Technical meeting on strengthening data on the unmet care needs of older persons

Meeting report, Kobe, Japan, 10-11 June 2024

World Health Organization

Centre for Health Development

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Abbreviations

ADLs	activities of daily living
CARETRACK	Consortium for Advancing Research and Evaluation in Tracking Unmet Health & Social Care Needs of Older Populations
DHS	Demographic and Health Surveys
EHIS	European Health Interview Surveys
LMICs	low- and middle-income countries
OOP	out of pocket
PAHO	Pan American Health Organization
SAGE	Study on Global Ageing and Adult Health
SCI	Service Coverage Index
SDG	Sustainable Development Goal
SHARE	Survey of Health, Ageing and Retirement in Europe
UHC	universal health coverage
WHO	World Health Organization
WHS+	World Health Survey Plus
WKC	WHO Kobe Centre (WHO Centre for Health Development)

Executive summary

The Technical meeting on strengthening data on the unmet care needs of older persons, held 10–11 June 2024 in Kobe, Japan, brought together international academics, members of the Consortium for Advancing Research and Evaluation in Tracking Unmet Health & Social Care Needs of Older Populations (CARETRACK) and World Health Organization (WHO) technical staff from regional offices and headquarters to address the critical issue of unmet health and social care needs among older persons. The discussions underscored the urgency of understanding and measuring these unmet needs to advance universal health coverage (UHC) by 2030.

The meeting commenced with an overview of the research activities on this topic conducted by the WHO Centre for Health Development (WHO Kobe Centre – WKC) from 2020 to 2023, which included a global systematic review and meta-analysis. This study utilized published data, mostly from high-income countries, to show that about 1 in 10 persons aged 60 years or older had an unmet health need, with affordability emerging as the most common barrier to accessing health services. Additionally, secondary analysis of national surveys from 83 countries of all income levels revealed stark contrasts in self-reported unmet health needs, partly due to differences in measurement methods, highlighting the importance of developing standardized measures to improve reliability, validity and comparability. The establishment of CARETRACK – a global research consortium with membership open to to all who have a professional commitment to or interest in fulfilling the health needs of older persons – was introduced to participants as a significant step towards advancing discussions about the methodologies and data needed to address the unmet health and social care needs of older populations.

Following this, representatives from various WHO regional offices and headquarters presented information about their related activities and recent findings. The European Region's report on financial protection highlighted a strong link between high out-of-pocket spending and increased unmet health needs. Meanwhile, the South-East Asia Region emphasized efforts to build capacity to measure these unmet health needs. A new WHO handbook, guided by the Tanahashi framework, was introduced that aims to guide assessments of barriers to effective health care coverage *(1)*. These presentations highlighted the critical role of measuring unmet health needs to provide a more nuanced understanding of service coverage and financial protection, particularly for older persons.

The feasibility of measuring unmet needs across different WHO regions was examined through ongoing research commissioned by the WKC. Research teams from the African, South-East Asia, European, Eastern Mediterranean and Western Pacific Regions presented their preliminary findings, revealing significant data gaps and regional challenges. A representative from the Region of the Americas presented data about unmet health needs from several countries, demonstrating what could be achieved in other regions. The presentations underscored the importance of considering regional contexts and vulnerabilities when assessing unmet needs. Policy analysis studies were discussed as an important area for future research to identify the possible drivers of unmet needs as well as policy interventions to reduce these needs.

During the final session, participants were informed about how the World Health Survey Plus (WHS+) captures information on unmet needs, and then engaged in an exercise to operationalize the measurement of unmet health and social care needs. For unmet health needs, the proposed indicator was defined as the proportion of the population reporting a perceived need for health care but

Group photo of meeting participants. Sitting in the front row, left to right: Sarah L. Barber, Samar Elfeky, Julie Byles, Shereen Hussein, Flavia Andrade. Standing in the second row, left to right: Paul Kowal, Valeria de Oliveira Cruz, Gabriela Flores, Nawi Ng, Benson Droti, Fredrick Makumbi, Jonathan Cylus, Megumi Rosenberg, Ding Wang, Herfina Nababan, Md Mizanur Rahman. (See Annex 2 for individual titles and affiliations.) ©WHO/Megumi Rosenberg

not receiving it during a given period. For social care, assessing limitations in activities of daily living and instrumental activities of daily living was suggested as a normative approach to determining need, along with asking questions about whether care was received. The discussions emphasized the complexities of measuring these indicators and the need for additional research to justify measurement choices, such as the recall period and the definition of "need".

Overall, the technical meeting highlighted the necessity for standardized definitions and methodologies to ensure accurate measurement of unmet health and social care needs among older persons and to facilitate the uptake of this evidence in decision-making. The ongoing research and activities discussed during this meeting represent significant advancements towards creating a common approach to monitoring and addressing these needs. Continual efforts to refine measurement tools and gather comprehensive data are essential for advancing UHC in a way that is responsive to the needs of older populations.

1 Opening

The Director of the WHO Centre for Health Development (WHO Kobe Centre – WKC), Dr Sarah L. Barber, welcomed the participants to Kobe, Japan, for the Technical meeting on strengthening data on the unmet care needs of older persons (Annex 1). She stressed the importance of measuring and understanding the unmet care needs of older individuals to ensure that countries are advancing towards universal health coverage (UHC) in a way that is responsive to older persons' needs. She expressed appreciation for the engagement of colleagues from the World Health Organization's (WHO) headquarters and each regional office, as well as WKC's external research partners (Annex 2).

