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Understanding patient barriers and enablers to accessing community resources: a qualitative study to inform navigation service delivery

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Abstract

Background Individuals face multifaceted barriers to accessing community resources, which can significantly impact their ability to obtain necessary support and services. This study examines barriers and enablers to access community resources among primary care patients and explores the interplay between individual- and system-level factors that influence access to resources.

Methods In this qualitative study, we conducted 32 semi-structured interviews with primary care patients who participated in a social prescribing trial that compared two navigation services: ARC (patient-centered longitudinal support) vs. Ontario-211 (free 24-hour helpline service) in two regions, Ottawa and Sudbury, in the province of Ontario, Canada. We conducted thematic data analysis with a deductive/inductive hybrid approach, employing Levesque's theoretical framework for access to health that examines the various system and individual level factors influencing access to healthcare services.

Findings At the system level, various systemic barriers encompassing broader organisational, structural, and policy-related elements influenced patients' access to community resources (outreach, availability, location, costs and accommodations for patient needs and preferences). These factors directly interacted with various patient-level factors (awareness of needs, ability to seek support, to reach resources and to pay for those, their physical and mental health, motivation, and confidence to engage in care) to determine access.

Conclusions Our findings highlight individual- and system-level barriers and enablers for accessing community resources among socially complex primary care patients with multiple unmet needs. As governments and organizations in Canada are increasingly investing in community-based services to address adverse social determinants of health (SDH), an upstream approach that reduces both systemic and individual-level barriers to access is warranted.

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Keywords Barriers, Enablers, Access, Community resources, Health needs, Social needs

Background

Social determinants of health (SDH) such as low education, low income, poor social connections, precarious housing, and unhealthy behaviours contribute 70–90% of unfavourable health outcomes [1–3]. An upstream approach to health that addresses an individual's access to needed resources is imperative to improve the overall health and well-being of individuals with unfavourable SDH [4, 5] and reduce health inequities [6]. Governments worldwide have implemented various community-based services and programs that can help address identified unmet health and social needs [7]. These resources include physical activity programs, parenting courses, smoking cessation initiatives, income supplementation and housing programs. Studies suggest that using these resources improves clinically meaningful health outcomes [8] quality of life, mental and physical well-being, self-esteem, and user satisfaction [9–11].

However, an individual's ability to access the needed resources is influenced by the interplay between various individual-level and system-level factors [12–14]. Individuals' social and intrapersonal characteristics, such as an individual's insufficient knowledge and health literacy, stigmatisation, poor mental and physical health, and accessibility issues like inadequate transportation, can impede their ability to access needed resources. Conversely, factors like social support and personal autonomy can facilitate access by enhancing an individual's capacity to engage with the community and broader organisational systems [15–19]. System-level characteristics can further influence access to services [15]. The systemic impediments include resource location, visibility and outreach, long waitlists and complex appointment mechanisms [18–21]. The provision of person-centred and holistic care can mitigate these barriers and promote equitable access [18, 20, 21].

Gaining a deeper understanding of the types and scope of these factors enables more effective assessment and provides opportunities for targeted support to help individuals overcome them. Navigators play a critical role in addressing the barriers individuals face by linking them with community-based health and social services through personalized, and often intensive support. Their tasks include identifying access barriers, co-creating care plans, offering emotional support, advocating for patients, and promoting self-efficacy [22]. Navigation programs have been shown to enhance access and utilization of resources to address SDH, reduce health inequities and improve outcomes related to chronic disease prevention, self-management, and overall health, particularly among vulnerable populations [16, 23–25].

Several frameworks for access to health care have been proposed [26], of which Levesque's Conceptual Framework of Access to Health [15], introduced in 2013, has been widely used [27]. Building on Penchansky's theory of Access [28], Levesque et al. [15] conceived access to healthcare as multidimensional, involving a dynamic interaction between the characteristics of healthcare seekers and the healthcare providers. This framework outlines five system-level dimensions - approachability, acceptability, availability and accommodation, affordability, and appropriateness, which correspond to five individual abilities of healthcare seekers: to perceive, seek, reach, pay, and engage.

These dimensions operate on a continuum of access from the early stages, which for a healthcare seeker reflect understanding one's health care needs, perceiving that care is available, and seeking that care, to later stages of access such as obtaining an appointment, paying for services, and receiving appropriate care. Access is realised only when barriers are overcome at each continuum stage. It is, therefore, essential to explore these dimensions to understand the individual's trajectory to access adequately. While Levesque's framework was initially developed and primarily used for researching healthcare access, it has more recently been applied to the study of access to community resources [29].

