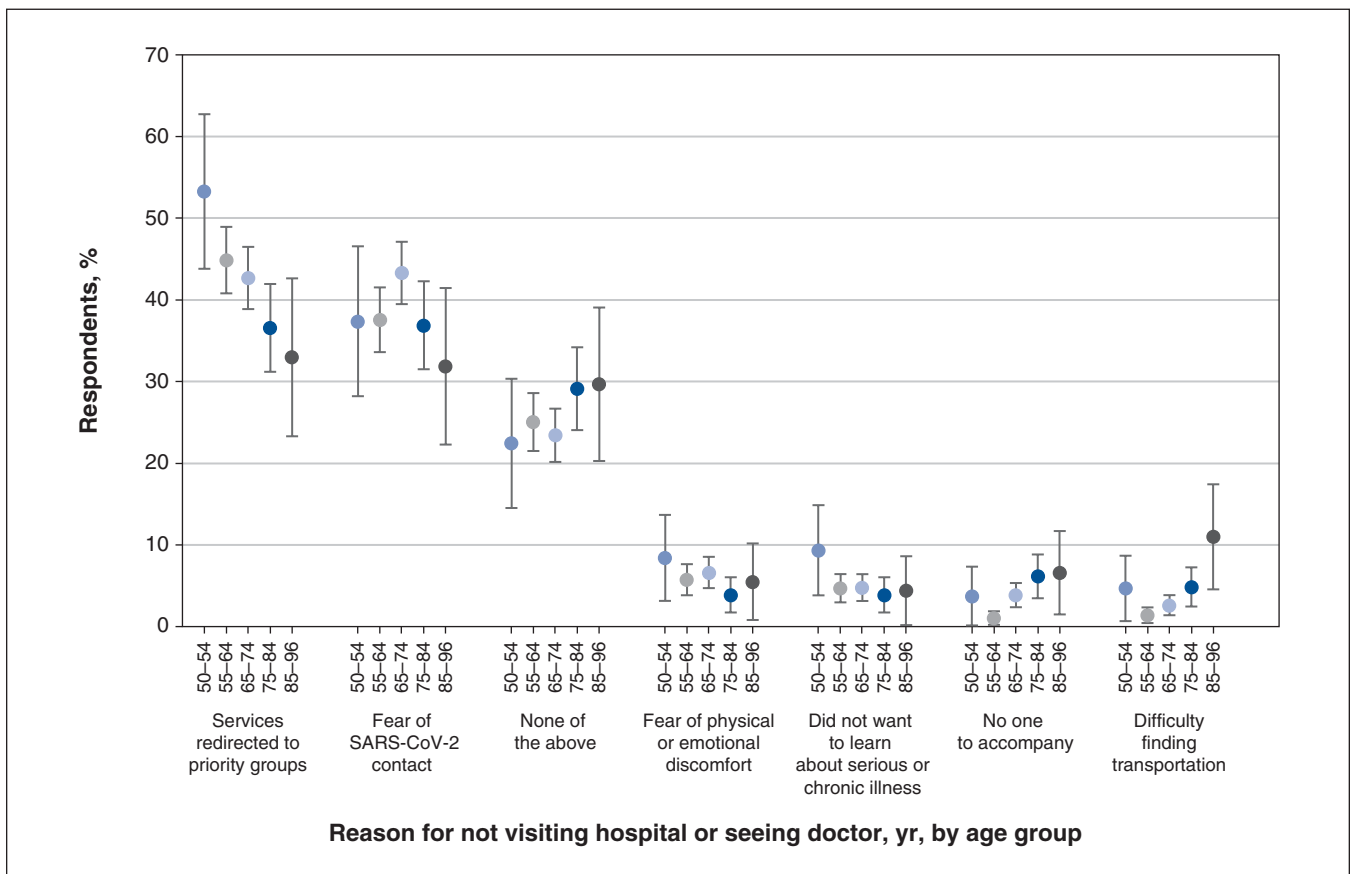


Figure 5: Reasons for not visiting the hospital or seeing a doctor while needing to as reported by participants in the Canadian Longitudinal Study on Aging COVID-19 exit survey (September–December 2020), stratified by age ($n = 1731$).