Dr Megumi Rosenberg, WKC Technical Officer for Metrics and Measurement and officer responsible for organizing the meeting, provided the background to the consultation meeting. One of WKC's research programmes is focused on measuring unmet needs for health and social care among older people. In 2021–2022, WKC conducted a global systematic review and secondary analysis of survey data from more than 80 countries to estimate the prevalence of unmet health needs. These findings were published in peer-reviewed journals and contributed to the WHO–World Bank UHC global monitoring reports. In 2023, the importance of measuring unmet needs was recognized by the Seventy-sixth World Health Assembly in resolution WHA76.4 *(2)* and the United Nations High-Level Meeting on Universal Health Coverage in its political declaration *(3)*. As expertise and interest in the topic grew, WKC supported the establishment of a global research consortium to advance methods for measuring the unmet health and social care needs of older people, especially in low- and middle-income countries (LMICs). The meeting was planned to take stock of research progress in this area and chart how to strengthen global data on unmet health and social care needs. Specifically, the objectives of the technical meeting included (i) assessing the feasibility of measuring unmet health and social care needs within and across regions, (ii) understanding regional and country perspectives on the practical value of data about unmet health and social care needs, and (iii) identifying region-specific and global needs for research and policy guidance on this issue.

2 Session 1: WKC research activities 2020–2023

2.1 Global systematic review and meta-analysis

Dr Md Mizanur Rahman of Hitotsubashi University, Japan, presented findings from his systematic review and meta-analysis of the global prevalence of unmet health and social care needs among people aged 60 years and older. The review included 101 studies from 56 countries published between 1996 and 2020. Most of the included studies on unmet health care needs (86%, 87 studies) were conducted in Europe and the United States of America, while the studies on unmet needs for long-term care or social care (14%, 14 studies) were mainly from China. Variations occurred across the studies in definitions and how unmet needs were measured. Based on a meta-analysis, the estimated prevalence of self-reported unmet health needs for older persons was 10%. Affordability, as reflected by costs for treatment and transport, was the most frequently reported reason for not receiving needed health care, while other reasons were related to availability, accessibility and acceptability. Unmet health needs were higher among those with lower socioeconomic status, poorer self-reported health and no insurance. The estimated prevalence of unmet needs for social care was 25%, assessed as people with one or more limitations in functioning who reported not receiving any care or support. Studies reporting on unmet needs for social care typically did not ask participants about the reasons for not receiving care. Details of this study can be found in reference *(4)*.

2.2 Global analysis of national and cross-national surveys

Dr Paul Kowal, from The Australian National University and International Health Transitions, presented findings from the research he led to assess the prevalence of unmet health needs in older adults in multiple countries, based on a secondary analysis of national surveys that had samples of adults aged 60 years or older. A total of 17 studies or surveys were identified, covering 83 countries and conducted between 2001 and 2019. The questions about unmet health needs varied across the surveys, for example, about the types of care, recall period or type of providers. The results ranged from low levels (less than 2%) of self-reported unmet health needs in adults 60 years or older in countries such as Andorra, Qatar, the Republic of Korea, Slovenia, Thailand and Viet Nam, to rates of more than 50% in Georgia, Haiti, Morocco, Rwanda and Zimbabwe. While differences in the studies' methodologies may limit the comparability of estimates between them, the results can be useful for each country. Details of this study can be found in reference *(5)*.

2.3 Establishment of a global research consortium

Dr Julie Byles, from The University of Newcastle, Australia, described the project she led to establish the Consortium for Advancing Research and Evaluation in Tracking Unmet Health & Social Care Needs of Older Populations (CARETRACK). The project was motivated by various global health agendas, the fact that older people are often underrepresented in statistics and the absence of a network for understanding and addressing the unmet care needs of older persons, despite strong interest in the topic worldwide. A series of global consultations were held with people from different professional, geographical and cultural backgrounds (e.g. content experts, context experts and the broader audience who might be interested) to gather information and resources and to develop a research agenda. The three major research priorities of the Consortium are to (i) increase the monitoring of the unmet health and social care needs of older people in diverse cultural, socioeconomic and environmental contexts; (ii) standardize and calibrate measures and methodologies for monitoring and understanding these unmet health and social care needs; and (iii) increase the global knowledge base regarding these unmet needs of older people *(6)*.

Dr Shereen Hussein, of the London School of Hygiene and Tropical Medicine and Analytical Research Ltd, Chair of CARETRACK, shared that the biggest current challenge for the Consortium is to generate income to enable it to undertake the necessary activities to achieve its stated objectives. Barriers to obtaining grants are partly due to the persistent misperception among major funders that population ageing is a problem only of rich countries and not a priority for global health.

2.4 Key discussion points from Session 1

The discussion of this session was moderated by Dr Benson Droti, of the WHO Regional Office for Africa, Department of Health Information Systems. The key points of this discussion are summarized below.

- Measuring and understanding the unmet needs of older persons is important everywhere, especially in regions with many LMICs where the health system's focus is still on the younger population and inadequate attention is paid to those not covered by or receiving existing services.
- Some LMICs, such as Thailand and Viet Nam, have a very low prevalence of unmet needs, which may be explained by their strong grassroots health care system and how it is likely to enhance the probability that basic health care needs will be met.
- Establishing a clear and standard definition of unmet health needs is required. Because survey questions used to measure unmet health needs often lack specificity regarding the type of

care required, it is important to include a full range of health services. This range should encompass health promotion, prevention, treatment, rehabilitation, palliative care and access to medicines.

- The finding from WKC's research led by Dr Rahman that 1 in 4 older persons with functional limitations has an unmet need for social care (mainly based on studies from China) is not surprising. Similar figures were found in the United Kingdom, even though it has well-developed health and social care systems. If data were available on social care needs from LMICs, the estimates would be expected to be higher.
- The family of Health and Retirement Studies (e.g. the Study on Global Ageing and Adult Health [SAGE] and the China Health and Retirement Longitudinal Study [known as CHARLS]; the English Longitudinal Study of Ageing [known as ELSA] in the United Kingdom; the Survey of Health, Ageing and Retirement in Europe [SHARE]) is a good data source for social care analyses; however, they are skewed towards higher income countries. A more common data source in LMICs is the Demographic and Health Surveys (DHS) or other surveys focused on reproductive health, and maternal and child health, which typically collect detailed data only from individuals who are aged 49 years or younger.
- The drivers of unmet needs are highly complex and depend on context. Supply-side factors include health systems architecture, service delivery and financial protection policies. Demand-side factors include perceptions, expectations, health-seeking behaviours, social support and gender norms. Benchmarking and calibration of indicators across different settings may be needed, along with qualitative or mixed-methods studies, to gain a deeper understanding of unmet needs and what is driving them in different countries. It may also be useful to study changes over time within countries to understand the dynamics of service coverage, financial protection and unmet needs.
- It is essential to standardize some core indicators for studying unmet needs. However, even with standardized questions, individual perceptions and expectations about whether care is needed will still introduce variability. Benchmarking and calibration studies may be required to improve comparability between countries and settings. Anchoring vignettes may be helpful in this process.