Studies seeking to understand barriers to needed services have primarily focused on access to healthcare services [30, 31]. Studies on access to health and social resources are usually confined to a population subgroup, such as patients with long-term neurological conditions, community seniors, or adults with chronic diseases [18, 20, 21]. There is a need for a deeper understanding of the factors that determine access among non-medically complex primary care patients who require multiple resources but face barriers in obtaining them. Our team developed Access to Resources in the Community (ARC), a social prescribing (SP) program designed to understand and address access barriers through navigation support for patients referred by primary care providers (PCP) in two regions of Ontario, Canada. In this qualitative study, we report on system and individual-level barriers and enablers to accessing community resources that patients experienced before participating in the ARC program.

Methods

We used the Consolidated criteria for Reporting Qualitative research to report this study [32].

Qualitative approach and research paradigm

We conducted this study from a constructivist perspective, employing a phenomenological epistemology that centres on the lived experiences of research participants [33]. Based on the notion that social phenomena are constructed through the communal creation of meaning about the underlying phenomena, we aimed to construct insightful accounts of the barriers and enablers impacting access to community resources, informed by the perspectives of primary care patients. We conducted an exploratory qualitative study using a deductive-inductive hybrid approach to thematic analysis [34]. We applied Levesque's access framework [15] and adapted it to examine patient experience accessing community resources.

Researcher characteristics and reflexivity

The research team maintained reflexivity throughout the data collection, data analysis, and writing process by recording self-reflection and personal biases, discussing them with peers, and challenging any established assumptions. Two senior research associates and a research assistant conducted all the interviews. Both research associates have experience in qualitative research focused on underserved populations and patient engagement. None of the interviewers were known to the respondents of this research before undertaking the study, and all the interviewers made conscious efforts not to accept potentially common assumptions at face value.

Context/setting

This analysis is based on in-depth interviews with selected patients who participated in the larger ARC-SP randomised control trial (RCT) we conducted in Ottawa and Sudbury (Ontario, Canada), which compared two types of patient navigation services offered to support patients' journey to access community resources. The two services were (i) ARC navigation services, where a lay patient navigator provided longitudinal, comprehensive, patient-centric support, and (ii) the Ontario 211 online directory and telephone helpline, which provided episodic, primarily informational support to the study participants [22]. We interviewed participants at the end of their intervention period (3 months) to understand their previous experience with accessing resources (before receiving navigation support) and their current experience, given the navigation support to which they were randomly assigned in this study. We report on the former, describing the factors that patients reported limited or enhanced their access prior to their involvement in this study.

Sampling strategy

All 326 study patients were invited to complete a post-intervention study survey three months after enrollment.

The survey included a question asking respondents to indicate their interest in participating in an in-depth interview about their experience with accessing community resources. We employed a purposeful sampling strategy at each study site to invite participants who had responded positively to that question. We aimed to maximize variation by gender, age, linguistic groups and study arm, and determined that a sample size of 15–17 participants per arm would achieve data saturation.

Data collection and processing

The study coordinator contacted selected patients who agreed to participate in the interview, explained its purpose, and obtained their informed consent. We conducted semi-structured, in-depth interviews with them using an interview guide we developed in partnership with members of a local coalition of health services planners, patient partners, PCPs, representatives from community resource centres and researchers that guided the study. The interview questions explored the patients' experiences with accessing the community resources both before and after being involved in this study. We conducted these interviews over the telephone in the respondents' preferred official language (English or French), each lasting 30–40 min and completed between February 2019 and August 2020. The research coordinator transcribed all audio-recorded interviews verbatim in the interview language and de-identified the transcripts using codes reflecting patient characteristics: region (Ottawa or Sudbury), gender, age, education level, financial situation, and preferred language. Another team member reviewed the audio recordings and transcripts for accuracy before conducting the in-depth analysis.

Data analysis

Interview responses about patients' experiences prior to their participation in ARC program were thematically analyzed with an inductive/deductive hybrid approach [34]. A coding list was developed deductively from Levesque's system-level and individual-level dimensions across the five categories: approachability/ability to perceive, acceptability/ability to seek, availability/ability to reach, affordability/ability to pay, and appropriateness/ability to engage. The description of each dimension was adapted to reflect access to community resources rather than primary care services. Two independent coders applied codes to all transcripts. Statements relating to more than one dimension or ability were attributed to both. Post deductive coding, we followed an inductive approach to allow any new themes to emerge directly from the data and reorganised the codes into categories. We further interpreted the data through an iterative process, comparing and contrasting patients' experiences within each category and connecting them with elements

of other dimensions. The data was analysed using NVivo qualitative data analysis software (version 14).

