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Barriers and Enablers to Primary Care Access for Equity-Deserving Populations in Ontario

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Introduction

Primary Care Access in Ontario

- Inequities in access and quality of care
    - *Including for newcomers, refugees, those living in the poorest and racialized neighborhoods and 2SLGBTQ+ communities*

- Critical time for primary care in Ontario
    - Need to centre community voices to inform action

Study Objectives

This research aimed to address gaps in literature:

- Learn directly from **community voices**: lived experiences and people working on the frontlines of primary care.
- Target **equity-deserving communities** with unique barriers.
- Apply an **intersectional lens**.
- Focus on **community-informed solutions**.

Research Methods

Research Questions

From the community perspective:

- What **barriers** do economically marginalized, racialized and 2SLGBTQ+ populations experience when accessing primary care in Ontario?
- What **solutions** can be implemented at the community and health system-levels to facilitate improved access for these populations?

Data Collection

Phase 1: Key informant interviews

- N=17
- Social workers, intake workers, system navigators, healthcare promoters, dietitians, outreach workers, community nurses and others

Phase 2: Focus groups

- N=35
- East Asian (n=7), South Asian (n=6), Southeast Asian (n=4), Black (n=9), 2SLGBTQ+ (n=4), trans and non-binary (n=6)

Research Findings

> *I have about two or three challenges. Number one is* ***limited availability.*** *You know, most of the primary care providers have limited appointment slots, which has made it difficult for me with to schedule visits. And I also have* ***financial barriers,*** *these primary care services are unaffordable for all the low-cost people. Complexity of the system is also my major challenge, especially for myself, I am* ***unfamiliar with the process*** *involved in finding accessing care, so this is very difficult for me.*
>
> — Black focus group participant

Multiple, Intersecting Barriers

- **Language barriers**
- **Appointment logistics**
- **Making sense of the system**
- **Socioeconomic barriers**
- **Discrimination**

Solutions

Community-based models

Multidisciplinary teams

Cultural safety

Education and training

Solutions: Community-based models

- Culturally adaptive and safe services rooted in communities
- Strong support networks and connections
- Trusted spaces that integrate social supports

> *They are a space for folks if you have a history of like addiction or substance use. And they* ***have a program for queer youth and connections with [the local] community health centre****, so they were actually able to really quickly set me up with a registered nurse practitioner. I walked across the street to give them a form at the community health centre, and then within a week,* ***I got connected****. So that was great, because before that I was doing walk-in clinics.*
>
> — Southeast Asian focus group participant

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Findings

Solutions: Multidisciplinary team

- Primary care practitioners collaborate with diverse healthcare professions to provide holistic care.
- Teams could be particularly beneficial in settings where there are gaps in gender-affirming, trauma-informed practices.

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Mental health, poverty, substance use, unemployment, all of that…We [see] the substance use, the lack of access to resources, and those things contribute to how and when and if people are able to access primary care. And it creates barriers for…[providing care to] vulnerable people, ***because they are medically and socially complex, and so those are things that some providers feel they're not equipped to take on if they're not in a team-based environment*** *where they have access to social work and other allied services. They may say, 'Well, no, you're too complex for me to take on.*

— Key informant, leadership in community health centre

Solutions: Cultural safety

- Value diverse range of worldviews.
- Actively address all forms of discrimination.
- Expand translation and interpretation supports.

I’m constantly trying to look for people who work from an ***anti-racist framework,*** *people who are able to provide an understanding of* ***diverse worldviews.*** *And not just provide the treatment to reduce the distress related to the illness, but also to* ***help people to thrive or to enhance their health.*** *Because oftentimes the focus when it comes to people from racialized backgrounds is, ‘Okay, let’s give them a medication and be done’…but the issue is also about the kind of* ***quality interaction where the patient feels heard and supported.***

— Key informant, community programs director

Findings

Solutions: Education and training

- Anti-racism, trauma-informed, and equity-focused training
- Helps providers understand and address systemic barriers

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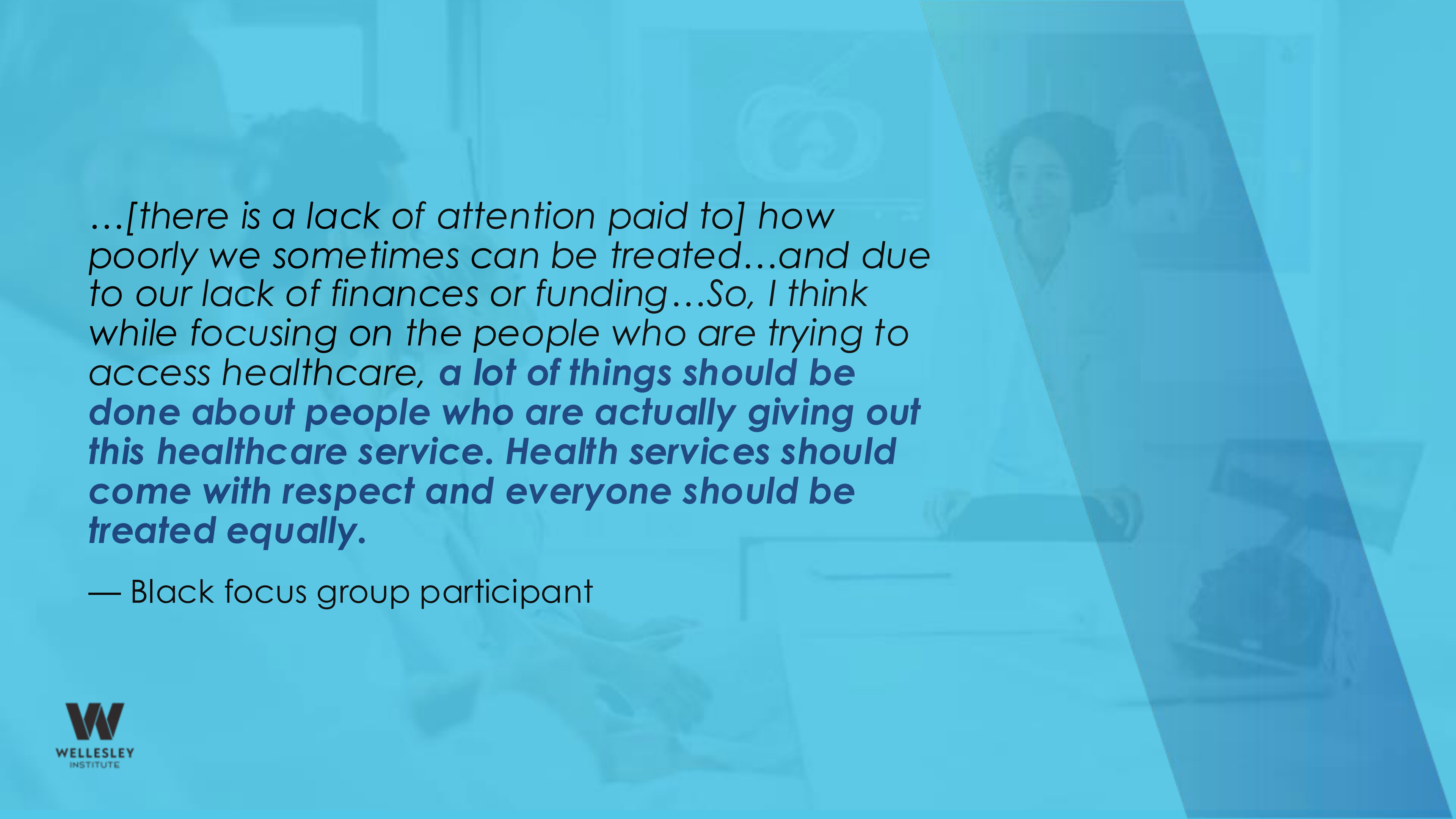

> *…[there is a lack of attention paid to] how poorly we sometimes can be treated…and due to our lack of finances or funding…So, I think while focusing on the people who are trying to access healthcare,* ***a lot of things should be done about people who are actually giving out this healthcare service. Health services should come with respect and everyone should be treated equally.***

— Black focus group participant

Key Messages

- **Primary care access is inequitable for many,** especially economically marginalized, racialized and 2SLGBTQ+ communities.
- **Barriers are complex and intersecting,** including language, safety, systemic navigation and employment-related issues.
- **Solutions must be community-informed**, culturally safe and address social determinants of health.
- **Collaboration is key across sectors,** disciplines and with the communities most impacted.
- **Policy and practice must align with lived realities** to build a more equitable healthcare system.

Policy Recommendations

Ontario's Primary Care Action Plan

- Mandate for **100% attachment**.
- Investment of $1.8 billion to connect two million Ontarians to primary care by 2029.
- To date, Ontario has:
  - Passed the *Primary Care Act*.
  - Funded **130** new and expanded primary care teams (June 2025).
  - Opened second round of proposals for **75** primary care teams (September 2025).

Our Recommendations

1. Build **new** primary care teams.
2. Prioritize areas where **the need is greatest**.
3. Commit to **equity-oriented models**.
4. Conduct **health equity impact assessments**.
5. Address and **reduce travel barriers**.
6. Set the standard with **innovative approaches** to care.

Research Outcomes

Outcomes

JUNE 2025

Primary care and the lived experiences of equity-deserving Ontarians: A research summary

Overview

Policy brief: Barriers and enablers to primary care access for equity-deserving populations in Ontario

JUNE 2025

A qualitative study of the barriers and enablers to primary care access for equity-deserving populations in Ontario

MARCH 2025

- Research report
- Policy recommendations
- Plain language summary
- Report back to community

Next steps:

- Ongoing knowledge dissemination
- New research on community-engaged models of care

Thank you.

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Scan the QR code to learn more about our project.

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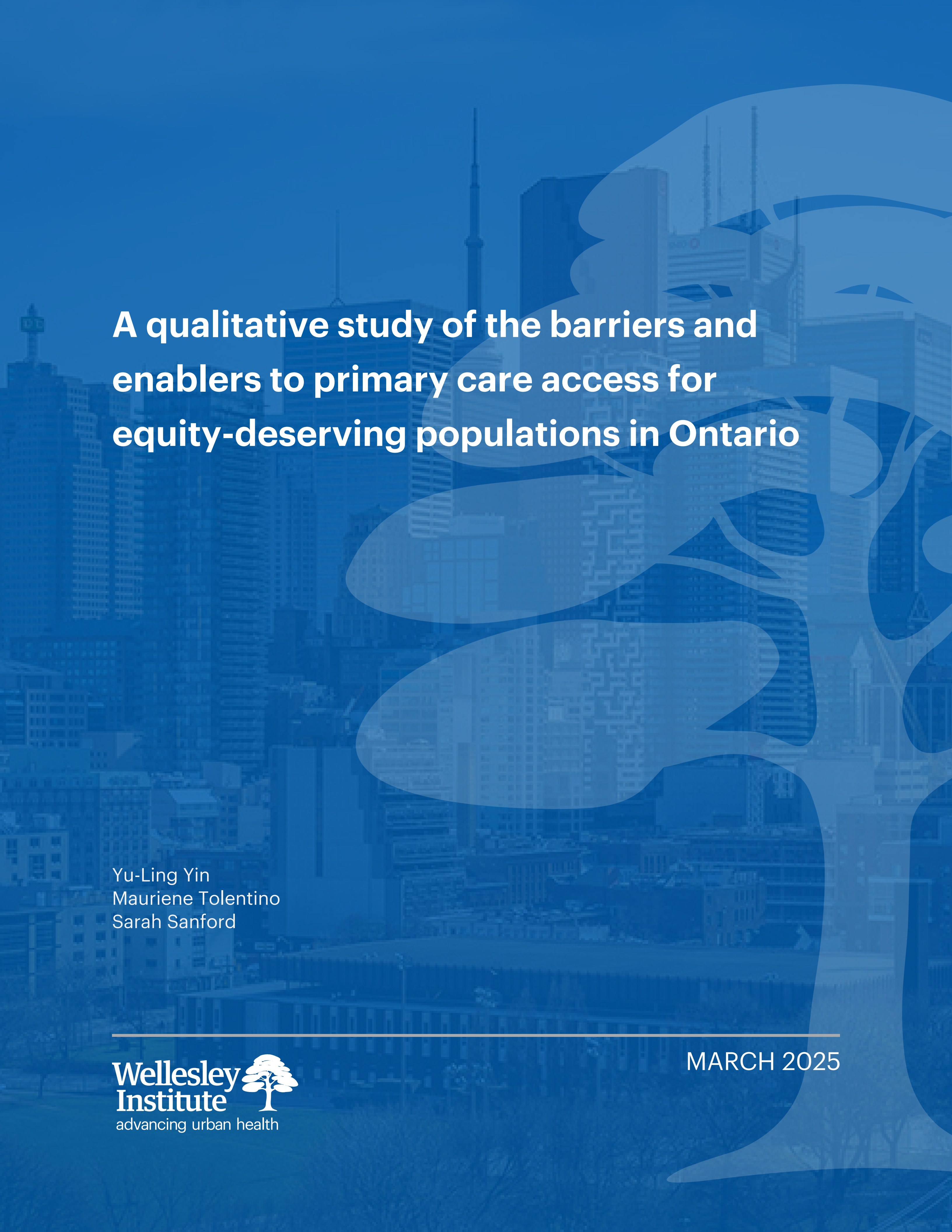