3 Session 2: activities of and updates from WHO regional offices and headquarters

3.1 European Region report on financial protection

Dr Jonathan Cylus, of the WHO Barcelona Office for Health System Financing and the European Observatory on Health Systems and Policies, under WHO's Regional Office for Europe, presented the latest report on financial protection from the European Region, published in 2023 *(7)*. The report explores the issues of financial hardship caused by catastrophic out-of-pocket (OOP) spending, leading to unmet health care needs and the role of health coverage policies on the distribution of OOP spending across the population in the countries in the Region. The Regional Office has developed a new method to measure catastrophic spending based on how much of a household's total budget can be spent on OOP health care costs before the household experiences catastrophic health spending. Using this method, poorer households have a lower threshold and richer households have a higher spending threshold. As a result, the report shows that poorer households consistently have a higher risk of facing catastrophic spending across countries. Further analysis showed that in Europe in general, countries with high rates of catastrophic spending also have high unmet needs. Since coverage policies for financial protection do not usually include dental care, poorer households often forgo dental care, while richer households are likely to experience financial hardship due to dental care utilization.

It would be helpful to have data about unmet needs that are linked to data about household budgets to examine whether households that have catastrophic OOP spending are also the ones that have unmet needs; however, data on unmet needs are rarely available from household budget surveys. Therefore, different data sets, such as the European Union statistics on income and living conditions or European Health Interview Surveys (EHIS), are used to obtain estimates of unmet needs. However, various surveys provide contrasting results, partly due to inconsistencies in the denominators used to produce their estimates. Understanding the policies that might affect older people differently than younger people would provide information that is vital to interpreting data about the disparities in unmet needs by age group.

3.2 Measuring forgone care in the South-East Asia Region

Dr Valeria de Oliveira Cruz, of WHO's Regional Office for South-East Asia, presented information about a series of activities that the Regional Office has undertaken in recent years to encourage the measurement of needs that were not met due to forgone health care in the Region. The first was a workshop organized in 2019

that focused on estimating the financial protection indicators for monitoring Sustainable Development Goal (SDG) indicator 3.8.2 ("Proportion of population with large household expenditures on health as a share of total household expenditure or income"). The workshop, attended by representatives from most countries in the Region, was the first occasion for a discussion about why it is essential to understand levels of unmet needs in relation to financial protection. Then in 2020, a desk review was undertaken to identify household surveys from the Region's countries and examine the kinds of questions asked in the surveys, including whether any were relevant to unmet needs. It was found that very few household surveys of countries in South-East Asia include questions that can clearly and directly determine levels of unmet health needs in the population, whether due to delayed or forgone care. In 2022, the Regional Office published its first publication about financial protection, which recognized unmet needs as an important problem *(8)*. This report was the basis for training sessions held for national statistical officers and policy-makers about methods for estimating and interpreting indicators of financial protection to monitor SDG indicator 3.8.2, in Jakarta, Indonesia, in December 2023. One of the sessions was jointly led by Dr Catherine Korachais and Dr Gabriela Flores, WHO Health Financing and Economics Department; Dr Nawi Ng, University of Gothenburg, Sweden; and Dr Megumi Rosenberg, WKC; to explain the measurement of unmet health needs. The Region is interested in working towards an agreed definition of unmet needs that can be applied in multiple studies to answer relevant policy questions.

3.3 Assessing barriers to health services and drivers of unmet needs

Ms Theadora Koller, from WHO headquarters, Department of Gender, Equity, Diversity and Rights for Health, introduced the new *Handbook for conducting assessments of barriers to effective coverage with health services: in support of equity-oriented reforms towards universal health coverage (1)*. The Handbook aims to help unpack why people lack effective essential health service coverage and face financial hardship or forgo necessary care. It uses the Tanahashi framework for effective coverage as its theoretical base to explore the barriers to access at different levels of service coverage, from availability, accessibility, acceptability and contact to effective coverage.

The Handbook advocates using a mixed qualitative and quantitative methods approach to conduct assessments of barriers. The assessment method has been piloted in several countries, including Greece, Nigeria, the United Republic of Tanzania and WHO's Region of the Americas, and will be implemented in Fiji and Ukraine. Ms Koller also introduced the recently formed Working Group for Unmet Needs and Barriers to Effective Coverage, which includes several departments and units within WHO headquarters. The first

meeting of the group was held on 26 April 2024. The Working Group proposes to strengthen cross-organizational strategic leadership within WHO in this area, for example by developing a background paper on measuring unmet needs, publishing a special journal issue on the topic and conducting joint work in countries, among other approaches.

3.4 Measuring forgone care in the context of global monitoring of financial protection

Dr Gabriela Flores discussed the importance of measuring unmet health care needs in order to gain a more nuanced understanding of service coverage and financial protection. The Service Coverage Index (SCI) is used to track the two UHC indicators that are monitored within the SDG framework: indicator SDG 3.8.1 ("Coverage of essential health services") and indicator SDG 3.8.2 (the indicator for catastrophic OOP spending for health care). Unmet need is an important indicator for capturing components not reflected in these indicators. Ideally, the complement of the SCI will be an indication of levels of unmet needs. This was demonstrated in the research by Dr Paul Kowal, which showed a negative correlation between the SCI and levels of self-reported unmet health needs at the country level. However, as the SCI is a composite of 14 tracer indicators rather than a complete measure of service coverage, its complement is not necessarily an adequate measure of unmet needs. Therefore, a direct measure of unmet needs is also essential, especially in high-income countries where the SCI is generally high.