Techniques to enhance trustworthiness

Authors KS and AM analysed the data and collaborated with other research team members to validate the findings. All coders recorded memos to explain their coding rationale, describe identified barriers and enablers, and explain the interrelations between system- and individual-level factors.

Findings

Profile of interview respondents

Our sample included 32 respondents: 22 from Ottawa and 10 from Sudbury, the majority of whom were females (23), >50 years of age (21), and had not attained a university degree (21). Thirteen respondents described themselves as Francophones (language spoken at home), and fifteen considered their financial situation as poor to tight. Based on the respondents' preference, 75% of the interviews were conducted in English, and the remaining 25% in French. The most common needs for which they accessed services included mental health, healthy lifestyle, social support, and financial support.

Barriers and enablers to access

We derived ten themes across the five system-level and patient-level dimensions of accessibility.

Approachability and Ability to perceive

Resource visibility and outreach

Services are considered approachable when populations they aim to serve can identify and know how to reach them. Systemic efforts to make a service more visible to its intended user are related to transparency, outreach, and provision of information and education about the services. Our study participants from both regions frequently noted a lack of awareness about available services. They shared that neither they, their PCPs, nor their social networks were usually aware of the available resources they could access to address their health and social needs. One of the respondents alluded to this as; *"I mean I asked around but, like I asked friends if they knew somebody that could help me, but there was no one, ok nobody knows nothing."* P1 [Female, Ottawa, no university degree, poor to tight finances, 56 years]. Few respondents obtained posters and flyers from their doctor's office, but this was not universal, as PCPs were often unaware of the breadth of services available for their patients. Community service organisations often failed to promote their services within and beyond medical centres, and had minimal or no associated information, such as costs and whether resources were covered by insurance. A respondent noted, *"I think a lot more*

people could benefit from knowing what kind of resources are out there...I mean even my doctor didn't realize that there was OHIP-covered physiotherapy, and I could get a sports medicine doctor without having to pay through the roof." P2 [Female, Ottawa, no university degree, 26 years; Francophone] Older respondents also reiterated the need for clear guidance on what's available and how to reach out to them – *"...and then even the most clued in people seem to need to get some help and you don't know where to go. There isn't a list anywhere that says here, yeah the government should send us a nice booklet, when you turn 60, 65, of where to find social things and health things..."* P3 [Female, Ottawa, university degree, 78 years].

Digital literacy

When information was available online, digitally competent respondents reported a positive experience with finding the required information. Yet, others reported barriers to accessing these resources due to a lack of devices, limited computer literacy, and inadequate or nonexistent internet connectivity in their area. This digital divide was particularly pronounced among older adults, who faced additional challenges in navigating online platforms. An older respondent exemplified, *"I knew there were some [resources], I found it a little bit difficult to find some it was a little confusing getting lost in the, you know paid popups coming up when you try to search online."* P5 [Male, Ottawa, no university degree, 54 years].

Acceptability and ability to seek

Accommodations for patient needs and preferences

The ability to access health services promptly and at a quality that meets patients' needs requires specific accommodations. There must be an alignment between the services offered and the patients' expectations and preferences. Several factors shaped respondents' acceptability of services, such as their perceptions of service relevance and effectiveness, quality of care received and the extent to which they felt understood by the service providers. A few respondents could not accept resources that did not align with their life circumstances and personal preferences, such as one-on-one services over group sessions, or if the service provider did not acknowledge their evolving needs. A participant noted, *"They weren't the appropriate resources, I found it a bit long. It doesn't just address my needs, but the needs of everyone who was there. So, for 2 hours session, I found that maybe half an hour, three-quarters of an hour would have been enough, if I had had a "one-on-one". And we could discuss things... that concerned me."* P14 [Female, Ottawa, university degree, 66 years, Francophone] Another participant reported that they did not feel the resource personnel grasped their situation well *"... it would be nice if it was*

somebody that kind of understood where you were at too, it doesn't do much good to have a program run by a lot of very well-meaning young people when they don't understand what your situation is." P3 [Female, Ottawa, university degree, 78 years].