A qualitative study of the barriers and enablers to primary care access for equity-deserving populations in Ontario

Yu-Ling Yin
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Wellesley Institute
advancing urban health

MARCH 2025

Wellesley Institute advances population health and reduces health inequities by driving change on the social determinants of health through applied research, effective policy solutions, knowledge mobilization and innovation.

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Acknowledgement of Traditional Land

We wish to acknowledge this land on which Wellesley Institute operates. For thousands of years, it has been the traditional land of the Huron-Wendat, the Seneca and the Mississaugas of the Credit. Today, this meeting place is still the home to many Indigenous people from across Turtle Island and we are grateful to have the opportunity to work on this land.

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Contents

Background

“…some populations face considerable barriers to accessing primary care.”

Primary care is a foundational part of the healthcare system and a key entry-point into other parts of the system for patients. Primary care services are delivered in community settings by providers of diverse practices, supporting a range of needs, including prevention, chronic disease and prenatal care[1]. In Ontario, 2.5 million people do not have a family doctor[2], and inequities exist for newcomers, refugees and those living in the poorest neighbourhoods, with the most racialized residents[3,4]. These disparities indicate that some populations face considerable barriers to accessing primary care.

Access to primary care is about more than basic attachment to healthcare providers or the supply and utilization of services[5]. Equity-deserving populations in particular may face barriers to access or poor quality of care, in addition to inequities in health outcomes[6]. For these groups, healthcare access is determined by numerous factors, including location and availability of services, the attitudes and skills of providers, past healthcare experiences and perceived quality of care. This conceptualization accounts for patient experiences, in addition to health system determinants, in defining healthcare access[7,8].

In previous work, Wellesley Institute reviewed research on barriers and facilitators to primary care for equity-deserving populations in Ontario to better understand how to improve access[9]. Those results indicated that common barriers faced by communities include culture (e.g., language, provider bias), discrimination and stigma, direct and indirect cost to the patient (e.g., uninsured services), appointment logistics (e.g., wait time and scheduling flexibility) and practice characteristics (e.g., care delivery models). These factors prevent equitable access to appropriate primary healthcare.

The lived experiences of equity-deserving populations accessing primary care is under-represented in the research.

Past research has offered some important insights into barriers that lead to inequitable access to primary care and potential facilitators to access in Ontario. However, there are critical gaps that remain. The lived experiences of communities are under-represented in the research, most notably for racialized and 2SLGBTQ+ communities, and the representation that does exist focuses primarily on challenges rather than the identification of solutions. Moreover, there is a marked lack of research on intersectionality and how access to primary care is impacted by socioeconomic status, racialization and 2SLGBTQ+ identity.

To address gaps identified in the literature, this qualitative study was designed to provide insight into how socioeconomic status, racial identity, sexual orientation and gender identity may intersect and influence experiences accessing primary care.Two main questions guided the research:

1) What barriers do economically marginalized, racialized and 2SLGBTQ+ populations experience accessing primary care in Ontario?

2) What can be done at the organizational and health system levels to facilitate improved access for these populations?

Methods

This qualitative research builds on Wellesley Institute's previous review of the literature by incorporating an intersectional lens and gathering perspectives from people with lived experiences and providers working directly with these communities[9]. It focused on barriers, as well as system-level and community-based solutions to facilitate access to primary care. Data was collected through interviews and focus group sessions with equity-deserving communities and key informants from the health and social service sectors. Data collection took place from September to December 2024.

Key informant interviews

Key informant interviews (n=17) were conducted with healthcare, community-based and social service providers working directly with communities in the provision of primary care or connecting community members with primary care. Key informants were recruited through diverse local community organizations, community health centres (CHCs), and other social service organizations in Ontario via publicly available email addresses, telephone numbers and referrals by other participants. Participants were included as key informants if they worked with equity-deserving communities in health and social service capacities and supported clients with access to primary care. An interview guide was developed by researchers YY, MT and SS, which aimed to build on the findings from Wellesley's scoping review on key barriers to primary care access[9]. The interviews were conducted virtually and participants were asked about their professional backgrounds, insights into barriers to primary care for the populations they serve, and potential solutions to improve access.

Focus groups

Focus group participants were recruited with support from community organizations, CHCs, and key informants from the current study who shared information about the research on listservs, social media and within networks.

Participants were included if they self-identified as: living in Ontario, being 18 years of age or older, belonging to at least one of the target equity-deserving groups (East Asian, Southeast Asian, South Asian, Black and 2SLBTQ+), being economically marginalized[1], and having experienced barriers to accessing primary care.

Ten focus groups were held with (n=35) adult participants from equity-deserving groups across Ontario via Zoom[*].

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[*] Although many participants had intersectional identities, they were asked to identify their preference for one specific focus group. Due to the recruitment response and participant availability, more than one focus group was held for most population groups: Black [2], South Asian [2], East Asian [2], trans and non-binary [2], Southeast Asian [1] and 2SLGBTQ+ [1].

The goal of the focus groups was to build on the findings from the literature and key informant interviews, and to gather solutions directly from those who are often excluded from the policymaking process. A preliminary analysis of key informant data identified key themes related to barriers to accessing primary care and corresponding solutions, which informed the development of the focus group facilitation guide. In the first part of the focus group, participants were asked questions about their past experiences and challenges in accessing primary care. This was followed by a discussion on potential solutions, including the resources, services and programs needed to respond to their needs.

Data analysis

All of the interviews and focus groups were recorded and transcribed verbatim using Otter.ai. Data was analyzed using thematic analysis techniques[10,11] and NVivo 15 software program for data management. The analysis involved an inductive approach where emerging codes were generated directly from the data.

Transcripts from interviews and focus groups were first coded into general categories using a coding matrix developed from the literature. As analysis progressed, codes were collated into broader themes, which were organized and refined with ongoing engagement with the data. Project team discussions occurred regularly throughout the analysis to corroborate interpretations, identify themes and patterns that represent commonalities and differences in participant experiences and perspectives, and reflect on points of divergence across the data.

Emerging themes from the key informant interviews were used to inform the data collection tools for the focus groups, and these themes were subsequently developed further using focus group data. In this way, a comparative approach was employed to iteratively analyze data collected from both participant groups[12].

Quotes from the data are used to illustrate the main themes reported in the results.

Ethics approval for the research was granted by the Toronto Metropolitan University Research Ethics Board in September 2024 (REB #2024-287).

Results

Sample description

Key informant participants

A total of 17 key informants were interviewed, representing diverse roles, organizations and regions in Ontario. Participants came from healthcare and social service settings, including clinical roles (clinician, nurse practitioners, midwife), health administration (system navigators, program coordinators, public health coordinators), social services (social workers, case managers, settlement workers), and one researcher. Some held leadership roles in community-based organizations, and several identified as community advocates in addition to their primary roles. Key informants worked across CHCs, clinics, settlement organizations and community-based organizations that work with specific populations (e.g., East Asian, 2SLGBTQ+).

While some key informants worked with clients or patients across Ontario (n=3), the majority were in the Greater Toronto Hamilton Area (GTHA) (n=10), and others were based in Southwestern Ontario (n=3), Eastern Ontario (n=2) and Northern Ontario (n=1). All key informants worked with low-income communities and some engaged with specific racialized communities, 2SLGBTQ+ populations, and migrants and newcomers.

Focus group participants

The study included 35 focus group participants and all responded to an anonymous sociodemographic survey[**]. The majority of participants resided in the GTHA (22), followed by Eastern Ontario (7), Southwestern Ontario (6) and Northern Ontario (1).

Participants identified as women (18), men (9), trans women (5), gender non-binary (4) and trans men (1). In the category of sexual orientation, participants identified as heterosexual (15), bisexual (14), queer (4), gay (2) and lesbian (1). Most identified as Black (16), and others as East Asian (10), South Asian/Indo-Caribbean (6), Southeast Asian (4) and White (1). English (26) was the most preferred language when accessing primary care, while others preferred Simplified Chinese (6) or Traditional Chinese (4).

Participants accessed primary care through walk-in clinics (18), CHCs (17), family doctors (15), specialized clinics (9), telehealth/virtual care (5) and student clinics (4), with varying frequency of visits. Participants reported having OHIP (22), private insurance (4),

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[**] Participants were able to choose more than one answer that applied to them for most of the sociodemographic questions. As such, some participants identified as more than one category (e.g. race, employment status, insurance status). This sample description reports only the counts where participants responded. Some questions had missing responses, which are noted in the table in the Appendix.

student insurance (4) or no insurance (7). Most participants reported living with a low income. Appendix A provides a full description of the sociodemographic survey results.

Challenges accessing primary care for equity-deserving patients

The thematic analysis yielded valuable insights on the barriers to primary care, and solutions to improving access and quality of care for equity deserving groups in Ontario.

The following findings focus first on barriers primarily from the perspectives of focus group (FG) participants and based on their experiences accessing primary care. The second section explores solutions, identified by both key informant (KI) and FG participants, to improve primary care access for equity deserving groups directly, and by improving the quality of care so that attachment to providers is sustained.

Challenges navigating the primary care system

Appointment logistics

Focus group participants detailed their ongoing experiences of logistical challenges trying to access an over-burdened primary care system with not enough healthcare providers. Many shared that they were not attached to one primary care provider or team, and those who were explained it had taken months or years to find a provider.

Participants who experienced a lack of primary care options described relying on alternatives such as walk-in clinics, emergency departments or school clinics. However, long wait times for walk-ins or emergency services were a concern.

