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**Title:** Unmet healthcare needs during the COVID-19 pandemic among adults: a prospective cohort study in the Canadian Longitudinal Study on Aging
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**Reviewer 1:** A. Mark Clarfield
**Institution:** Geriatrics, Soroka Hospital
General comments (author response in bold)

These data are from early in the pandemic and this fact should be better emphasized in both the intro and the discussion. I am sure things have changed in some (many?) ways since then. Do you have later comparable data? If so and you could compare changes in time, that would add a lot to your observations. If not, OK too but the fact that this study comprises an early "snapshot " point should be strengthened.
**Unfortunately, we do not have later comparable data as the CLSA COVID-19 Questionnaire Study was only conducted from April to December 2020. This has been added as a limitation, "*…nearly 24,000 adults in Canada in the first year of the pandemic. Data from later in the pandemic was not available but given the use of a cohort with ongoing data collection, future work may be possible.*" (Interpretation, page 10).**

Given point 1, I suggest adjusting wording throughout – e.g. in Limitations, line 4, instead of "…during the COVID-19 pandemic…", something like: "…at least early on in the pandemic…"
**This has been added to the limitations section, "*…nearly 24,000 adults in Canada in the first year of the pandemic*" (Interpretation, page 10). It has also been added to the objectives, "*The objectives of this study were to describe unmet healthcare… among adults in Canada in the fall of 2020 throughout the first year of the COVID-19 pandemic*" (Introduction, page 4).**

Two major findings are (at least to me) counterintuitive and need more discussion:
a. The fact that older persons described fewer problems. You address this briefly, but might this be a cohort effect in that they be more tolerant than younger cohorts of problems of access, i.e., simply more stoical? Other possible explanations?
b. Better educated reported more problems; perhaps they were less stoical, i.e., used to getting services and perceived themselves as previously good at maneuvering websites etc., but frustrated by their lack of success? i.e., the mirror image of point 'a' above. Needs more discussion
**a. While surprising, this is a result consistently seen in the literature. However, there has not been much as research focusing on reasons why older adults are less likely to report unmet needs. Most of the work on unmet healthcare needs is cross-sectional, which makes it difficult to establish causes. However, older adults did use more virtual services during the pandemic so they may have experienced a smaller interruption in care and this has been added to the Interpretation, "*In Ontario, the lowest decline in primary care visits was observed in older adults, who were also more likely to use virtual visits*" (Interpretation, page 9). Older adults were also less likely to report symptoms of depression and stress,**

**possibly meaning they were less likely to perceive difficulties accessing care. This has been added:**
**b. Individuals with higher levels of education have consistently reported greater levels of unmet need in Canada. During the pandemic, they may have reported greater unmet need due to experiencing a relatively larger disruption as they used more healthcare services prior to the pandemic. This has been added to the interpretation, "*Participants with higher education levels had higher odds of indicating challenges accessing healthcare, consistent with pre-pandemic CCHS research, possibly due to perceiving greater disruption as they typically had higher levels of healthcare utilization before the pandemic*" (Interpretation, page 9).**
**Those with higher levels of income have also been seen less likely to forego care, which may have been a problem during the pandemic when services were redirected, "*Individuals with higher levels of income tend to be less likely to forego care, as has been noted even during the pandemic, meaning they may have greater expectations for accessibility of services*" (Interpretation, page 9).**

**Reviewer 2:** Seraphine Zeitouny
**Institution:** Centre for Health Services and Policy Research, School of Population and Public Health, The University of British Columbia
General comments (author response in bold)

Throughout the manuscript, authors weren't consistent when referring to the target population. For instance, while the title states that the study targets older adults, the abstract includes results and implications affecting adults.
**Thank you for identifying this inconsistency. The participants were 50-96 years of age. Throughout the study, our focus has been revised to focus on adults, rather than older adults.**

The CLSA contains individuals aged between 45-85 years old. Did you exclude other age groups only to retain those above 50 yo? Is that how you defined older adults?
**At baseline (2010-2015), the CLSA recruited individuals that were aged between 45 to 85. When the CLSA COVID-19 Questionnaire was conducted in 2020, the minimum age of all participants included in the sample included was 50. We now just use the term adults instead of "older adults".**

During the pandemic, how were participants recruited or invited into the study? And most importantly, did they fill the questionnaires online, by mail, other?
**Participants were recruited using either telephone or email, depending on if active email information was available. This has been added to the Methods section, "*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) via email (N=34,428) or telephone (N=8,083) if email information was not available. Of all the invited members, 28,559 completed the baseline survey (response=67%), with 23,832 completing by web and 4,727 by telephone.*" (Methods, page 5).**

In survey question #2, did "see a doctor" imply virtual visits or was it only limited to in-person consultations? Since questionnaires were administered individually, was that clarified in the survey?

**There was no further clarification in the survey to specify if the visits to the doctor were in person or online. We now acknowledge this as a limitations that our survey did not specifically ask about virtual or in-person visits, in Methods section: "*The questions did not differentiate between virtual and in-person care*" (Methods, page 6).**

Consider clarifying the language around "see a doctor" and indicate whether it was only limited to in-person consultations.
**This was not clarified in the survey, so we are unable to further address this in the study.**

I was surprised that the results section did not include any numbers.
**We agree! The journal website indicates that they numbers should be in the tables and not repeated in the text but after referring to other published papers we have now added some numbers throughout the results section.**

Household income was retrieved from data cycle 2015-2018. Yet, it does not reflect income in 2020, particularly since many individuals have lost their jobs during the pandemic.
**Unfortunately, participants were not asked again for their household income in the COVID-19 Questionnaire study. This limitation has been now described, "*Although we examined several predictors, including pre-pandemic unmet healthcare needs, some of the data had been collected in FUP1 and may not reflect the participants' current situation*" (Interpretation, 10)**

The guidelines for COVID-19 testing eligibility kept evolving over time and across provinces. How do you think this has affected your results about barriers in accessing COVID-19 testing?
**This has been added as a limitation, "*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*" (Interpretation, page 10).**

The authors stated that "Ontario and BC residents reported higher levels of unmet needs given the high case counts in the province." If authors made such inference based on the first nine months of the pandemic, this statement is not accurate since the caseload in BC was relatively more minor compared to Ontario and other provinces.
**This statement has been deleted. Instead, a sentence describing the limitations of individually discussing the provinces, "*The fluctuations in case counts and testing guidelines across time and regions made it difficult to describe the reasons behind unmet needs*" (Interpretation, page 10).**

Typos in SARS=CoV-2, Cis (as in confidence intervals)
**Amended, thank you!**

In the methods section, add a reference for the use of VIF
**As the variation inflation factors were not reported in the results section, this line was cut from the methods section.**