Language significantly influences access to services, particularly for linguistic minorities, who often experience systemic inequalities in accessing care in their preferred language, despite legal protections [35]. The inadequate linguistic proficiency leads to service underutilization. Our respondents noted a decline in communication when the services did not reflect cultural diversity or were not offered in both Canada's official languages (English and French). A few respondents encountered linguistic barriers, which made it difficult for them to accept and engage with resources. One respondent highlighted: *"I consider myself Francophone, and even if the city of Ottawa considers itself bilingual, there are not that many resources in French. I would say there is a gap between what politicians and people say and reality". P4 [Female, Ottawa, university degree, poor to tight finance, 33 years; francophone].*

Similarly, cultural competence and sensitivity are crucial in determining access to healthcare services, particularly among culturally diverse populations, such as those in Canada. Providers must understand and respect their patients' cultural backgrounds, which can significantly influence health outcomes and patient engagement. Services that lack cultural competency and sensitivity can jeopardize individuals' acceptance of a resource or service. A respondent noted this as, *"in terms of cultural appropriateness in terms of the activities it would be nice if there were something that reflected more multicultural interests... so like you know the Resource Center has been great but the programming that they have is sort of uni-cultural". P10 [Female, Ottawa, university degree, 78 years; francophone]* A few respondents noted that their access was limited by service hours that did not align with their schedules, competing priorities and unavailability of services on weekends or outside work hours. Yet, others appreciated the quality of care they received and highly valued the welcoming environment, knowledgeable service providers, provision of family-centred care, being followed up, and being shown empathy.

Awareness of needs and ability to seek support

Respondents' awareness of their health and social needs and decision to seek care varied, shaped by their ability to recognize needs and understand that resources were available to address them, and possessing the necessary health and digital literacy. Most of our respondents demonstrated awareness of their needs, as their PCPs had proactively engaged them in identifying needs and assessing their readiness to address them before referring

them to the ARC-SP intervention. These initial discussions with their PCPs motivated some respondents to actively seek support on their own by reaching out to their social networks and exploring online. A subset of the respondents reported difficulties in recognizing and articulating their needs coherently. For example, one respondent noted *"I'm grasping for the right words and how to communicate what I need, sometimes I don't even know what I need so I'm trying to figure that out like, and you know this is what I'm experiencing...I have to sort of figure out how to ask questions..." P11 [Male, Ottawa, university degree, poor to tight finance, 61 years].*

Availability and ability to reach

Local service (in) availability and gaps

Availability refers to the physical existence of resources and services with sufficient capacity that can be reached in a timely manner. Many respondents noted limited or a lack of appropriate services as a significant obstacle to achieving access, often reflected in long waitlists, sometimes extending for months. Some of the resources were restricted to larger cities or specific age groups, creating local service gaps and exacerbating inequities in access. A Sudbury-based respondent echoed similar concern *"In the Ottawa area there's whole clinics sort of things set up for people for adults with autism and that sort of thing, but again in Sudbury there just doesn't seem to be". P6 [Male, Sudbury, no university degree, 24 years],* even though Sudbury has a sizable population for such services to exist. Another respondent noted *"I found is that I'm not eligible to have access, either because I'm not old enough, too old, I don't live in the area, so it's really the eligibility conditions". P4 [Female, Ottawa, university degree, poor to tight finance, 33 years, francophone]* The sense of insufficiency appeared to deter some individuals from attempting to access. A homeless participant who lived out of his car noted that a prevailing sense of scarcity (feeling that there wasn't enough to go around) discouraged him from attempting to access available services. *"I need affordable housing and it is not there, so why would I call them? it is like going to the gas station to fill Fuel up and you find that there is no gas." P15 [Male, Ottawa, no university degree, poor to tight finances, 52 years, francophone]* On the contrary, in one instance, a community resource was not offered due to a lack of enough enrollments in the program.