Due to wait times, participants described having to dedicate several hours or even a full day to an appointment in primary care. Many expressed that a lack of structure or transparency around appointment booking, in addition to the ‘bottlenecks’ due to multiple steps in the process (e.g., picking up medications after waiting to see a doctor), required a level of flexibility that was very challenging for them to meet,

> *There are long waits [at the walk-in clinics]. So, I find myself going like an hour early before the working unit actually opens, and I will still meet a queue there, and it takes long so I spend half of the day there just to see a doctor. And then, if you are not fortunate, you may have to go and come back because you have been referred to do some random tests, right? So there are lots of bottlenecks in the process, even when you go to run the test, [or something] as simple as prescriptions, sometimes we are giving four or five hours just to pick up prescriptions.* (FG07, Black focus group participant)

Many participants also reported long travel times, partly because of shortages of primary care options where they live. Transportation to appointments can be a challenge since participants have added factors to think about, such as cost, lack of transportation options, time dedicated to commutes, and other responsibilities such as work or childcare. Participants also described rigid policies on being late for or missing appointments that were not responsive to their social or economic conditions.

Related to logistical challenges, participants raised other issues such as limited or inflexible options to communicate with their providers, and feeling dismissed, rushed or unable to adequately discuss their health concerns. Because of these negative interactions with providers, some participants shared that the effort of seeking care when sick may not be worth their time and energy.

Language barriers

Several focus group participants identified language barriers as a challenge in primary care, particularly for racialized immigrants and newcomers whose native or preferred language is not English. Some participants with language barriers expressed difficulty in communicating their health needs to primary care providers, which impacted their confidence or delayed access to care.

Where formal language support was unavailable, participants reported instances where they relied on informal solutions, such as translation apps or assistance from friends and family. One participant recounted a situation where a miscommunication occurred during a medical appointment without proper translation support,

> *I think an interpreter is very important. For the lady, my friend, she has a cell phone that's a translator [app] that actually doesn't work. There's some mistakes. She said, 'Thank you. Thank you doctor to take care of me' in Chinese. Then she used the cell phone to translate. Then she said, 'Oh, I see the doctor's face changed. Why?' She doesn't know. Then she checked back to the translation that she wanted to say, "Thank you", but the cell phone translated it into 'Shame on you'.* (FG33, East Asian focus group participant)

When translation support is not provided, participants report that providers often put the responsibility on patients, which does not always go smoothly.

Key informants in health and social service settings discussed language as a substantial challenge for equity-deserving groups who represent large, non-English linguistic communities in Ontario. Many also noted insufficient language supports (translation and interpretation services) across various healthcare settings (including in sole provider offices and walk-ins),

> *There is a limited choice [that patients have] when they are looking at primary care, when they have to find people who speak the same language as them. I know some of them managed to find somebody to translate for them, but it does not always happen, as it is not very easy to find a translator.* (KI06, Community intake worker)

Participants raised that a lack of healthcare providers who speak languages other than English is a recurring issue, and when patients find providers who speak their language, appointment availability is often limited. A few also noted that some of their clients have been refused services due to language barriers. They emphasized that these challenges are compounded by difficulties navigating the healthcare system and accessing resources and information, much of which is only available in English or French.

Making sense of the health system

In addition to barriers to finding family doctors and appointment logistics, many participants shared their general confusion about the primary care system in Ontario. Many noted a lack of accessible information and struggled to access basic information on how to obtain a family doctor or get referrals to specialists without one.

While challenges with navigating the primary care system was shared across focus groups, newcomer participants noted having difficulties getting accustomed to Canada's healthcare system. They described important divergences from their home countries, such as different insurance systems or organization of care models.

In addition to trying to better understand how the healthcare system works, several participants described the many competing priorities they faced after arriving in Canada,

> *I had a lot of trouble getting my health card. And I thought that after getting the health card, life would be easy, but it was not because the (responsibility is on) the person or the family to (find their own) family doctor by themselves. Because we are new here, we had to do a lot of things to survive, (find a) better house, a job, the education if the children are in schools and lots of things. So, I think it's the responsibility of the government; while making the health card, they should appoint the family doctor at that time.* (FG12, South Asian focus group participant)

Participants detailed layered challenges related to making sense of the primary care system, including tasks such as applying for insurance and managing their documents, transferring their medical records across countries, provinces or health facilities, and identifying the right place to go for different types of paperwork requirements. One participant, who was an international student, described their confusion about differences between OHIP versus the University Health Insurance Plan (UHIP),

> *I think one of the biggest difficulties that I face is understanding the difference between the healthcare system…we have insurance that is provided by school… but the thing is, before I even apply to OHIP, I need to have a local ID or something like that. So I have to then do paperwork and all that. And I feel sick around August, September time… So how am I supposed to process all those like documents. I need to go to those office and give them those paper when I was sick, so there was no way to do it. So I need to wait, at least I get my identification that everything sort out, and then I can get my UHIP and OHIP and all that. And… I don't even need to get to a doctor anymore.* (FG28, East Asian focus group participant)

As a result of these challenges, participants reported experiencing delays in care, feeling stressed because they did not receive timely treatment, and uncertainty around their health and well-being.

Participant narratives suggest that intersecting barriers and challenges can negatively affect patient experiences and impact access to primary care for equity-deserving patients. Some participants shared examples of how barriers can be detrimental or even prevent access to life-saving preventions and treatments. One participant described a situation in which their friend had not received the recommended preventive cancer screening because she did not have a family doctor and faced major barriers (including language) to navigating the healthcare system,

> *She doesn't speak English. She has no family doctor, and she goes to a hospital very close to her home…So she went there then, because she doesn't have a family doctor, but of course, she has no appointment, she could not see the doctor.…Then she went to [a different] hospital…[waited] for nine hours. The nurse, they just tell her, 'Oh, there's no cancer. You go home.' Then she went home and after more blood came out, she called me then I said, 'We go to the emergency'…So they received us at the emergency…Then the whole day she has the tests…a few days after that she got a phone call…sadly, she has cancer. It is already stage three… So this is the result, no family doctor, no English, nobody.* (FG33, East Asian focus group participant)

Difficulty navigating the primary care system to get necessary health services, in combination with logistical issues (e.g., long wait times or a lack of health clinics) and lack of language supports, can greatly impact experiences and create barriers for equity deserving groups accessing necessary primary care services in Ontario.

Social and economic barriers

Many focus group participants identified socioeconomic barriers as a major challenge they faced. They explained that it was difficult to find a healthcare provider who understood how social and economic factors impacted their experiences accessing primary care and how they might limit access to certain items related to their health (e.g., medications, items for managing health conditions),

> *For me, the main barriers for getting a family doctor, or, sorry, a nurse practitioner…is getting someone who's sensitive to your background and financial constraints. Because if you don't have a stable income, it's very difficult to access certain things, and that can just make things worse in your life…I want to get on specific meds, but, it's very expensive, and I don't have insurance, and I'm unemployed. So it's a double financial burden. So it's quite difficult to deal with that.* (FG24, 2SLGBTQ+ focus group participant)

For participants with public insurance (OHIP), costs associated with accessing primary care include medication not publicly covered, getting medical forms filled out, and fees for missing appointments. Participants described how these fees can add up to create financial barriers for patients, especially for people with multiple health conditions or those who require frequent access to the healthcare system. Several participants reported paying several thousand dollars a year out of pocket for health-related costs.

Participants also discussed facing social and economic barriers that, combined, can prohibit them from dedicating a whole day to attend a doctor's appointment, such as time and cost for travel, and caregiving responsibilities,

> *One of the barriers is distance between my house to the hospital. Most of the time I need to have for the transportation. And also the child care barrier, so if I want to visit the hospital, give me paying child care for my daughter…I have difficulties in booking appointments. Most of the time I get to book appointment, and maybe because of one thing or the other, the appointment is being cancelled and due to a lack of finances.* (FG16, Black focus group participant)

Participants who were uninsured or waiting for health insurance explained that they face additional financial barriers simply because they pay out-of-pocket for primary care. They described struggling to manage daily expenses, being unable to afford necessary care for themselves or their family members, and avoiding care altogether because of other competing priorities, such as having to buy groceries or provide care to others.

Participants explained how social and economic factors that may feel sensitive to share with primary care providers, such as gender and immigration status, can impact whether a person chooses to access care. A lack of sensitivity to these factors among health providers, or in the response of primary care organizations, was described as a barrier to patient-provider trust,

> *At some point there are people that are afraid to go to primary care…because maybe they're afraid that they might not have a professional doctor, one who can't handle their situation…and sometimes they don't even trust the doctors to disclose exactly what is affecting them. So, keeping secret is one of the major things a professional doctor working in primary healthcare should learn. Should learn how to release the proper information. There are some people that you can disclose information to, and they will use the information to judge you or maybe use it against you. Yeah, they should learn how to, how to be emotional and sympathize with people.* (FG14, Black focus group participant)

In some cases, participants described their experiences of a lack of understanding from health providers in response to diverse social and economic situations as deterring them from accessing primary care altogether.

Stigma, misgendering, discrimination and lack of safety

Most participants discussed experiencing different forms of stigma and discrimination, particularly misgendering and racism, when accessing primary care and in interactions with providers. Many attributed these negative experiences to their social and economic conditions and identities, leaving them feeling bullied, judged, unheard and shamed,

> *I worked with a nurse for a long time who, when I asked questions, would opt to say that she just doesn't know and she also did not offer me medication, like an insulin that would actually work better for my body, because I was uninsured at the time, and so I couldn't afford it. So she's like, '[You] can't afford it, so I didn't give it to you.' And that was a gutted feeling, because there was an idea of shame…so there was a lot of internalization of 'I'm not taking care of myself well enough, or I'm not doing enough of the right things.* (FG25, Trans and non-binary focus group participant)

Several queer, trans and non-binary participants recounted instances where their gender was questioned or not affirmed in healthcare encounters and sometimes in their medical files. Participants reported that in such instances, they often have to self-advocate and educate providers about things like the use of correct gender and pronouns,

> *There was a case where my gender was misinterpreted, because prior to when I came out, I didn't change or update my information in the healthcare system. So, when I went there for a healthcare checkup recently, my gender was missing. And, you know, they kind of had a hard time understanding what I meant when I said I was trans and I'm bi right now…So I think because of how I identified, it actually slowed down the process or the progress of them attending to me.* (FG22, Trans and non-binary focus group participant)

In addition to impacting their level of trust with providers, this example demonstrates how having to educate providers in appointments can take work and even delay care.

Participants also recounted racism in their interactions with health providers and some detailed being frequently dismissed or ignored in encounters,

> *So, there's anti-Blackness and there's transphobia. I would arrive at a meeting and the care team is there and everyone's misgendering me, but I'm standing in the lobby and I'm like, 'Hi, I'm here. You're talking about me. You can speak to me. Also, you are using the wrong pronouns, which are on my file'…so I am hyper aware of the power dynamic, and I know that my practitioner is as well. Psychologically and emotionally, it feels like taunting, 'What are you going to do about it? Because I'm the one who writes your scripts. I'm the one who will say yes or no to you'.* (FG25, Trans and non-binary focus group participant)

This quote points to the unequal power dynamics in interactions and the participant's feeling of vulnerability due to their reliance on the provider for medical prescriptions. Another focus group participant recounted racist experiences, including being dismissed and regarded as inferior because of their race, particularly while interacting with White healthcare providers,

> *Another major barrier is – I would like to say I am Black – and actually, I've been bullied. I've faced the discrimination aspect, the White [provider] doesn't want to regard the Black, and they see us as an animal, especially whenever we appear, they don't even pay proper attention to us, and that is bad....But at some point we don't want to react. We just pipe low and do as if nothing happened...I know they cannot eliminate [the] discrimination aspect, but they can minimize it. So they should look for a way. These are the major problems. Most time I find it so difficult to mingle with the White [provider] because they don't even see us as anything. So there are a lot of barriers. There are a lot of issues that make us not to have access to the healthcare [system] at some point.* (FG14, Black focus group participant)

The experiences of participants varied from overt racism to more subtle micro-aggressions from providers and staff, but all left participants feeling mistreated and unsafe in primary care environments.