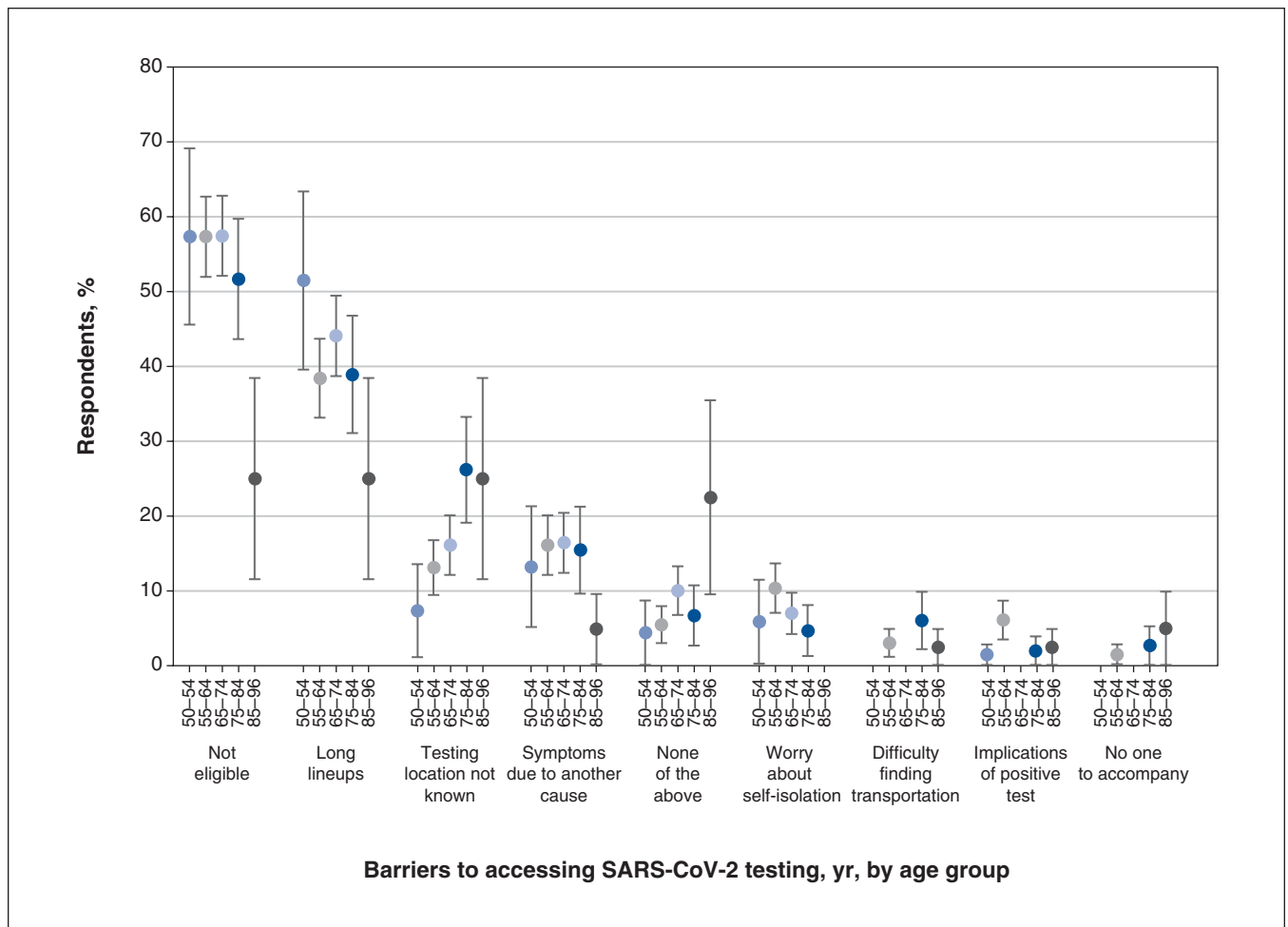


Figure 6: Barriers to accessing testing for SARS-CoV-2 infection as reported by participants in the Canadian Longitudinal Study on Aging COVID-19 exit survey (September–December 2020), stratified by age ($n = 914$).