Administrative or procedural issues

While some respondents appreciated the flexibility of accessing the resources through walk-in and online services, many reported poor appointment mechanisms as common barriers. A few respondents struggled to make the first connection with resource personnel and encountered several back-and-forth phone calls, while others

could never connect despite several contact attempts, or received inconsistent information from different staff. A newcomer mother in Ottawa expressed, *"I called several times, it rang, but no one picked up. I looked up the address in the map and found it was not far from my house. I walked there. When I got there, I rang. I heard, but no one opened the door for me."* P7 [Female, Ottawa, university degree, 41 years; Francophone] Such challenges were especially burdensome for individuals in crisis who lacked support and accompaniment from family or friends. Completing long and complicated forms and extensive paperwork was also reported as a major barrier and participants reported feeling overwhelmed, especially those with limited literacy skills, cognitive impairments or in crisis. An elderly respondent reported difficulties completing the paperwork resulting from an accident and was unaware that she could receive support for this need: *"I had a concussion, and they gave me like you know 25, 30 pages of information to fill out, and I mean I was fumbling through it."* P3 [Female, Ottawa, university degree, 78 years].

Transportation vis-à-vis ability to reach

An individual's ability to reach a resource is substantially influenced by their access to transportation. Approximately half of the study participants used personal vehicles, public transit or had family and friends drive them to appointments, demonstrating social support in improving their ability to reach. On the contrary, living alone, lacking social support, not owning a vehicle or a driving license, and having uncomfortable and confusing bus routes hindered access for some. These barriers often intersected with physical health challenges, as individuals experiencing pain or limited mobility relied on others for assistance in reaching services. Sometimes resources were located at the other end of the city or in a neighbouring community, requiring them to spend extra time in transit. The challenges were further exacerbated for those unable to allocate additional time for commuting due to competing priorities or those who were not in good physical condition to travel long distances. A female respondent echoed a similar concern as *"travel, yeah it was like, I have a friend that was bringing me to my appointments so she can't always bring me."* P8 [Female, Sudbury, university degree, poor to tight finances, 50 years].

Affordability and ability to pay

Direct, indirect and opportunity cost

Levesque's model identifies three categories of costs related to the use of healthcare services: direct costs (out-of-pocket expenses), indirect costs (like transportation expenses), and opportunity costs (including lost wages). While all Ontarians receive state-sponsored Ontario

health insurance, many community-based services are not covered, or the coverage is insufficient to meet the requirements. At the individual level, affordability was influenced by out-of-pocket service costs, respondents' financial situation, and private health insurance coverage. For instance, limited or insufficient financial means and high cost of services were deterrents to accessing therapeutic interventions such as physical activity programs for managing chronic or acute pain and injuries, particularly for those on welfare schemes, those without savings, retirees, or individuals with low income. *"...I told them I was on welfare and they said well it's still gonna cost money right so that, that wasn't an option because I don't have money."* P1 [Female, Ottawa, no university degree, poor to tight finance, 56 years] Respondents also noted that resources priced too high become unaffordable over time limiting care sustainability *"on our own, we did try private counselling it was 175 dollars an hour which is not something that we can maintain for any period of time."* P6 [Male, Sudbury, no university degree, 24 years] Only one participant reported insurance as an enabler to their access, while for several others, a lack of private health insurance rendered them ineligible for programs. *"Yeah that was the downside because the cost of it, my insurance company covered only two visits at the cost, so anything further than that would have to be out of pocket."* P9 [Male, Sudbury, no university degree, 28 years] Some respondents also reported difficulty affording transportation (fuel, parking or bus tickets) or gas required to be able to reach resources, especially with other expenses taking priority. A patient alluded *"Even bus passes are expensive right and when you're trying to catch up on your billsI can get a bus pass but even that costs right, it can also be your groceries for the week, so or food you know so I have two daughters too, so this has affected my whole family"* P8 [Female, Sudbury, university degree, poor to tight finance, 50 years].

Appropriateness and ability to engage

Motivation and confidence to address needs

Study participants showed mixed responses, with some expressing strong motivation, autonomy and capability to seek information about services, scheduling appointments and actively engage with them to reach their health goals, others demonstrated lower confidence and struggled to maintain long term commitments, often due to limited skills and support. One of the respondents expressed *"...if I'm interested in something or I want to find out something I know how to look, I know how to talk to people, I know lots of teachers, you know who can recommend things, no, I don't think that's any trouble at all."* P12 [Female, Sudbury, no university degree, 65 years] Another participant noted how initially he felt motivated to adhere to their fitness plan, but found it increasingly

difficult to comply with plans, over time. *“the problem is I just can’t, I can never, never keep it up like, I may have a couple months where I’ll go but then something will happen then I might start only going once a week, and then I might not for like two, three months and then I’ll, then it’s you know never, never consistent.”* P13 [Male, Ottawa, no university degree, poor to tight finance 54 years].