In addition to a lack of trust and confidence in the primary care system due to recurring experiences of discrimination, some participants described learning to "settle" or stay silent to avoid conflict, worsened quality of care or the threat of not receiving basic care they needed, such as prescriptions for gender-affirming medications. Others reported that they sometimes chose to avoid seeking care altogether.

Several participants believed that experiences of discrimination can be due to a lack of education or training on specific health, economic and cultural needs of equity-deserving communities, while others pointed out that training and education do not always lead to safe environments or a lack of discrimination in practice,

> *I'll bring it down to intention versus impact, in an interpersonal way, but I think it can also be applied to structures and systems. There are organizations that are specifically designed to work with members of specific communities, and the [antidiscriminatory] philosophy is there and the intentions...However, what happens when a person arrives into the space and who is employed at that time, and what is going through their mind that is unchecked? Somebody else is now receiving the brunt of that which then comes out into, we can say, "lowercase v" violence, right, especially because of the vulnerability of somebody coming to look for care. [...] there's a continuous vetting practice that I think we [as gender-diverse people] always have to do.* (FG02, Trans and non-binary focus group participant)

This quote points out the potential harm by well-intentioned providers and organizations when left unexamined and when there is not the space for the community to evaluate experiences of primary care policy and practice in an ongoing way.

The lived experiences of participants demonstrate compounding difficulties in seeking care, including logistical challenges, system navigation, social and economic barriers, and discrimination and lack of cultural safety. When not addressed, these intersecting barriers can create major challenges accessing care and even lead to patients delaying and avoiding healthcare.

Solutions for increasing primary care access for equity-deserving patients

Several solutions were identified for improving equitable access to primary care:

- **Enhance and better resource community-based models and multidisciplinary teams** that are better equipped to provide culturally responsive care, address intersecting barriers and support system navigation.
- **Prioritize anti-discrimination and cultural safety**, including by expanding language services and through policies that focus on inclusion and antidiscrimination.
- **Improve education and training for providers** to reinforce system-wide changes that strengthen cultural competence and safety.

Delivering primary care services to equity-deserving groups

A noteworthy theme across focus group and key informant interviews was the way in which primary care is designed and delivered across the system. Participants reported the need for flexible and responsive primary care options (e.g., in terms of hours, time allotted to appointments) that are also equipped to deal with socioeconomic challenges.

Participants also identified already existing models, approaches and resources in primary care that, if expanded and properly resourced, would improve access to care for equity-deserving communities. The following sections describe these, which include community based solutions, multidisciplinary teams, language supports and resources for primary care access and navigation.

Community-based solutions

Within primary care, community-based health services were widely recognized by key informants as crucial to achieving access for equity-deserving groups because they are positioned to address the needs of diverse populations by providing culturally adapted and patient-centred care.

The relationship-building work that community-based organizations undertake to develop connections in health and other sectors was described as invaluable for ensuring that the right kinds of programs and services are reaching equity-deserving groups. Community organizations often build strong support networks and connections for clients including across legal, immigration/settlement, social services, work and income programs,

> *"We spent a lot of time at the front end of our program building connections with our local shelters, youth networks, other healthcare providers, all kinds of folks who then served as really kind of...access points to care. And what's resulted is that we serve predominantly BIPOC folks."* (KI04, Midwife and community advocate)

Community Health Centres, in particular, were recognized by participants as providing the best care for patients from equity-deserving groups because of factors such as the availability of language services, culturally competent care for local communities, geographical location, and programs that target the social determinants of health,

> *I think that CHCs do a much better job, just by virtue of what they are, being a lot more intentional about racism and discrimination at the provider level...but also, what are the systemic challenges? So, for example, perhaps you're a newcomer, you're maybe working a lower-paying job. Maybe you don't have insurance, supplemental insurance, so you don't have medication insurance. CHCs do a really good job of finding ways around that...there are the things related to accessing care that are wholly related to the social determinants of health that I think CHCs think about a bit more thoroughly.* (KI09, Community researcher)

In addition, KI participants working in community-based organizations described their work helping patients access care, including providing transportation, services for patients without OHIP, completing paperwork for gender-affirming procedures or immigration applications, building much-needed social support networks, locating funds when insurance did not cover procedures or medications, and acquiring culturally and genderaffirming items.

KI data indicates that community organizations tend to be more attuned to thinking about how spaces, policies and procedures can determine experiences and barriers to accessing primary care for equity-deserving patients,

> *"[Oftentimes there is not] the kind of medical care that [2SLGBTQ+ patients] would feel comfortable with. Something as simple as that the electronic medical records may not be updated. It might be using language like, 'your husband' or 'your wife,' with no opportunity for that person to put their pronouns…And that prevents folks from even walking in through the door. Oftentimes we talk about physical space. When you walk into a space, what does that look like? Do they have gender neutral washrooms? Do they have safer space signs? Do they have anything that indicates that this person is going to be taken care of in a way that they deserve?"* (KI11, System navigator)

Focus group participants echoed the idea that community-based services tend to provide more inclusive approaches to care that responds to diverse needs. For example, a participant who previously had difficulty finding a family doctor shared their experience,

> *I am a client at [community organization]. So, they are a space for folks with kitties. They are a space for folks if you have a history of like addiction or substance use. And they have a program for queer youth, and they have connections with [the local] community health centre, so they were actually able to really quickly set me up with a registered nurse practitioner. I walked across the street to give them a form at the community health centre, and then within a week, I got connected. So that was great, because before that I was doing walk-in clinics.* (FG06, Southeast Asian participant)

Collaboration between the CHC and the community organization improved the experience of this participant in accessing services. Other participants suggested the way that primary care services and related supports are physically designed was important. For example, the co-location of health and social services was seen as ideal by many participants,

> *If you're queer, you probably have to go to certain places to feel more comfortable to access healthcare or other care…I just wanted one centralized place to get all my needs met at and it was very difficult to find that…definitely [it would help with the] financial constraints…instead of going to various different spots to get everything that you need to be addressed when it comes to your health.* (FG24, 2SLGBTQ+ focus group participant)

Participants explained that if health and social services were situated in close proximity to one another, it would also lessen the financial and time burden. Those who were active patients at CHCs also suggested that the centres can be a convenient place to access various healthcare services in one spot (e.g., physicians, allied health providers such as dental services).

Some focus group participants described that CHC environments allowed for more time and better interactions with healthcare providers who are more attuned to cultural factors, such as the use of patients' correct names and pronouns. Participants described this as reassuring in sometimes stressful primary care environments,

> *Also, the attitude of the nurses [at the CHC], because there are more nurses than patients, you can get more attention from them, and then...because there isn't a burnout or a very hustle and bustle environment for the workers there as well. Sometimes, especially in the downtown area for some of the hospitals' big clinics, it could be very crowded and people get very angry and anxious... that is one plus I would say about the CHC...wait time is good, attitude is good, process time is good. Generally, the whole process, I feel like I receive more assurance...because there is more attention. And they take the time to explain to me this and that.* (FG28, East Asian focus group participant)

There was a general agreement about the potential for CHCs and other community-based services (e.g., legal, immigration, settlement, and employment services) to address equity and social determinants of health, largely because the supports, networks and skills required to deliver equitable care already exist locally. However, many participants stressed that they require greater investment to meet the level of need in communities.

KI participants described in detail how they struggled to provide services to their many clients with insufficient staff or resources. They explained they often felt they could be providing more support to clients and for longer periods and were sometimes forced to turn away clients because programs were full or had a wait list. Several participants additionally described the burnout they and their colleagues experienced stretching themselves to support vulnerable or isolated clients.

FG participants also identified broader challenges impacting their experiences in primary care, such as gaps in resourcing and staffing, a lack of accessible clinics and diverse options to access care (e.g., after hours, online platform), restricted appointment times and length,

> *My hope is that enough people who actually want to are given the resources to hold the spaces for care in the way that they need to, and they're also not having too many patients to see in a day, or overcrowded clinics, or not enough support staff to help them...And I feel like from there, it'll be so much easier to have time to listen to us when we're in the room, you know, and not think about how many people have to fit into one day.* (FG02, Trans and non-binary focus group)

Participants pointed to an ideal primary care system as one that is not burdened by issues related to a lack of resourcing and capacity.

Participants also stressed that effective community-based services are limited by broader policy contexts (e.g., insufficient funding to social and economic benefit programs) driving socioeconomic inequities. These contexts also contribute to barriers, such as costs related to healthcare access and lack of insurance coverage. Several FG and KI participants expressed the need to implement solutions that reduce financial barriers to primary care. These included expanding OHIP for people currently uninsured, new or expanded programs or subsidies to cover costs for medication, non-medical treatments (e.g., nutrition, devices), and allied or other supportive health services.

Multidisciplinary teams

Another important part of primary care delivery raised by most key informant participants was the role of multidisciplinary teams in meeting the needs of equity-deserving groups. They explained that to adequately address the diverse, complex and unmet needs of patients, multi-professional collaboration is vital.

This kind of model already exists in primary care, including collaborative teams of social workers, midwives, cultural/system navigators, dietitians, nurse practitioners, mental health workers and occupational therapists, in addition to physicians. As well as meeting diverse needs, participants pointed out that leveraging the complementary expertise of providers in healthcare settings could increase efficiency in systems,

> *Who do we consider the beholders of primary care? Can we…[better] leverage the skills and knowledge of a range of healthcare providers? I've had a chance to do that in my work. My team and I have taken over the early [prenatal program], we are now the first face people see when they have complications that arise in early pregnancy. And it frees up the doctors to do more complex work. And it serves the system well. We don't cost the system nearly as much. So I think, considering HR issues and how we would maybe keep extending the scope of the folks that are already working in a healthcare system could go a long way.*
> (KI04, Midwife and community advocate)

Other participants explained that greater focus on multidisciplinary care could involve opening up opportunities for nurse practitioners (NPs) to be able to bill for services, and that better compensation, especially for positions other than physicians in primary care is also needed. Several participants emphasized this particularly for access to primary care in remote or non-urban settings where family doctors who practice gender-affirming, trauma-informed care are relatively few.

> *For folks who are in rural areas where there might be just one provider, never mind just for gender-affirming care, just for that general area period, that can be very tricky, and so in those cases, it's about having those conversations, tough conversations, about, if your family doctor isn't an option for you, what other options are available?* (KI11, System navigator)

Because of inadequate options in remote areas, enhancing the scope and flexibility of diverse practitioner roles and increasing team-based delivery to better address needs was identified by several participants as a way to increase access and quality of care for equity-deserving patients.

Some participants explained that team-based collaboration brings together a range of skills and scopes of practice to better address complex social and health issues. In some cases, sole providers refuse new patients because they cannot manage complex needs,

> *Mental health, poverty, substance use, unemployment, all of that…We [see] the substance use, the lack of access to resources, and I think all of those things contribute to how and when and if people are able to access primary care. And it creates barriers for…[providing care to] vulnerable people, because they are medically and socially complex, and so those are things that some providers feel they're not equipped to take on if they're not in a team-based environment where they have access to social work and other allied services. They may say, 'Well, no, you're too complex for me to take on.'* (KI17, CHC leadership role)

Participants' discussion of collaboration also extended beyond internal or formal healthcare teams to partnerships with other community-based service providers. They described how these connections, while often more informal, enable a deeper understanding of patients' cultural backgrounds and unique needs.

Focus group data also suggests a general preference for primary care provided by an integrated healthcare team rather than a single provider. This approach was described as facilitating better communication and coordination, reducing the need for referrals, and improving ease of access to a range of necessary health services.

System-wide resources for primary care access and navigation

Many participants discussed the helpful support that frontline service providers and community organizations provide with system navigation. This involves addressing information gaps, demystifying services, and providing support with understanding how the health system works for newcomers and other equity-deserving patients. Many key informants emphasized the importance of this work, especially when people lack support from family and community social support networks.