As for monitoring financial protection, this should entail both financial barriers to access and financial hardship due to OOP expenditures. However, financial barriers to access and the resulting unmet needs are currently not reported by global monitoring because they are more challenging to measure due to a lack of common definitions, a lack of standardized survey instruments and differences in data sources and units of analysis (i.e. OOP expenditure is analysed at the household level while financial barriers and unmet needs are typically analysed at the individual level). An example from the Lao People's Democratic Republic was shown in which households in the poorer quintiles had higher rates of financial barriers to access and much lower rates of catastrophic health spending, suggesting that poorer households are not utilizing care and have unmet needs. In contrast, wealthier households tended to have higher rates of catastrophic health spending but lower rates of needs that were unmet for financial reasons, suggesting that they are paying a high cost to meet their needs *(9)*. Dr Flores emphasized that to improve understanding of unmet need, clear guidance is needed on its definition, as well as standardized survey questions and studies with sufficient sample size. She added that it would be useful to explore the drivers of financial hardship among households with different age compositions (i.e. younger households, multigenerational households, adult-only households

and older households) and their links with policies for older people in different countries.

3.5 Key discussion points from Session 2

Dr Megumi Rosenberg moderated the discussion of this session, the key points of which are summarized below.

- So far, within WHO there has been strong interest from health financing experts in measuring and understanding financial barriers to care access and the resulting levels of unmet needs in order to monitor financial protection more accurately. However, it is important to ensure more engagement from those working in the areas of ageing and health information systems to improve data about the unmet needs of older persons, including unmet needs for social care.
- Assessments of barriers should ideally consider different care pathways, the barriers faced at different stages along the care-seeking journey, where people tend to drop out of the care pathway due to financial or other barriers, and the coping mechanisms people use to overcome barriers.
- Gender-related barriers and other sensitive issues related to access may exist. Qualitative research has revealed some of these. Data collection methods can and should be designed carefully to enable inquiries around autonomy and sensitive issues related to women's health.
- The dynamic among financial barriers, unmet needs and financial hardship due to OOP health spending is of great interest. However, limitations to the data make it difficult to disentangle the relationships (e.g. the data on financial barriers and unmet needs cannot be linked with data about financial hardship at the household level). The research arm of the European Commission is conducting model-based simulation analyses to study some of these relationships.
- Reported unmet needs and high levels of OOP spending might reflect a gap between the types of services offered by a State and the services desired by its people. A State might cover basic essential services, but those services might not be what people perceive they need or want. Therefore, it is possible to find high levels of self-reported unmet needs and catastrophic health spending (e.g. due to seeking private care) despite good public coverage of essential services, which could be problematic for policy-makers. Thus, understanding the context of service delivery and people's expectations is paramount when devising policy responses and interventions. Furthermore, it is important to understand and validate people's perceived needs (e.g. through diagnosis or testing for biomarkers). This understanding can also act as a check on whether the metric chosen accurately captures what it is intended to measure.

4 Session 3: current feasibility of measuring unmet needs for health and social care, by WHO region

In early 2024, WKC commissioned regional assessments of the feasibility of measuring unmet health and social care needs among older people based on a review of the literature, survey mapping and a demonstrative analysis of some secondary data. One research team per region was selected to conduct these assessments except in the Region of the Americas, which already had sufficient information about this topic. The draft assessment reports were shared as background papers for this meeting. In this session, the respective research teams presented their preliminary findings and information about their progress, and a representative from the WHO Regional Office for the Americas/Pan American Health Organization (PAHO) presented relevant information about their Region. WKC plans to publish briefs about the regional assessments by early 2025.

4.1 African Region

Dr Fredrick Makumbi, of Makerere University, Uganda, presented on behalf of his team. There is a projected growth in the number of older persons in Africa; however, currently only limited attention is paid to their health and social care needs. The team's systematic review identified 17 relevant studies, 7 of which were included in a meta-analysis. The results of the meta-analysis showed that the overall prevalence of unmet health needs is 32%, with a significant difference between the prevalence of unmet health needs for unspecified conditions (11%) and specified conditions (69%). The key drivers of unmet health needs are clear and include accessibility and the quality of services (i.e. supply factors) and socioeconomic and demographic characteristics of the individuals (i.e. demand factors). Information comes from countries in eastern, western and southern Africa, and mainly addresses access to health care; there are limited studies focusing on social care issues, and only three studies focused on individuals aged 40 or 50 years and older. The example analysis using the 2013 Kenya Household and Health Expenditure and Utilization Survey highlighted the inequalities in unmet health needs, which disproportionately affect less affluent older persons. Dr Makumbi noted the need to standardize the measurement of unmet needs, especially concerning recall periods or time frames, whether the need is identified based on a self-report or self-perception or an objectively assessed need, and whether the need is a general or non-specific need or a need for care for a specific condition. He also mentioned the necessity for more research on this topic in the Region.

Dr Benson Droti agreed that there is a significant gap in information about unmet needs within the health sector and emphasized the importance of addressing this gap. He suggested adding questions or items to routine health information systems and facility assessment surveys to evaluate unmet needs across the entire population. Dr Droti expressed his desire to collaborate with the Makerere University School of Public Health, where Dr Makumbi's research team is based, and other global institutions to shift the conversation from focusing on a shortage of data and information on unmet needs to discussing the information gathered from countries.

4.2 Eastern Mediterranean Region

Dr Shereen Hussein presented on behalf of her team. The team started their work later than other teams, so it is still in the early stages.

Dr Hussein began by emphasizing the diversity and challenges in the Eastern Mediterranean Region. For example, the Gulf countries are experiencing fast and pronounced population ageing, while North African countries show slower rates of population ageing. Most countries face fiscal challenges, except for those in the Gulf region. Many countries are experiencing conflicts, and the burden of noncommunicable diseases is large and growing.