Physical and mental health

The capacity to actively make the effort to seek resources and reach them was largely a result of patients’ health status. Respondents frequently highlighted how physical limitations imposed by impaired health conditions, like poor physical health due to chronic pain, consequences of surgeries, and mobility issues, significantly hindered their ability to access and engage with community services. Others described experiencing muscle weakness, low energy, and feeling physically exhausted, which prevented them from accessing services. Yet others described struggling with anxiety and panic attacks, interfering with their ability to seek help and reach resources. *“I’m, I’m struggling with an addiction to alcohol, I also have a lot of pain, like I got an arthritic back so I am, I’m constantly in pain, I can’t really move, I have to either be lying down or, or you know even sometimes sitting is too much.”* P11 [Male, Ottawa, university degree, poor to tight finance, 61 years].

Overall, participants’ awareness of their own needs, along with their motivation, confidence, and overall physical and mental health, were personal attributes that significantly affected their ability to access. Only a few patients who received support addressing both systemic barriers and their own internal challenges felt empowered to access the resources they needed and effectively manage their health.

Discussion

This study elucidated structural and individual-level barriers and enablers that primary care patients in Ontario experience when accessing non-clinical health and social resources in their communities. Patients’ knowledge about available services and their experiences in accessing community resources were influenced by several factors, including the system’s transparency, information dissemination and outreach efforts, resource availability within patients’ geographic region in a timely manner, and accessibility through flexible appointment mechanisms. Patients’ ability to pay for a resource was influenced by the high cost of services, their household income, and insurance coverage. These findings compared positively with previous studies that identified similar service-level access barriers, including lack of adequate information [19, 36–47], low availability [20, 48, 49] or lack of resources [19, 36–38, 41, 46, 49, 50],

technological limitations [19, 36, 38], long waitlist [7], [38], [36–38] [43, 46, 47, 49–51], and high cost of services [19, 36–38, 41, 44, 50, 51]. Other structural barriers, like poor transportation, lack of internet access, and gaps in insurance coverage, exacerbate inequitable access to care [19, 36, 38, 39, 41, 42, 45, 52].

Improving individual access barriers requires an upstream approach. Community-based organizations should be accessible to patients and PCPs, and they need to provide comprehensive and up-to-date information about their services, including location, hours of operation, eligibility criteria, appointment processes, and associated fees. Digital presence is also sought to enhance approachability and increase people’s awareness of the resources. Community outreach activities can lead to increased access, improved awareness and knowledge [53].

Our findings suggest that patients experienced several extrinsic (objective) and intrinsic (intra-personal) individual-level barriers that interacted with the systemic factors and impeded their ability to access community services. For example, both transportation and mobility determine the ability to reach; the availability of public transportation is system-linked and often lies beyond the control of individuals and typically requires systemic support, while mobility reflects unique limitations experienced by an individual. Consistent with previous studies, patient’s financial and working status [39, 42, 43, 46, 49] digital [47, 49] and literacy skills, social support [41, 45, 47, 49], and time constraints [37, 38, 42, 45, 46, 51, 52] inevitably affected their abilities to be aware of their own needs and the ability to seek and reach relevant resources. Referral routes to community services are often complex and difficult to navigate, especially for users who are socioeconomically vulnerable, linguistically and culturally diverse, newcomers, or those with limited ability to recognise their needs and seek support. Our study respondents underscored the value of aligning service delivery with patients’ preferences, personal schedules and choice of official language. Provision of patient-centered care, extending into culturally sensitive care, has been associated with positive outcomes such as patient satisfaction and treatment adherence [54, 55].

An individual’s ability to engage in care is strongly determined by their capacity and motivation to participate in care and commit to completion [15]. Patients’ motivation and self-efficacy point to intrinsic strengths of individuals to achieve access to services, yet these intrapersonal factors can also be influenced by external factors [56], such as access to information, service quality [19, 38, 41–43, 45, 50], patient’s trust [19, 37–39, 41, 42, 44–46] and prior experience with services [19, 42–44, 46], as observed in our study. Improving access to services can be achieved by increasing their visibility

through a strong online presence or by advertising in locations frequently visited by potential users, such as primary care clinics. Additionally, providing clear and user-friendly step-by-step help-seeking guidelines that explain the process of connecting with services may further support individuals in accessing the help they need. Patients need skills and tools to identify their needs and how to address them independently (e.g. ARC comprehensive assessment tools) [22]. Providing navigation services can help patients develop the required skillset to navigate the system better, improve communication, reduce barriers and effectively engage with care providers to meet their unique needs and situations [57]. Patient navigators conduct motivational interviewing to understand patient barriers and use person-centred, culturally sensitive and collaborative approaches to provide contextualised support to enhance patients' abilities and connect them to appropriate services. Such programs have been shown to be effective in linking primary care patients to social care, improving patient experience with quality of care and service utilisation, and equitable access to community-based care [19, 23, 58].