Effective programs and roles (e.g., multicultural healthcare workers, system navigators) already exist within the system to help patients connect to the system and particularly to culturally relevant services. Key informant participants in this study supported clients and healthcare providers in system navigation, locating relevant information and finding safe spaces for care,

> *Most people don't know where you can go to get care. And so, it's…knowing what the access points are and then really taking it upon ourselves as providers to fill in those gaps to highlight what those places are…the value of the network is…putting our collective brains together to know, 'Okay, here's a good place. We've vetted it. We know that it's a safe place to go, where people's immigration status is not going to be compromised when they're accessing care, and then to be able to share that with the communities that we serve.'* (KI05, Community health coordinator)

Key informant participants described their efforts to compile up-to-date data on primary care providers, programs and networks of resources, and different health insurance programs, but identified a strong need for better supports to help patients identify available services and how to access these,

> *Maybe education for the new immigrants or newcomers…So, a lot of times when I meet my clients, I would feel they really need, like a "Canadian Healthcare System 101" lesson. But when we look for information like that, [it's scattered and]…very hard to locate. I think if the government, or the system, can generate something…'Our Canadian [primary care] system is like this. So this is what you can do.' I sometimes imagine there will be a map showing all these other family doctors, and then the language that they speak. And there would be filters that you can choose all Mandarin-speaking doctors [or other providers]…but right now, I don't think we have this very transparent or easy-to-use tool.* (KI06, Community intake worker)

Key informants also identified a gap in centralized information or resources for patients (e.g., about language of providers, wait times, gender-affirming care). Along these lines, some participants indicated that system navigation work could be better supported or even formalized across the system for greater impact,

> *The biggest gap is…a broad scan of what providers are taking [patients] and where they're at in terms of their team. There are gaps, because, of course, we can't get all that information…[it highlights a need to support] spaces for providers to share information in terms of who's taking [patients]? What does this look like? What are wait times like? And so a larger community is where we're able to mitigate those gaps…I would love to have something that's province-wide where we could perhaps have clinical system navigators from across the province on a platform where we can all connect and have a bit more 'up-to-date' information as to where wait times are at…with providers who have committed to providing trauma-informed and culturally safe services to 2SLGBTQ folks…but again, that costs funding and time and person-power.* (KI11, System navigator)

Several KI participants emphasized that any centralized systems to support access for equity-deserving groups across Ontario should also include community perspectives in system planning and delivery, and the ongoing evaluation and improvement of these resources.

Focus group participants echoed the need for greater attention to system-wide navigation supports for patients across Ontario and agreed that centralized sources of information would be helpful. Some also detailed their extensive efforts trying to navigate the system and identify clinics or providers that were accepting new patients.

Focus group participants identified a need for better access to quality information about the primary care system in Ontario. The idea that online information sources should include details about whether a provider has specific competencies, such as providing gender-affirming and anti-oppressive care was also raised. Other participants pointed out that centralized sources of information about different providers and primary care settings would require ongoing evaluation from trusted community sources about whether providers are actually providing gender-affirming or anti-racist care in practice.

Prioritizing anti-discrimination and cultural safety in primary care

The impact of discrimination was described as a deterrent to seeking care by participants with lived experiences. In response, participants stressed the importance of anti-discrimination and inclusion of diverse identities, including patients from various socioeconomic backgrounds, in primary care settings. The need to develop capacity for anti-racism and cultural competence within these settings was emphasized.

Key informant participants highlighted the importance of delivering primary care in a way that values a range of worldviews and ideas about health and promotes a holistic understanding of patients' needs, cultural perspectives and their social and economic context. Participants connected cultural competence with quality of care in their primary care encounters. For example,

> *I'm constantly trying to look for people who work from this anti-racist framework, people who are able to provide an understanding of diverse worldviews, and not just provide the treatment to reduce the distress related to the illness, but also to be able to help people to thrive or to enhance their health. Because oftentimes the focus when it comes to people of colour or from racialized backgrounds is, 'Okay, let's give them a medication and be done'...but the issue is not just about how many minutes you spent with someone [it is about the] kind of quality interaction where you feel that you have been heard, you have been supported.* (KI10, Community programs director)

Focus group participants emphasized the importance of building strong, respectful and trusting relationships with providers, and the few who had found a provider who had these qualities reported drastically improved experiences. Participants described the need to feel seen and respected to comfortably discuss their health concerns.

For example, the importance of identity affirmation, including using correct pronouns and names, was identified as a fundamental part of building trust and fostering a safe, inclusive environment by trans, non-binary and gender-diverse participants. One participant explained,

> *For me, I would say it really feels good [when someone uses my correct pronouns]. It makes you feel comfortable over time, and you just want to remember this mentality that you're safe with this particular healthcare provider who accepts you for who you really are.* (FG25, Trans and non-binary focus group participant)

Participants explained that actions that affirm their identities can strengthen the patient-provider relationship, contributing to a more positive healthcare experience, and similarly identified the need for more primary care options that prioritize anti-discrimination. As one participant stated,

> *If there's information that has been laid out for healthcare providers to understand that they shouldn't discriminate...I feel like everyone should be treated equally...So if there's a clinic that accepts everyone, the workers understand that discrimination is not tolerated and all of that, then it would actually be very nice for everyone.* (FG27, Black focus group participant)

As this quote suggests, some participants pointed out that there should be more accountability for ensuring anti-discrimination policies are upheld in practice.

Other participants indicated that sharing personal information, such as gender or immigration status, with healthcare providers requires trust. Participants expressed that a safe environment requires that providers take care to maintain confidentiality and address fears that information could be used against patients. Respect for personal information and privacy was described as an important way of recognizing and valuing how social conditions contribute to patients' overall well-being.

Expanded language services

The need for expanded language supports was highlighted by most key informant participants in this study, who emphasized integration of language services as a crucial part of culturally competent primary care. Key informant participants described that language supports (translation, interpretation, provider language skills) are important for navigating the healthcare system, stressing that patients often require information in their language to properly understand health concerns and understand vital information.

Many key informant participants described dedicating a lot of time and effort into facilitating communication for clients in the context of primary care,

> *I'm very aware, coming from a different culture, that...you know, in English, we have a whole roster of lingo around LGBTQ that is respectful and validated... In other countries, we don't always have naming...there is just insult names that we have...So, when I know in advance, obviously I'm working with a trans client, I would actually have the conversation with the translator before...and we would go through not just the questions that we would need to ask the clients, but I would ask them to let me know...the words that you would be using in that language...does this sound respectful? We need to know ahead of time. Because I don't want to sit there and tell someone to translate what I say and then it's translated in a way where that doesn't come off right...or is offensive.* (KI02, Community outreach and system navigator)

Participants explained that language barriers can intersect with cultural barriers, particularly when communication difficulties occur due to the incompatibility of meaning and concepts across different cultural contexts. It was noted that formal language services are often inaccessible and unaffordable, and should more appropriately address the cultural dimensions of language for equity-deserving patients.

Some focus group participants shared their need to connect with providers who can speak their preferred language as they felt it provided greater understanding and cultural alignment in patient-provider interactions. A few participants described providing language support to friends and family members navigating the system and in primary care appointments. In several of these cases, participants joined appointments after the initial encounter to provide last-minute support or to rectify communication errors. As well, many focus group participants detailed numerous obstacles (work, caregiving, financial) that could limit their ability to provide language support in a timely manner.

In this light, better access to immediate translation or interpretation services helps to ensure accurate communication between patients and providers, and that information (e.g., about health conditions, diagnoses and care options) is contextualized within the patient's cultural understanding of their health.

Key informants highlighted existing resources and roles, such as settlement workers and multicultural health programs, where professionals assist patients in navigating the healthcare system in their preferred language, and facilitate culturally appropriate care for the patient. Some participants identified that language services should be better supported at the systems-level to make resources more accessible across primary care,

> *It's not perfect, but…we use phone-based interpretation services, and I think that should be legally required that any healthcare provider [offer this service]…that needs to be normalized, and it needs to be enforced, because it's not acceptable that people are turned away from medical appointments or go to medical appointments and do not properly understand what's being said to them. I think that that should be standard practice.* (KI08, Community program coordinator)

Participants identified that the primary care system also needs better mechanisms to connect patients with healthcare providers who speak languages other than English or French with translation services.

Education and training for primary care providers

A key part of fostering cultural competence and safety in the healthcare system, identified by both participant groups, was through the education and training of primary care providers. Anti-racist, anti-discrimination and cultural competence education was identified as ideally providing the skills for providers to be able to interrogate their own values and biases and reflect on how they bring these into interactions with patients.

One key informant participant explained that basic training is often necessary to improve understanding of how to be inclusive of diverse gender identities,

> *[Training on cultural competence is not] mandatory...it's optional for all the practitioners. So I don't think that queer language, queer health, should be an afterthought for service providers....[Most healthcare providers] are not in community often, unless they choose to be. So, they don't know us or what we need. They know...how to make bodies work and function, but they don't know us...I don't know if just a webinar or workshop would be enough but at least it would be a start for them to get more educated. Even a small thing like having pronouns and forms with preferred names, not assuming that every gay person in the world needs to get tests for STIs, which happens with a lot of my friends who are gay men or cis or trans males. So I think those kinds of things that for community, seem very obvious, but once you go out there are not.* (KI05, Community health coordinator)

This quote indicates that improved understanding involves challenging biases in dominant approaches to delivering healthcare (e.g., assumptions about types of care needed for specific communities).

Other participants stressed that cultural competence should be intersectional, with a focus on racialized or newcomer 2SLGBTQ+ groups, and that primary care education should involve knowledge about the multiple dimensions of a patient's identity and their social and economic conditions,

> *So the intersectional approach, or the anti-oppressive approach to care, is missing [in healthcare training] much of the time. The person isn't seen as a whole person, and...parts of their identity aren't necessarily taken into consideration when they're coming to access care. You may see me as a Black woman, but you may not think about my immigration status, my poverty level, and those being barriers to me actually showing up to an appointment. So that is sometimes missing in the interactions when folks seek primary care.* (KI16, CHC leadership role)

Key informant participants emphasized that holistic approaches, including those that consider a patient's identity, cultural backgrounds and social and economic conditions, are important for inclusion in primary care settings. This knowledge, skillset and practice was recognized as an important part of cultural safety and the competence of healthcare providers that requires greater support in the primary care system.

Along these lines, participants raised the need for the ongoing education of healthcare providers that recognizes there are no 'one-size-fits-all' solutions to providing competent care to diverse patients. While they acknowledged that cultural safety training is only one piece of the puzzle, there was general agreement that without basic understanding in this area, the risk of adding to the trauma of equity-deserving patients is considerable.

Focus group participants noted that healthcare providers should be better informed on how to navigate and respond to cultural differences, establish rapport and meet diverse patient needs. Participants called for more anti-oppressive training and education for healthcare providers, especially to improve experiences of racialized communities and trans, Two-Spirit and gender-diverse communities. Participants also noted the need for training of health providers about how to respect patient identities,

> *I would also say lack of education and training that's for the healthcare providers. I mean, they're not really well educated on how to talk to Two-Spirit persons. I've had situations where a healthcare provider generally knows the right pronouns he could actually use to describe me, and that generally go well with me.* (FG11, Trans and non-binary focus group participant)

Participants highlighted the importance of training on the intersecting ways social determinants (like income, immigration status or race) can impact patients' health. A few participants described their primary care provider positively because they felt they had recognized and respected their identities and understood how social and economic factors could impact their health and well-being. Several connected this to the provider keeping their practice and knowledge 'up-to-date' and 'attuned' with current contexts.