Early impressions from the literature review are that there appear to be gaps in the countries covered by relevant studies. Many studies are from a few countries, such as the Islamic Republic of Iran, Jordan, Lebanon and Saudi Arabia. Preliminary findings show that the drivers of unmet health needs include external factors, such as the COVID-19 pandemic and wars and other conflicts. The survey mapping found a lack of surveys of older persons, challenges in obtaining access to the few available surveys, and small sample sizes of older people. The team is supplementing its literature review and survey mapping with a review of country-level indicators and a call for evidence to identify other existing or forthcoming data. Dr Hussein provided an example of how data about social connections among older persons might be analysed as a proxy for the availability of informal care in the absence of data from more direct measures of unmet needs for social care.

Dr Samar Elfeky, of WHO's Regional Office for the Eastern Mediterranean, shared her reflections, noting that it may be important to consider the languages spoken in the region (e.g. Farsi, French, Urdu) when searching for relevant literature and data sources, and not limit searches to studies published in Arabic and English. She also mentioned that other vulnerable populations in the Region, such as refugees and displaced people and expatriate communities, also have unmet needs but are not represented in national surveys. She mentioned the political instability in the

Region, which contributes to the lack of evidence and the lack of reliability of the evidence. She also reiterated that, in principle, unmet needs should cover the full range of health services, from promotive and preventive to curative and palliative care.

4.3 European Region

Dr Nawi Ng presented on behalf of his team. He began by providing some background on the projected growth of the population of people aged 60 years and older in most European countries, the high old-age dependency ratio and OOP spending for health care among the older population. The information highlighted the importance of prioritizing and understanding the needs of older persons in the Region. Through the team's literature review, they reported on the prevalence of and reasons for unmet health needs in 44 countries in the European Region, both before and during the COVID-19 pandemic. Based on a secondary analysis of data from the EHIS and SHARE, they showed that estimates of unmet needs for individuals aged 60 years or older in the European Region differed between countries and surveys. The EHIS data set generally showed a higher average of unmet health needs (23.5%) than the SHARE data set (12.8%). They also demonstrated a novel intersectional approach to identifying vulnerable populations based on a combination of factors, including gender, country of origin, education level and income level. This type of information can inform targeted interventions. However, ensuring sufficient sample sizes to perform such analyses can be challenging for many surveys. Notable findings for this Region are the availability of multicountry data about unmet health and social care needs and the potential to perform intersectional analyses to identify specific population subgroups experiencing high unmet needs.

Dr Jonathan Cylus pointed out that while multicountry data sets exist for the European Region, it is important to consider which approach is best for measuring unmet needs. The differences in the analysis of results from the EHIS and SHARE might be due to differences in the denominators used (i.e. the total population or a subpopulation with perceived needs), but there could also be other reasons. There are opportunities to learn from trend data, when one survey is repeated over time, and by interpreting results alongside the policy context in each country. Dr Cylus questioned the rationale underlying the recall period of 12 months used in both the EHIS and SHARE.

4.4 South-East Asia Region

Dr Md Mizanur Rahman presented on behalf of his team. The evidence synthesis based on the literature review showed that most studies from the South-East Asia Region came from India and Thailand, and none were available from Bhutan. Around half of the 14 included studies were specifically about older persons in

6 countries. The meta-analysis based on these studies found that, on average, 23% of older people in the Region have unmet health needs. The common reasons for forgone care are costs, long waiting times and distance from services. The review found no published studies on unmet needs for social care among older persons in the Region.

The mapping identified 36 surveys from 10 countries in the Region, and none specifically targeted older people. Using data from the 2022 Bangladesh Household Income and Expenditures Survey, the prevalence of unmet health needs among people aged 60 years or older was calculated to be 7.2%. About 68% of those people reported that their problem was "not serious" and gave that as the reason for forgoing care, followed by high treatment costs (21%) and the long distances to health facilities (5%).

Dr Valeria de Oliveira Cruz suggested including languages other than English in the literature review, such as Thai and Indonesian. For the survey mapping, she shared that Bhutan had just released a large survey data set, combining data from the DHS, the Multiple Indicator Cluster Survey and the Household Financial Survey, which could be explored. Generally, unmet needs for prescription medicines and access to medicines are significant problems in the Region. With regards to the distance from a facility being a reason for unmet needs in countries such as Bangladesh, where there are many primary care facilities in the community, it might be due to people bypassing community-based facilities to receive services from medical professionals in hospitals and clinics. Dr Oliveira Cruz suggested that financial protection through tax-based or social insurance should be strengthened to reduce cost barriers. She also favoured measuring unmet needs for any health issue and not for specified conditions.

4.5 Western Pacific Region

Dr Paul Kowal presented on behalf of his team. He provided some background on the Western Pacific Region, explaining that between 2000 and 2050, the population in most countries and areas in the Region is projected to grow, including the population of those aged 60 years and older. This implies that there will be an increase in the demand for health care and social care, as life expectancy will also rise but not necessarily the number of years lived in full health. He presented a conceptual model of the interactions between need, demand and supply in health care, explaining that unmet needs occur when there are gaps between the three. Dr Kowal's team has identified 26 studies representing 16 countries in the Region that can be used to analyse unmet health needs. As an illustration he discussed data from a high-income country (i.e. Australia), two upper-middle-income countries (i.e. China and Malaysia), and four low-and-middle-income countries (e.g. Cambodia, Mongolia, the Philippines and Tonga) to show the frequency of individuals or

their families going without needed medicine or treatment during the past 12 months, disaggregated by sex and age group. The data showed a notable increase in unmet health needs as age increased. In addition, nine studies representing five countries were identified that can be used to analyse unmet social care needs. Data from Australia and Malaysia were used to illustrate the kinds of social support needed, the availability of the support and the types of providers.