Strengths and limitations

While most of the literature surrounding barriers to accessing community resources [19, 41, 48, 49, 59] focus on specific subgroups of populations such as patients with long-term neurological conditions [20] or street-involved youth in Canada [48] among other subgroups [41, 59–61] this study uniquely contributes by embedding an evaluation of systemic and individual-level factors that influence access among non-medically complex primary care patients within a theoretical framework. Using Leveque's [15] framework, we systematically examined the barriers and enablers in a cohort of respondents who were pre-identified as having multiple unmet health and social needs. This theoretical lens not only clarified the multifaceted nature of access but also illuminated how individual-level abilities interact with broader system-level dimensions, for instance, how limited approachability of services can compound individuals' difficulties in seeking care. To our knowledge, Levesque's framework has not previously been applied to explore access challenges in socially prescribed individuals [27] for needs that, in theory, could be met by existing community-based services. By employing this framework in the context of our study, we generate new insights into access dynamics that can inform more targeted interventions. For example, at the individual level, enhancing access may require greater use of navigation or link worker services. In contrast, at the system level, interventions such as government programs, targeted funding, and structural reforms may be necessary to address broader barriers.

Notably, our data collection overlapped with the early phase of the COVID-19 pandemic, when virtual care was starting to emerge. While some participants used online tools to find information and resources, none mentioned using virtual care, and it's unclear whether those options were available to them at the time. Although not the intent of phenomenological epistemology studies, we recognise that the purposive sampling from two Ontario regions used here does limit the generalizability of our findings to another context. As such, it is essential to broaden this qualitative study to gather diverse patient perspectives on the barriers they face, as well as their insights on how to better support their needs and improve access to resources. The characteristics of patients interviewed for this study may not adequately reflect the diverse and multicultural experiences of other patients in Ontario.

Conclusions

Our study highlights key systemic and individual-level challenges that hinder equitable access to community-based resources. Governments worldwide are increasingly investing in community-based services to address the undesired SDH. Our findings demonstrate that individuals requiring such services face important barriers in accessing them and underscore the need to combine these investments with upstream and downstream initiatives that address these barriers. Such efforts could include patient-centred programs such as navigation services that provide tailored logistical, informational and emotional support to enhance the individual's ability to access services, as well as efforts to reduce systemic barriers which impede the individual's ability to access the required services. The latter includes adopting simplified and standardised enrolment mechanisms to reduce the burden of accessing the service, enhancing outreach of the available services to improve their visibility, and reducing enrolment fees or mechanisms for subsidising these.

Abbreviations

| | |
|-----|--------------------------------------|
| PCP | Primary care provider |
| SP | Social prescribing |
| ARC | Access to resources in the community |
| SDH | Social determinants of health |

Supplementary Information

The online version contains supplementary material available at <https://doi.org/10.1186/s12875-025-03029-z>.

Supplementary Material 1.

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Authors' contributions

SD is the study's principal researcher and is leading the research project. SD, AG, FD, ML, and PT developed the initial grant proposal. PT was involved in data collection and initial coding. KS and AM analysed the data and drafted the manuscript. All authors collectively contributed to manuscript editing and approved the final manuscript.

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Data availability

The datasets analyzed during the current study are available from the corresponding author upon reasonable request.

Declarations

Ethics approval and consent to participate

This study received approval from the OHSN Research Ethics Board (#20180056-01 H), Bruyère Continuing Care Research Ethics Board (#M16-18-013), Hôpital Montfort Research Ethics Board (#18-19-04-002), University of Ottawa Research Ethics Board (#H-06-18-830), Laurentian University Research Ethics Board (#6013930) and Ontario Tech University Research Ethics Board (#14735). This study involved human participants and was carried out in full compliance with the ethical principles of the Declaration of Helsinki, which provides guidelines to safeguard the rights, safety, and well-being of individuals involved in research. All participants gave verbal informed consent to participate and to have their interviews recorded.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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