Prepandemic unmet needs were strongly associated with all 3 outcomes. Participants with chronic conditions had higher odds of reporting challenges accessing services and not going to a hospital or doctor when needed. These findings suggest that those with health conditions faced difficulties accessing health care during the pandemic, raising concern about future consequences.

Limitations

Despite a low response rate, our study described the unmet health care needs of nearly 24 000 adults in Canada in the first year of the pandemic. Data from later in the pandemic were not available, but given the use of a cohort with ongoing data collection, future work may be possible. Although we examined several predictors, including prepandemic unmet health care needs, some of the data had been collected in the first follow-up and may not reflect the participants’ current situation. We could not quantify the change in unmet needs due to slightly different measures used in the first follow-up and the pandemic. Whereas formally validated measures of unmet health care needs were not used, we described how participants perceived the availability of

services. The fluctuations in case counts, public health restrictions and testing guidelines across time and regions made it difficult to describe the reasons behind unmet needs. Lastly, recruitment for the CLSA at baseline included only community-living adults aged 45 to 85 years and excluded people who were living in institutions, residents of the 3 territories or First Nations reserves, and people who were not able to participate in English or French, which has the potential to limit the generalizability of the results.¹⁶

Conclusion

We examined how the perception of access to health care services among Canadians was affected by the COVID-19 pandemic early in the pandemic. The findings suggest that unmet need was lower in older age groups and varied by sex, education, income, immigrant status, racial background and region. Given that the presence of chronic conditions and prepandemic unmet needs were also associated with higher odds of reporting unmet health care needs, there is evidence that people with preexisting vulnerabilities experience difficulties when trying to access health care services. Efforts must continue to ensure accessible care for Canadians.

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Funding: Funding for this study was obtained from the Public Health Agency of Canada (PHAC). Funding for the support of the Canadian Longitudinal Study on Aging (CLSA) COVID-19 Questionnaire-based

study is provided by Juravinski Research Institute, Faculty of Health Sciences, McMaster University, Provost Fund from McMaster University, McMaster Institute for Research on Aging, Public Health Agency of Canada and the Nova Scotia COVID-19 Health Research Coalition. Funding for the CLSA is provided by the Government of Canada through the Canadian Institutes of Health Research (CIHR) under grant reference LSA 94473 and the Canada Foundation for Innovation. The CLSA is led by Dr. Parminder Raina, Dr. Christina Wolfson and Dr. Susan Kirkland. Dr. Raina holds the Raymond and Margaret Labarge chair in optimal aging and know-ledge application for optimal aging, is the director of the McMaster Institute for Research on Aging and the Labarge Centre for Mobility in Aging and holds a tier 1 Canada research chair in geroscience. Lauren Griffith is supported by the McLaughlin Foundation professorship in population and public health.

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Data sharing: Data are available from the Canadian Longitudinal Study on Aging (CLSA; www.clsa-elcv.ca) for researchers who meet the criteria for access to deidentified CLSA data.

Acknowledgements: This research was made possible using the data-biospecimens collected by the Canadian Longitudinal Study on Aging (CLSA). Funding for the CLSA is provided by the Government of Canada through the Canadian Institutes of Health Research (CIHR) under grant reference LSA 94473 and the Canada Foundation for Innovation, as well as the following provinces: Newfoundland, Nova Scotia, Quebec, Ontario, Manitoba, Alberta and British Columbia. This research has been conducted using the CLSA baseline tracking data set version 3.7, baseline comprehensive data set version 5.2, follow-up 1 tracking data set version 2.2, follow-up 1 comprehensive data set version 3.0, GEN3, Epigenetics version 1.1, COVID-19 questionnaire data under application number 21CON001. The CLSA is led by Dr. Parminder Raina, Dr. Christina Wolfson and Dr. Susan Kirkland.

Disclaimer: The opinions expressed in this manuscript are the authors' own and do not reflect the views of the Canadian Longitudinal Study on Aging.

Supplemental information: For reviewer comments and the original submission of this manuscript, please see www.cmajopen.ca/content/11/1/E140/suppl/DC1.