Ms Ding Wang, of WHO's Regional Office for the Western Pacific, reflected that there is considerable potential to explore the issue of unmet needs further in the Region. The Region is very diverse, so there cannot be a single regional narrative. Understanding the health sector architecture in each country matters. In the Republic of Korea, for example, people can be reimbursed for purchasing digital health technology, such as a personal health tracker. In contrast, basic health services might be difficult to obtain in small island countries. The bureau of statistics in many countries often collects data that can be used to obtain information about unmet needs, although the health sector may not be aware of this. Analysing these data about unmet needs and comparing them against the policies in countries or policy changes would be valuable to increase the understanding of what might be driving unmet needs in different countries.

4.6 Region of the Americas

Although Ms Natalia Houghton, of the Regional Office for the Americas/PAHO, was unable to attend the meeting in person, a recorded presentation was shown. Ms Houghton began by outlining PAHO's commitment to assessing and reducing barriers to access health services by at least 30% by 2030. To this end, by leveraging household survey data, PAHO has conducted original research to understand these barriers across the Region of the Americas, especially in rural and dispersed communities. In the analysis, the Regional Office used a tracer indicator of unmet needs measured through forgone care, which is the most common indicator available in household surveys in the Region. The presentation detailed the survey questions used across different surveys to assess health care needs, care-seeking behaviour and the reasons for not seeking appropriate care. Explanations about how different concepts have been operationalized were provided, such as "health care need", "met health care need" and "unmet health care need due to forgone care". In their latest survey mapping, 18 eligible surveys were identified from 18 countries in the Region and used to provide data about self-reported unmet needs and types of access barriers using the Tanahashi framework for effective coverage. In some countries, such as Haiti, Honduras and the USA, financial barriers dominate the reasons for unmet needs. In these countries, health reforms have not included policies that adequately address financial barriers.

In contrast, in countries with adequate financial protection and that have achieved >90% universal coverage, such as Chile, Colombia and Peru, the population reported fewer financial barriers but mentioned other types of barriers, such as a lack of trust or long waiting times as the reasons associated with forgone care. This demonstrates the benefit of tracking unmet needs to guide policy reforms. It also shows that while quantitative data can be used to track progress at the regional and global levels, qualitative data are useful at the country level to understand the reasons for unmet needs. Areas for future work include standardizing survey instruments and indicators for data about access barriers in the Region, supporting countries in selecting tracer indicators of access barriers, developing new ways to collect quality data about access barriers, and exploring the effects of sociodemographic, economic and disease-related variables on care-seeking behaviours.

Dr Megumi Rosenberg noted that although the data on unmet needs from PAHO do not focus on older persons, a lot can still be learned from the work in the Region. PAHO's experiences give a positive message that it is possible to systematically collect and analyse data on unmet needs by leveraging existing surveys and reporting the data as part of health system performance monitoring. Due to the differences in surveys, the data are not necessarily comparable across countries, but they can still be informative to each country.

4.7 Key discussion points from Session 3

The discussion of this session was moderated by Dr Flavia Andrade, Professor of the University of Illinois School of Social Work. The key points of this discussion are highlighted below.

- Several issues that are related to the operationalization and measurement of unmet needs require further investigation: the difference between normative or objective need and felt or perceived need; acute or short-term need and chronic or long-term need; a partially met need and a fully met need; needs met or not met by the type of provider, among others. It may be helpful to undertake validation studies using existing multicountry surveys (e.g. the World Health Survey) to inform the selection or formulation of ideal survey questions.
- While the regional assessments mostly reported on measures of unmet needs for health that are not specific to certain health conditions, when considering the health needs of older persons, it will also be important to understand those related to multimorbidity that includes mostly chronic diseases, disability, and cognitive impairments or dementia.
- Different types of survey data, such as panel or longitudinal data, might also provide important insights about the dynamic factors that may affect levels of unmet need, including health and financial protection policies and the diffusion of innovations,

such as digital and artificial intelligence technology, that have evolved rapidly in recent years.

- CARETRACK has started a repository of data sources and survey instruments for measuring unmet needs, and this could be used as a starting point for building a global database of the unmet needs of older persons.
- In the absence of nationally representative data on unmet needs, or to complement them, regional or subnational data could be analysed, when available. This information may be useful for understanding the dynamics between contextual and structural factors, and between individual drivers and facilitators. The information may also be useful for understanding subgroups with high levels of normative need, as well as those with particular disadvantages in accessing health care.
- Engaging with ministries of health, bureaux of statistics and in-country researchers will be the key to accessing relevant data and improving the collection of data on unmet needs in each country.
- While cross-country comparability is important for global monitoring, reporting and benchmarking, the usefulness of data for each country should not be overlooked, even if they are not comparable with data from another country.
- There are regional variations and gaps in evidence, data and knowledge related to unmet needs. Therefore, different regions might need to prioritize different actions or approaches to measuring unmet needs. Countries may also require assistance in building the capacity to translate such knowledge into policies or practice.

5

Session 4: operationalizing the measurement of unmet needs for health and social care

5.1 Measuring unmet care needs in the World Health Survey Plus

Dr Paul Kowal gave a presentation about the World Health Survey Plus (WHS+) on behalf of Dr Nirmala Naidoo of WHO headquarters, with whom he has worked closely on implementation of the survey in various countries. The WHS+ is intended to be a one-platform survey to which any technical unit in WHO can add questions to avoid burdening countries with multiple different health surveys. Its implementation will be aligned with other surveys (e.g. the DHS, Multiple Indicator Cluster Survey, Living Standards Measurement Study) to ensure no data are duplicated. In 2023, the WHS+ was implemented in Bangladesh, Cambodia, Ghana and Nepal, and in 2024, it is being implemented in Cox's Bazar refugee camp, Bangladesh.

The WHS+ collects data about the socioeconomic and demographic characteristics of households and individuals and information about health care utilization, including reasons for forgone care, with separate questions about outpatient and inpatient care. Examples from the 2023 WHS+ in Cambodia and Ghana were used to show the main reasons for not seeking care and for needing care but not receiving it. The WHS+ also asks questions about difficulty with activities of daily living (ADLs), whether help has been needed in the past 12 months, and whether the help has been received. These items can be used to measure unmet needs for social care.