Many participants similarly identified a need for better understanding on the interconnection between anti-racism and sensitivity to socioeconomic position,

> *I think for Black people…who are trying to access healthcare services…[there is a lack of attention paid to] how poorly we sometimes can be treated…and due to our lack of finances or funding…So, I think while focusing on the people who are trying to access healthcare, a lot of things should be done about people who are actually giving out this healthcare service. Health services should come with respect and everyone should be treated equally.* (FG13, Black focus group participant)

Several participants described feeling lucky and relieved when they finally connected with a provider who was knowledgeable and recognized their broader contexts. Participants also noted that providers who are mindful of their biases can build trust in the clinical relationship, and they felt that in these cases, they were more likely to return for care.

While education was noted as a valuable approach to improve cultural safety, and thus access to care, several participants discussed that education on its own would be insufficient. Participants identified the need to change norms and reinforce training efforts through other avenues, including organizational policies (e.g., standardized forms, policies, features of space, including gender-neutral washrooms) and broader systemic changes (e.g., funding for specific programs).

Discussion

This study explored the experiences of equity-deserving groups accessing primary care in Ontario, and the experiences of frontline providers working with these groups. The findings confirm existing research showing that racialized and 2SLGBTQ+ communities from low socioeconomic backgrounds face numerous barriers accessing primary care services[9].

The results highlight the close relationship between the availability of primary care services and the quality of services in framing patients' experiences[13]. Taken together, the challenges discussed in this paper prevented initial access, as well as a continued connection, to primary care for many participants. Participants described challenges connecting with family doctors and other primary care providers due to logistical issues like long wait times, lack of flexibility in terms of appointment times, and shortages of clinics where they lived.

Study findings also suggest a reliance by participants on services such as emergency departments and walk-in clinics for their primary care needs. While these services were often the only option for participants, they do not offer the continuous and preventive care that primary care services are designed to provide.

In addition to the usual logistical barriers described in other studies, this research highlights the challenges experienced navigating the primary care system in Ontario. Most participants, including newcomers to Canada and those who are long-term residents, encountered difficulties making sense of the way the system works, including finding options for acquiring gender-affirming and culturally appropriate services and supports. Both key informant participants and those with lived expertise reported a substantial need for more up-to-date, accessible and centralized information and supports to help patients access primary care.

The importance of addressing the social determinants of health across communities to improve equitable access to primary care was also a critical theme in the study. Participants described experiencing challenges related to financial constraints and other social and economic contexts (e.g., work and caregiving responsibilities), which further limited their flexibility and choice in accessing health and related services.

The focus on intersectionality in the design of this research is distinctive in that the findings represent the perspectives and experiences of people who identify as belonging to more than one equity-deserving group in relation to race, sexual orientation and gender identity and economic status. Accordingly, the findings clearly reflect experiences of intersecting barriers across various factors including economics, discrimination, language and immigration status.

Experiences of discrimination shaped access to the primary care system for participants in this study who identified as belonging to intersecting 2SLGBTQ+ and racialized groups. Participants detailed how providers, health organizations and the care system often fail to consider important factors such as socioeconomic and cultural backgrounds (including gender identity and sexual orientation), preferred language and immigration status. The lack of culturally safe care, combined with broader social and economic barriers, was described as an issue in limiting access to essential health services.

The study importantly identifies potential solutions to barriers to accessing primary care from the perspective of equity-deserving patients and frontline community-based service providers, groups who are frequently excluded from deliberation about policy and program planning. The solutions identified in the research all require policy change and support for implementation across the system.

Key solutions identified in the study included integrating cultural competence in primary care, which was highlighted as vital in improving communication and trust and minimizing harm in provider-patient interactions. Cultural competence and humility, together with other equity-oriented practices such as anti-racism and trauma-informed care, can create safe environments for patients when accessing services[14]. Participants emphasized that anti-racist and trauma-informed approaches (sensitivity to experiences of harm, violence and discrimination) are needed to actively counter systemic discrimination in healthcare. These approaches can also help providers be responsive to intersecting social determinants of health and barriers patient populations may face in accessing care.

Despite developments in cultural competency in healthcare settings and health professional curriculums, the findings of this study suggest it remains a common issue across primary care settings[15]. The importance of centering reflection in care practice and moving beyond cultural awareness to navigating power imbalances and systemic discrimination has been discussed for many years, and linked to the ongoing impacts of historical factors such as colonialism in healthcare experiences[16-19]. The persistence of this issue reveals the continued need to identify new ways and renew commitments to meaningfully apply these approaches across health systems to address health inequities.

Many participants in this study identified substantial direct and indirect financial barriers associated with primary care. This finding confirms other research that emphasizes a need to adequately address the social determinants of health in primary care settings[20,21]. To be effective, programs and planning related to access for equity-deserving groups should integrate an intersectional lens and address the ways that travel, time off work, medication, and other health-supporting costs could be deterrents to many patients. Policies to address the economic barriers to accessing primary care are also needed.

At the same time, study findings point to effective practices and programs that already exist in primary care, including community-based interventions (e.g., CHCs), multidisciplinary health teams, and system navigation support and resources often provided by frontline service providers. This includes important roles such as multicultural healthcare workers that address cultural and linguistic barriers and facilitate access, particularly among immigrant populations[22]. Community-based health organizations are also uniquely positioned to meet the diverse needs of local communities, including addressing the social determinants of health, trauma- and violence-informed and culturally safe care, and care tailored to patients with intersectional identities and diverse backgrounds[23,24].

Key informant participants described many examples of programs and services in communities for which there were wait lists or from which equity-deserving patients were turned away. Prior research has outlined that funding mechanisms in Canada do not adequately allow community-based programs to carry out equity-oriented mandates. In addition, funding mechanisms are infrequently structured to be responsive to emerging and changing priorities at a local level[23]. As such, the challenge lies in resourcing, scaling up and sustaining existing models and practices to improve access across the system, and ensuring that best practices related to equity in primary care (e.g., cultural competence, team-based care, programs that address social determinants of health) are widely taken up[25].

Policy and accountability frameworks that prioritize equity and cultural safety are important companions to robust funding, infrastructure and institutional support for primary care programs that meet the needs of equity-deserving communities. Existing strategies can guide implementation solutions, such as Ontario Health's Equity, Inclusion, Diversity and Anti-Racism Framework, that lists several areas for action such as investing financial and people resources towards equity-oriented practices[26].

Limitations

In addition to the many strengths of this research, there are several areas identified that require further exploration in future research.

First, language barriers were not discussed in-depth across all of the focus groups, likely due to the limitation that participants only included those who spoke English. Focus groups were not offered in other languages. Given that language can impact access to primary care, future studies should prioritize multilingual perspectives to better capture the specific experiences of those facing language barriers, particularly those from immigrant and refugee communities.

Second, while this study included specific groups in the sample, other experiences could be further explored. Key informants identified Middle Eastern and Spanish-speaking populations as experiencing distinct barriers to care. Data also suggests that participants with disabilities or those living with multiple chronic conditions have complex healthcare needs and experience unique barriers to primary care that warrant future exploration[27]. Additionally, while a comparative analysis of experiences across geographic regions was not conducted, future research could provide a more nuanced understanding of the specific challenges and interventions to improve access to primary care in rural areas such as Northern Ontario.

Given the focus of participants on financial and economic dimensions to healthcare access, future research could also examine how billing practices, insurance coverage and privatization of services contribute to disparities in healthcare access. Given ongoing changes in the primary care landscape, a closer look at how these structural factors intersect with systemic inequities could provide deeper insight into how to improve access to primary care for equity-deserving populations.

Conclusion

This qualitative study explores the barriers experienced by equity-deserving populations that limit access to primary care in Ontario, including socioeconomic and cultural factors, discrimination, appointment logistics and system navigation barriers. Solutions to address barriers include culturally safe care and community support to respond to a range of needs, including social and economic conditions faced by equity-deserving patients.

The study is unique in its inclusion of a diverse group of participants from intersecting social locations (racialization, economic position, gender identity and sexual orientation) with lived experience of challenges accessing the primary care system. The identification of solutions from the perspectives of community members will ideally lead to policy change with a direct positive impact on these groups. More research and future exploration of other communities and linguistic groups is needed, as well as research exploring different experiences accessing primary care across different regions in Ontario.

> **"The identification of solutions from the perspectives of community members will ideally lead to policy change with a direct positive impact on these groups."**

References

1. Kiran T, E. A., Mangin D, et al. . (2022). Brief on Primary Care Part 1: The roles of primary care clinicians and practices in the first two years of the COVID-19 pandemic in Ontario. *Science Briefs of the Ontario COVID-19 Science Advisory Table, 3*(67). https://doi.org/ https://doi.org/10.47326/ocsat.2022.03.67.1.0
2. Ontario College of Family Physicians. (July 11, 2024). New Data Shows There Are Now 2.5 Million Ontarians Without a Family Doctor https://ontariofamilyphysicians.ca/news/new-data-shows-there-are-now-2-5-million-ontarians-without-a-family-doctor/
3. Sundareswaran, M., Martignetti, L., & Purkey, E. (2024). Barriers to primary care among immigrants and refugees in Peterborough, Ontario: a qualitative study of provider perspectives. *BMC Primary Care, 25*(1), 199. https://doi.org/10.1186/s12875-024-02453-x
4. Howard, M., Wu, F., Kiran, T., Frymire, E., Lapointe-Shaw, L., Jaakkimainen, L., Glazier, R., & Green, M. (2023). The Impact of the COVID 19 Pandemic on Continuity of Care with Ontario Family Physicians. *The Annals of Family Medicine, 21*(Supplement 1), 3671. https://doi.org/10.1370/afm.21.s1.3671
5. Gulliford, M., Figueroa-Munoz, J., Morgan, M., Hughes, D., Gibson, B., Beech, R., & Hudson, M. (2002). What does 'access to health care' mean? *J Health Serv Res Policy, 7*(3), 186-188. https://doi.org/10.1258/135581902760082517
6. Szymczak, J. E., Fiks, A. G., Craig, S., Mendez, D. D., & Ray, K. N. (2023). Access to What for Whom? How Care Delivery Innovations Impact Health Equity. *Journal of General Internal Medicine, 38*(5), 1282-1287. https://doi.org/10.1007/s11606-022-07987-3
7. Levesque, J.-F., Harris, M. F., & Russell, G. (2013). Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *International journal for equity in health, 12*(1), 18. https://doi.org/10.1186/1475-9276-12-18
8. Jindal, M., Chaiyachati, K. H., Fung, V., Manson, S. M., & Mortensen, K. (2023). Eliminating health care inequities through strengthening access to care. *Health Services Research, 58*(S3), 300-310. https://doi.org/https://doi.org/10.1111/1475-6773.14202
9. Sanford, S., Yin, Y., & Sheppard, C. L. (2024). *Barriers and Enablers to Primary Care Access for Equity-Deserving Populations in Ontario: A Scoping Review*. https://www.wellesleyinstitute.com/wp-content/uploads/2024/09/Barriers-and-Enablers-to-Primary-Care-Access-for-Equity-Deserving-Populations-in-Ontario-AScoping-Review.pdf
10. Smith, J., & Firth, J. (2011). Qualitative data analysis: the framework approach. *Nurse Res, 18*(2), 52-62. https://doi.org/10.7748/nr2011.01.18.2.52.c8284

11. Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa
12. Boeije, H. (2002). A Purposeful Approach to the Constant Comparative Method in the Analysis of Qualitative Interviews. *Quality and Quantity, 36*(4), 391-409. https://doi.org/10.1023/A:1020909529486
13. Spithoff, S., Kiran, T., Khuu, W., Kahan, M., Guan, Q., Tadrous, M., Leece, P., Martins, D., & Gomes, T. (2019). Quality of primary care among individuals receiving treatment for opioid use disorder. *Canadian Family Physician, 65*(5), 343. http://www.cfp.ca/content/65/5/343.abstract
14. Public Health Agency of Canada. (2023). Common Definitions on Cultural Safety: Chief Public Health Officer Health Professional Forum. https://www.canada.ca/content/dam/hcsc/documents/services/publications/health-system-services/chief-public-healthofficer-health-professional-forum-common-definitions-cultural-safety/definitionsen2.pdf
15. Wilson, L., Wilkinson, A., & Tikao, K. (2022). Health professional perspectives on translation of cultural safety concepts into practice: A scoping study [Systematic Review]. *Frontiers in Rehabilitation Sciences, 3*. https://doi.org/10.3389/fresc.2022.891571
16. Kirmayer, L. J. (2012). Rethinking cultural competence. *Transcultural Psychiatry, 49*(2), 149-164. https://doi.org/10.1177/1363461512444673
17. Bhui, K., Warfa, N., Edonya, P., McKenzie, K., & Bhugra, D. (2007). Cultural competence in mental health care: a review of model evaluations. *BMC Health Serv Res, 7*, 15. https://doi.org/10.1186/1472-6963-7-15
18. Authority, B. F. N. H. (2016). Creating a Climate for Change: Cultural Safety and Humility in Health Services for First Nations and Aboriginal Peoples in British Columbia. https://www.fnha.ca/Documents/FNHA-Creating-a-Climate-For-Change-Cultural-Humility-Resource-Booklet.pdf
19. Varcoe, C., Annette, B., & and Blanchet Garneau, A. (2019). Beyond stress and coping: the relevance of critical theoretical perspectives to conceptualising racial discrimination in health research. *Health Sociology Review, 28*(3), 245-260. https://doi.org/10.1080/14461242.2019.1642124
20. Pinto, A. D., & Bloch, G. (2017). Framework for building primary care capacity to address the social determinants of health. *Canadian Family Physician, 63*(11), e476-e482. https://www.cfp.ca/content/cfp/63/11/e476.full.pdf
21. Katz, A., Chateau, D., Enns, J. E., Valdivia, J., Taylor, C., Walld, R., & McCulloch, S. (2018). Association of the Social Determinants of Health With Quality of Primary Care. *The Annals of Family Medicine, 16*(3), 217-224. https://doi.org/10.1370/afm.2236

22. Torres, S., Labonté, R., Spitzer, D. L., Andrew, C., & Amaratunga, C. (2014). Improving health equity: the promising role of community health workers in Canada. *Healthc Policy, 10*(1), 73-85.
23. Lavoie, J. G., Varcoe, C., Wathen, C. N., Ford-Gilboe, M., Browne, A. J., & On behalf of the, E. R. T. (2018). Sentinels of inequity: examining policy requirements for equity-oriented primary healthcare. *BMC health services research, 18*(1), 705. https://doi.org/10.1186/s12913-018-3501-3
24. Ford-Gilboe, M., Wathen, C. D., Varcoe, C., Herbert, C., Jackson, B. E., Lavoie, J. G., Pauly, B., Perrin, N. A., Smye, V., Wallace, B., Wong, S. T., & Browne, A. J. (2018). How Equity-Oriented Health Care Affects Health: Key Mechanisms and Implications for Primary Health Care Practice and Policy. *The Milbank Quarterly, 96*(4), 635-671. https://doi.org/https://doi.org/10.1111/1468-0009.12349
25. Browne, A. J., Varcoe, C., Ford-Gilboe, M., Nadine Wathen, C., Smye, V., Jackson, B. E., Wallace, B., Pauly, B., Herbert, C. P., Lavoie, J. G., Wong, S. T., & Blanchet Garneau, A. (2018). Disruption as opportunity: Impacts of an organizational health equity intervention in primary care clinics. *International journal for equity in health, 17*(1), 154. https://doi.org/10.1186/s12939-018-0820-2
26. Government of Ontario. (2020). Ontario Health's Equity, Inclusion, Diversity and Anti-Racism Framework. https://www.ontariohealth.ca/sites/ontariohealth/files/2020-12/Equity%20Framework.pdf
27. Gulley, S. P., & Altman, B. M. (2008). Disability in two health care systems: access, quality, satisfaction, and physician contacts among working-age Canadians and Americans with disabilities. *Disabil Health J, 1*(4), 196-208. https://doi.org/10.1016/j.dhjo.2008.07.006

Appendix A. Focus group sociodemographic survey results

This table contains a description of focus group participants' sociodemographic characteristics. The study included 35 focus group participants, and all responded to an anonymous sociodemographic survey[***]. Participants were able to choose all of the answers that applied to them for most of the questions. As such, some participants identified as more than one category (e.g. race, employment status, insurance status).

Demographic characteristic	n	%
Region		
Greater Toronto Hamilton Area (GTHA)	22	61.1
Eastern Ontario	7	19.4
Southwestern Ontario	6	16.7
Northern Ontario	1	2.8
Rural or urban		
Rural	5	13.9
Suburban/semi-urban	9	25.0
Urban	22	61.1
Age		
Mean age	38.64	
(SD)	(15.72)	
Age range	23-72	
Gender identity		
Woman	18	50
Man	8	22.2
Trans woman	5	13.9
Gender non-binary	4	11.1
Trans man	1	2.8

[***] There are 36 survey respondents total due to one participant who completed the survey but did not attend a focus group. Because the survey was anonymous, it was not possible to identify and remove their sociodemographic data.

Demographic characteristic	n	%
Sexual orientation		
Heterosexual/straight	15	41.7
Bisexual	14	38.9
Queer	4	11.1
Gay	1	2.8
Lesbian	1	2.8
Missing	1	2.8
Race/ethnic background		
Black	16	44.4
East Asian	10	27.8
South Asian/Indo-Caribbean	5	13.9
Southeast Asian	4	11.1
White	1	2.8
Primary care source		
Walk-in clinics	17	47.2
Community Health Centres	16	44.4
Solo practice (Family doctor)	14	38.9
Specialized clinics	8	22.2
Telehealth/virtual care	5	13.9
Student clinic	4	11.1
Missing	3	8.3
Preferred language when accessing primary care[+]		
English	25	69.4
Simplified Chinese	6	16.7
Traditional Chinese	4	11.1
Missing	1	2.8
Employment		
Full-time	8	2.2
Part-time	9	25.0
Self-employment	5	13.9
Student	4	11.1
Retired	4	11.1
Not currently employed	8	22.2

[+] The predominance of English preference is partly due to the study design as this research did not provide translation options for focus group interviews.

Demographic characteristic	n	%
Frequency of primary care use		
More than once a month	5	13.9
Monthly	7	19.4
Every few months	15	41.7
Once or twice a year	2	5.6
A few times in their lifetime	4	11.1
Never	3	8.3
Insurance status		
Ontario Health Insurance Plan (OHIP)	21	58.3
Private insurance	4	11.1
Student insurance	4	11.1
Uninsured	7	19.4
Missing	1	2.8
Household income and size		
$0 to $14,999 18 50	18	50
$15,000 to $39,999 4 11.1	4	11.1
$40,000 to $64,999 7 19.4	7	19.4
$65,000 to $89,999 5 13.9	5	13.9
$90,000 or more 1 2.8	1	2.8
Missing	1	2.8
Mean income	$31,142	
Mean household size	2.49	
Mean income per person	$12,506	

Appendix B. Key definitions

Term	Definition
2SLGBTQ+	The acronym that stands for Two-Spirit, lesbian, gay, bisexual, trans, queer (or questioning) and other non-dominant gender and sexuality identification[1].
Anti-racism	A systematic method of analysis and a proactive course of action. The anti-racism approach recognizes the existence of racism, including systemic racism, and actively seeks to identify, reduce and remove the racially inequitable outcomes and power imbalances between groups and the structures that sustain these inequities[2].
Cultural competency	The ability to self-reflect on one's own cultural values and how these impact the way one provides care, as well as continually learning to gain a deeper understanding of another's culture. It includes each health professional's ability to assess and respect the values, attitudes and beliefs of persons from other cultures and respond appropriately in planning, implementing and evaluating a plan of care that incorporates health-related beliefs and cultural values, knowledge of disease incidence and prevalence, and treatment efficacy[3].
Cultural safety	An outcome focused on the experience of the patient and based on respectful engagement that recognizes and strives to address power imbalances inherent in the healthcare system. Cultural safety results in an environment free of racism and discrimination, where people feel safe when receiving healthcare[4].
Discrimination	An action, behaviour, decision or omission that treats a person or a group of people unfairly and badly for reasons linked to personal traits, such as their race, age or disability. Discrimination can be intentional or unintentional, and even rules, practices and procedures

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[1] https://www.the519.org/education-training/glossary/

[2] https://www.ontariohealth.ca/sites/ontariohealth/files/2020-12/Equity%20Framework.pdf

[3] Common Definitions on Cultural Safety: Chief Public Health Officer Health Professional Forum - Canada.ca

[4] Common Definitions on Cultural Safety: Chief Public Health Officer Health Professional Forum - Canada.ca

Term	Definition
	that seem harmless can cause discrimination if they have the effect of putting certain groups of people at a disadvantage. Discrimination can also be direct or indirect. Indirect discrimination happens when a rule or policy that does not cause a problem for most people has an unfair effect on a person or group that is related to their personal traits[5].
Genderqueer or non-binary	Individuals who do not follow gender stereotypes based on the sex they were assigned at birth. They may identify and express themselves as “feminine men” or “masculine women” or as androgynous, outside of the categories “boy/man” and “girl/woman.” People who are non-binary may or may not identify as trans[6].
Gender-affirming care	The social, psychological and health supports and care that affirms a person's gender identity[7].
Intersectionality	A theoretical framework by Black feminist legal scholar Dr. Kimberle Crenshaw that posits that multiple social categories (e.g., race, ethnicity, gender, sexual orientation, socioeconomic status) intersect at the micro level of individual experience to reflect multiple interlocking systems of privilege and oppression at the macro, social-structural level (e.g., racism, sexism, heterosexism)[8].
Precarious migration status	Describes absence of any of the elements normally associated with permanent residence and citizenship in Canada, including work authorization, the right to remain permanently in the country, not depending on a third party for one’s right to be in Canada (e.g. sponsoring employer), and social citizenship rights available to permanent residents (e.g. public health coverage). Precarious status in Canada includes temporary workers, international students, and refugee applicants, as well as those who may have expired forms of status[9].

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[5] https://www.chrc-ccdp.gc.ca/individuals/human-rights/about-discrimination

[6] https://www.the519.org/education-training/glossary/

[7] Gender-affirming care: Definitions - Canada.ca

[8] https://nccdh.ca/resources/entry/public-health-speaks-intersectionality-and-healthequity

[9] L. Goldring, C. Berinstein and J. Bernhard (2009) Goldring-et-al-2009-Precariousstatus.pdf

Term	Definition
Social determinants of health	Social determinants of health refer to a specific group of social and economic factors within the broader determinants of health. These relate to an individual's place in society, such as income, education or employment. Experiences of discrimination, racism and historical trauma are important social determinants of health for certain groups such as Indigenous Peoples, 2SLGBTQ+ and Black communities[10].
Systemic racism	Organizational culture, policies, directives, practices or procedures that exclude, displace or marginalize some racialized groups or create unfair barriers for them to access valuable benefits and opportunities. This is often the result of institutional biases in organizational culture, policies, directives, practices and procedures that may appear neutral but have the effect of privileging some groups and disadvantaging others[11].
Socioeconomic status	Refers to an individual or group's social and economic position in society, typically determined by factors such as income, wealth, education, occupation, prestige, which influence access to resources and opportunities[12].
Trauma-informed care	Approach to care that acknowledges and understands the impacts and root causes of historical intergenerational trauma, recognizes the symptoms of trauma in patients, and integrates this knowledge into policies, procedures, practices and settings. Trauma-informed care is a commitment to provide services in a manner that is welcoming and appropriate to the unique needs of those affected by trauma[13].