5.2 Operationalizing indicators of unmet needs for health and social care

Meeting participants engaged in an exercise to develop operational definitions for indicators of unmet health and social care needs by considering the commonly available survey questions discussed during the 2-day meeting. Participants were divided into two groups, each assigned to discuss an indicator of unmet needs for health care or of unmet needs for social care. Subsequently, the two groups reconvened in a plenary session to report the results of their discussions.

The group that discussed an indicator of unmet needs for health care proposed describing the indicator as the "perceived unmet health care need", defining it as "the proportion (%) of the population that reports perceiving a need for health care but not receiving it over a given period". The denominator for the indicator would be the number of people who reported a perceived need for health care during a given period, and the numerator

would be the number of people who did not receive health care, despite perceiving a need for it. The preferred data source for this information would be a nationally representative household survey, such as a health survey, living standards survey or a multipurpose survey that does not focus on specific diseases, programmes or patient groups; and the unit of analysis should be the individual, with the potential to explore multilevel models or other approaches to examine commonality within different group levels. Examples of questions that could be used to identify perceived health care needs include questions about the last time care was needed or about health conditions, illnesses or injuries during a given period. Further research and analysis would be necessary to justify and validate the choice of a recall period and other details of the indicator. Unmet needs should be analysed together with information about the reasons for needs not being met, and this can be collected using the Tanahashi framework for effective coverage to identify barriers related to availability, accessibility and acceptability.

The group that discussed multiple aspects of measuring unmet needs for social care recognized that most people might not relate to a question about the last time they needed social care. So instead of using perceived needs, the group proposed establishing a normative level of need by asking about ADLs and instrumental ADLs, which are often included in surveys of older persons. They also considered expanding the scope from functional capacity to include factors such as a person's life space (e.g. how much someone gets out and about) and social participation. It is also important to understand the settings in which care is provided, such as private homes (i.e. home care) or retirement villages (i.e. residential care), and whether the care is paid for and how that influences the data collected. At the same time, the group acknowledged the complexities and practical difficulty of including individuals in institutional care in surveys and categorizing different types of care and settings. It would be useful if participants could choose from multiple responses to a question about who provides care, given that care can be provided by different individuals or services simultaneously and at different times. Each question that asks about a specific difficulty or need for help should also ask whether help was received, who provided it, what form it took, where it occurred and how adequately it met the person's needs because a need could be only partially met. A few questions could collect information about receiving specific services, such as house-cleaning or transport, because people might not recognize or report the use of these services in connection with their functional needs. Additionally, the group considered the potential of using observational measures during interviews to assess living conditions and other signs that might indicate a need for care.

To try to uncover the reasons for unmet needs, questions should be asked that address issues of availability, affordability, acceptability, accessibility and trust. The group proposed two denominators for the indicator of unmet social care needs: one that includes only people who need help to calculate unmet needs as either the proportion of people needing help or the odds of a person needing help, and another that considers the whole population to obtain the prevalence of unmet need at a population level. The potential data sources include the WHS, SAGE and the Health and Retirement Studies. The data should be disaggregated by gender, age, living arrangements, rural or urban area, disability level and immigration status. There might be some limitations to the data, such as the exclusion of people in nursing homes or with dementia, and there is the potential that cultural norms and expectations affect what is perceived as a need and care. Finally, the group suggested the possible use of country-level vignettes to identify the standard of care in a country and to interpret the need according to what is available in that country .

6 Conclusions

Information about the level of unmet needs for health services in a population (i.e. from health promotion to prevention, treatment, rehabilitation and palliative care) can be complementary to, and help validate, current indicators used for the global monitoring of UHC, namely the SCI and data about catastrophic OOP expenditures. Furthermore, information about the determinants and levels of unmet needs for health and social care in the older population is important to guide health system reforms in the context of global population ageing. Data about vulnerable subgroups obtained by sampling and disaggregation analysis are generally important. These data are available for many countries, although they are collected using survey instruments that are not uniform in their structure. The comparability of data between and within countries is limited, but data can still offer important insights for countries. Going forward, policy analyses based on longitudinal data could clarify which actions lead to a reduction in unmet needs, and these analyses could inform the design of interventions. Given the highly contextual nature of self-reported unmet needs and their drivers or reasons, ultimately, richer data – including qualitative data – are required to obtain a complete picture of unmet needs for the full range of health and care services, as well as for the barriers to access. The meeting group made practical proposals to harmonize the measurement of self-reported unmet health and social care needs. Further analyses of the response patterns to different survey questions about unmet needs could provide a rationale for the choices that need to be made when standardizing a survey question or module.

Recommendations for future research include the need to conduct (i) validation studies to test the effects of survey design on response outcomes; (ii) policy analyses to better understand the observed levels of service coverage, health spending and unmet needs within a country; (iii) longitudinal or trend analyses of levels of unmet need within a country to understand the short- and long-term impacts of policies; and (iv) multicountry analyses of the determinants and levels of unmet social care needs. Key platforms and strategic opportunities to disseminate research and influence policy were also identified, including special journal issues on related topics, such as in the *International Journal of Health Equity*, and an organized session on the topic in the 8th Global Symposium on Health Systems Research, which will be held in Nagasaki, Japan, in November 2024. WKC will follow up with WHO colleagues at headquarters and in regional offices to prioritize actions in response to these recommendations.

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Annex 1. Meeting programme

Day 1: Monday, 10 June 2024

Time	Item	Participants
11:00–12:00	**WHO internal meeting**	WHO participants
12:00–13:00	**Luncheon** Short round of introductions Group photo	All participants
13:00–13:10	**Opening**	
13:00–13:05	Welcome remarks	Sarah Louise Barber WHO Kobe Centre (WKC)
13:05–13:10	Overview of the meeting agenda and objectives	Megumi Rosenberg WHO Kobe Centre
13:10–13:55	**Session 1: WKC research activities 2020–2023**	
	○ Global systematic review	Md Mizanur Rahman Hitotsubashi University
	○ Global analysis of available surveys	Paul Kowal International Health Transitions and The Australian National University
	○ Establishment of a global research consortium	Julie Byles The University of Newcastle, Australia Shereen Hussein London School of Hygiene and Tropical Medicine and Analytical Research Ltd
13:55–14:45	**Discussion**	Moderator: Benson Droti, WHO Regional Office for Africa
14:45–15:00	Coffee/tea	

Time	Session	Speaker
15:00–16:30	**Session 2:** **WHO regional offices and headquarters activities and updates**	
	○ European regional report on financial protection	Jonathan Cylus WHO Regional Office for Europe
	○ Measuring forgone care in the South-East Asia Region	Valeria de Oliveira Cruz WHO Regional Office for South-East Asia
	○ Assessing barriers to health services and drivers of unmet needs	Theadora Koller WHO headquarters
	○ Measuring forgone care in the context of global monitoring of financial protection	Gabriela Flores WHO headquarters
16:30–17:00	**Discussion**	Moderator: Megumi Rosenberg WHO Kobe Centre

Day 2: Tuesday, 11 June 2024

09:00–09:30	**WHO internal meeting**	WHO participants
09:30–10:45	**Session 3: Current feasibility of measuring unmet needs for health and social care by WHO region**	
	○ African Region	Fredrick Makumbi Makerere University and Benson Droti WHO Regional Office for Africa
	○ Eastern Mediterranean Region	Shereen Hussein London School of Hygiene and Tropical Medicine and Analytical Research Ltd and Samar Elfeky WHO Regional Office for the Eastern Mediterranean
	○ European Region	Nawi Ng University of Gothenburg and Jonathan Cylus WHO Regional Office for Europe
	○ South-East Asia Region	Md Mizanur Rahman Hitotsubashi University and Valeria de la Oliveira Cruz WHO Regional Office for South-East Asia
	○ Western Pacific Region	Paul Kowal The Australian National University and International Health Transitions and Ding Wang WHO Regional Office for the Western Pacific

Time	Session	Speaker
	○ Region of the Americas	Recorded presentation by Natalia Houghton Regional Office for the Americas/Pan American Health Organization
10:45–11:30	**Discussion**	Moderator: Flavia Andrade University of Illinois
11:30–13:00	Lunch	
13:00–14:30	**Session 4: Operationalizing the measurement of unmet needs for health and social care**	
	Measuring unmet care needs in the World Health Survey Plus (WHS+)	Paul Kowal on behalf of Nirmala Naidoo WHO headquarters
	Breakout sessions: operationalizing the measurement of unmet needs for health and social care	All participants
14:30–15:15	**Report back to plenary and discussion**	
15:15–15:45	Coffee break	
15:45–17:00	**Conclusions** ○ Recap of meeting outcomes ○ Research priorities for 2024–2025 biennium ○ Key dissemination platforms and strategic opportunities to influence policy	Moderator: Megumi Rosenberg WHO Kobe Centre Rapporteur: Herfina Nababan WHO Kobe Centre

Annex 2. List of participants

External participants

- Dr Flavia Andrade, Professor, University of Illinois School of Social Work, Urbana, Illinois, United States of America (Region of the Americas)
- Dr Julie Byles, Emeritus Professor, College of Health, Medicine and Wellbeing and Director of the Centre for Women's Health Research, The University of Newcastle, Newcastle, Australia (Western Pacific Region)
- Dr Shereen Hussein, Professor of Health and Social Care Policy, London School of Hygiene and Tropical Medicine and Analytical Research Ltd, London, United Kingdom of Great Britain and Northern Ireland (Eastern Mediterranean Region)
- Dr Paul Kowal, Senior Research Manager, The Australian National University and Senior Consultant, International Health Transitions, Canberra, Australia (Western Pacific Region)
- Dr Fredrick Makumbi, Associate Professor, Department of Epidemiology and Biostatistics, Makerere University School of Public Health, Kampala, Uganda (African Region)
- Dr Nawi Ng, Professor of Global Health, School of Public Health and Community Medicine, Institute of Medicine, Sahlgrenska Academy, University of Gothenburg, Gothenburg, Sweden (European Region)
- Dr Md Mizanur Rahman, Associate Professor, Hitotsubashi Institute for Advanced Study, Hitotsubashi University, Tokyo, Japan (South-East Asia Region)

WHO regional offices

- Dr Jonathan Cylus, Senior Health Economist, WHO Barcelona Office for Health Systems Financing, Barcelona, Spain, and London Hubs Coordinator, European Observatory on Health Systems and Policies, London, United Kingdom, WHO Regional Office for Europe
- Dr Benson Droti, Team Lead, Health Information Systems, Universal Health Coverage/Life Course, WHO Regional Office for Africa, Brazzaville, Congo
- Dr Samar Elfeky, Regional Adviser, Health Promotion and Social Determinants of Health, and Regional Focal Person for Health for Older People, Department of Healthier Populations, WHO Regional Office for the Eastern Mediterranean, Cairo, Egypt

- Ms Natalia Houghton, Specialist, Health Systems and Services Analysis, Monitoring and Evaluation, WHO Regional Office for the Americas/Pan American Health Organization, Washington, DC, USA
- Dr Valeria de Oliveira Cruz, Regional Adviser, Health Financing and Governance, Department of Health Systems Development, WHO Regional Office for South-East Asia, New Delhi, India
- Ms Ding Wang, Heath Economist, Health Policy and Service Design, Division of Health Systems and Services, WHO Regional Office for the Western Pacific, Manila, Philippines

WHO headquarters, Geneva, Switzerland

- Dr Gabriela Flores, Senior Health Economist, Department of Health Financing and Economics
- Ms Theadora Koller, Senior Technical Lead/Unit Head (health equity), Department of Gender, Equity, Diversity and Rights for Health

WHO headquarters, Centre for Health Development (WHO Kobe Centre), Kobe, Japan

- Dr Sarah L. Barber, Director
- Mr Loïc Garçon, Programme Officer (Management)
- Dr Megumi Rosenberg, Technical Officer
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