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[10] Social determinants of health and health inequalities - Canada.ca

[11] https://www.ontariohealth.ca/sites/ontariohealth/files/2020-12/Equity%20Framework.pdf

[12] https://pmc.ncbi.nlm.nih.gov/articles/PMC3863696/

[13] National Collaborating Centre for Indigenous Health (2017). "What's New is Really Old: Trauma Informed Health Practices Through an Understanding of Historic Trauma" & Royal College of Physicians and Surgeons "Indigenous Health after Primer" (2019)

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JUNE 2025

Primary care and the lived experiences of equity-deserving Ontarians: A research summary

Overview

Primary care is a foundational part of the healthcare system. Yet 2.5 million people in Ontario do not have a family doctor.

Wellesley Institute conducted interviews and focus groups with low-income Ontario residents who were East Asian, Southeast Asian, South Asian, Black and 2SLBTQ+, as well as with service providers, to examine how socioeconomic status, racial identity, sexual orientation and gender identity may intersect and influence experiences accessing primary care.

The researchers looked to answer two specific questions:

1. What barriers do low-income, Black, other racialized and 2SLGBTQ+ populations experience accessing primary care in Ontario?
2. What can be done at the organizational and health system levels to facilitate improved access for these populations?

What is primary care access?

Primary care access is more than simply being connected (attached) to a healthcare provider.

It includes many factors, such as the location and availability of services, the attitudes and skills of providers, patients’ past healthcare experiences, and the quality of care they receive.

The findings

Challenges faced by equity-deserving Ontarians accessing primary care

Appointment logistics

Long wait times, lack of flexibility around appointment times, and shortages of nearby clinics were all cited by research participants as barriers to primary care. This meant participants too often relied on emergency departments or walk-in clinics for their primary care needs.

Language barriers

Racialized immigrants and newcomers whose native or preferred language is not English expressed difficulty communicating their health needs to primary care providers. This impacted their confidence in these interactions, or delayed their access to care.

Making sense of the health system

Most research participants, including newcomers to Canada, had difficulties understanding how the health system works and how to navigate it. This led to delays in care, and feeling stressed because they did not receive timely treatment.

Social and economic barriers

Out-of-pocket costs, especially for people with multiple health conditions, can create financial barriers for patients. Costs, combined with a perceived lack of sensitivity to this issue among health providers, deterred some from accessing the care they need.

Stigma and discrimination

Most equity-deserving participants experienced different forms of stigma and discrimination, particularly misgendering and racism, and particularly among those who identified as belonging to intersecting 2SLGBTQ+ and racialized communities. This contributed to a lack of trust in the system.

> ***"At some point there are people that are afraid to go to primary care…"***
>
> **Black focus group participant**

The findings

Solutions for increasing primary care access for equity-deserving patients

Community-based models

Community-based health services – Community Health Centres in particular – were seen as crucial because they focus on providing culturally adapted and patient-centred care for equity-deserving populations. They also often build strong support networks and connections for clients across legal, immigration/settlement, social services, work and income programs.

Multidisciplinary teams

Multidisciplinary teams – primary care practitioners combined with social workers, nurse practitioners, cultural/system navigators, mental health workers, dietitians, etc. – better address complex health and social issues. These teams could be particularly beneficial in non-urban settings, where, for example, family doctors who practice gender-affirming, trauma-informed care are relatively few.

Anti-discrimination and cultural safety approaches

Primary care should be delivered in a way that values a range of worldviews about health, promotes a holistic understanding of patients' needs, and actively addresses all forms of discrimination. Patients who felt culturally safe had dramatically improved experiences. Because language barriers can intersect with cultural barriers, there is also a need to expand translation support services.

Improved education and training for providers

Anti-racism, anti-discrimination and cultural competence training for providers should include giving them the skills to reflect on their own values and biases, and how they bring these into interactions with their patients. Importantly, education and training should be part of a multi-level strategy, including system changes, to facilitate equitable access and health outcomes.

> ***"It really feels good [when someone uses my correct pronouns]. It makes you feel comfortable over time, and you just want to remember this mentality that you're safe with this particular healthcare provider who accepts you for who you really are."***
>
> **Trans and non-binary focus group participant**

> ***"This study is unique in its inclusion of a diverse group of participants from intersecting social locations (racialization, economic position, gender identity and sexual orientation) with lived experience of challenges accessing the primary care system. The identification of solutions from the perspectives of community members will ideally lead to policy change with a direct positive impact on these groups."***
>
> **Wellesley Institute study authors**

About this document

This document summarizes for a general audience a research document entitled "A qualitative study of the barriers and enablers to primary care access for equity-deserving populations in Ontario."

All documents were funded by the Ministry of Health of the Province of Ontario, Grant #739. The views expressed in these publications are the views of Wellesley Institute and the authors and do not necessarily reflect those of the Province.

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Visit www.wellesleyinstitute.com to view the research report on which this summary is based.

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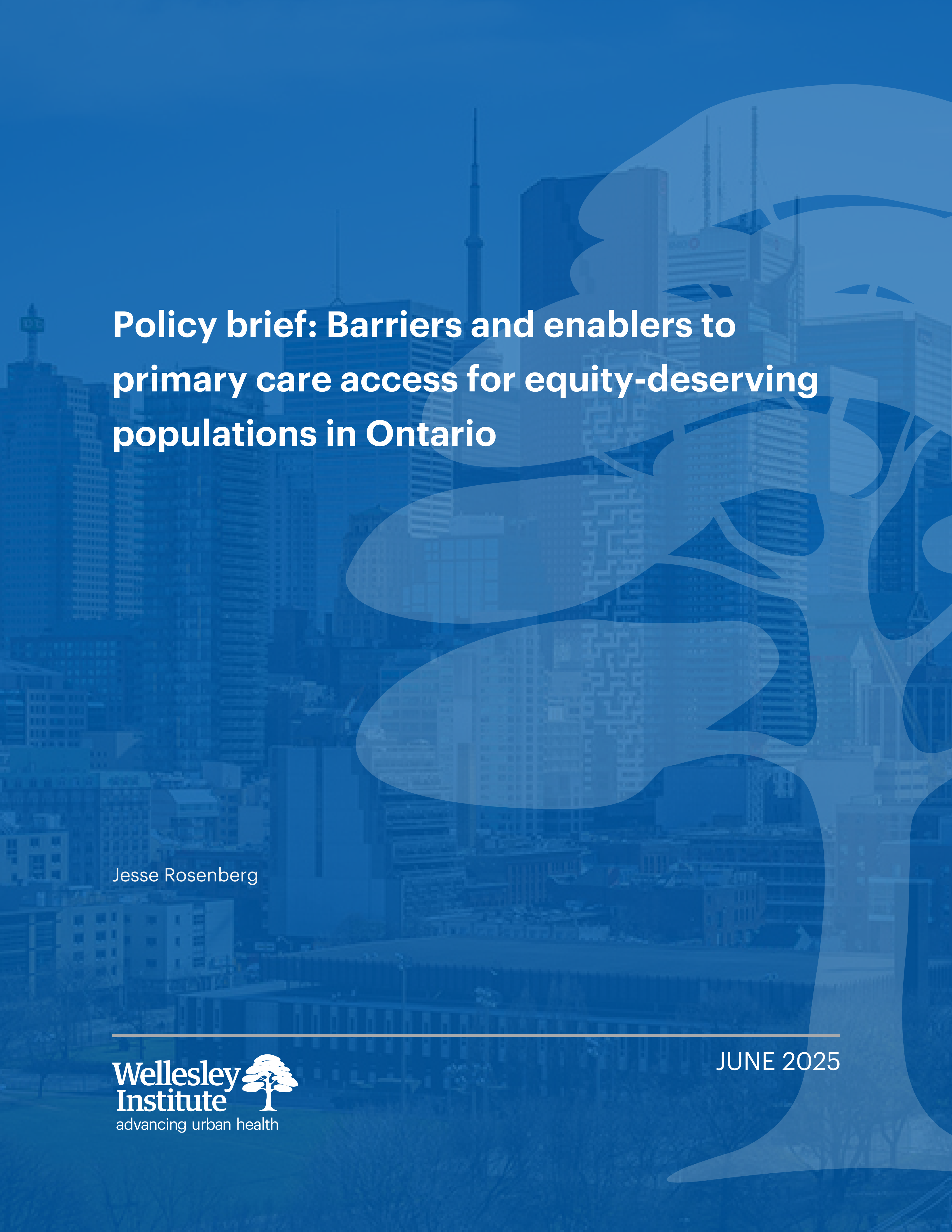

Policy brief: Barriers and enablers to primary care access for equity-deserving populations in Ontario

Jesse Rosenberg

JUNE 2025

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Wellesley Institute advances population health and reduces health inequities by driving change on the social determinants of health through applied research, effective policy solutions, knowledge mobilization and innovation.

About this document

This policy brief reflects the findings in the research report by Wellesley Institute entitled "A qualitative study of the barriers and enablers to primary care access for equity-deserving populations in Ontario."

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Acknowledgment of Traditional Land

We wish to acknowledge this land on which Wellesley Institute operates. For thousands of years, it has been the traditional land of the Huron-Wendat, the Seneca and the Mississaugas of the Credit. Today, this meeting place is still the home to many Indigenous people from across Turtle Island and we are grateful to have the opportunity to work on this land.

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Introduction

Primary care is the foundation of Ontario's healthcare system and a key entry-point into other parts of the system for patients. Primary care services are delivered in community settings by many different types of providers supporting a range of needs, including prevention, chronic disease and prenatal care[1].

In Ontario, 2.5 million people do not have a family doctor[2]. Newcomers, refugees and those living in the poorest neighbourhoods and the neighbourhoods with the most racialized residents are even worse off than others[3,4]. Equity-deserving populations in particular may face barriers to access or poor quality of care, in addition to inequities in health outcomes[5].

Solving this crisis requires more than simply being connected (attached) to a healthcare provider[6]. Healthcare access is determined by numerous factors, including location and availability of services, the attitudes and skills of providers, past healthcare experiences, and perceived quality of care. Safe and effective patient experience is also necessary for the system to improve health and health equity[7]. Advancing all of these factors is essential to what the healthcare system's goal should be: healthy primary care access.

In recent research work, Wellesley Institute reviewed research on barriers and facilitators to primary care for equity-deserving populations in Ontario to better understand how to improve access[8]. That work also examined the lived experiences of communities that are under-represented, including racialized and 2SLGBTQ+ communities.

For consideration, we provide initial recommendations below. These recommendations are intended to advance primary care attachment as the province begins to roll out its new team-based care model across the province.

Recommendations

Our healthcare system is fragmented, making it difficult for Ontarians to navigate. By taking action that ensures patients with the largest barriers to achieving healthy access are helped, everyone in Ontario will be able to receive the right care in the right place at the right time.

Recommendation 1: New primary care teams

As the government has wisely committed, finding enough primary healthcare providers to ensure everyone in Ontario is attached is a necessary first step.

Recommendation 2: Improved equitable geography

Equity should be considered in the roll-out of these new primary care teams.

The government's decision to advance primary care by postal code is a proxy for need, but racialization, income, and newcomer status should also be considered as part of the selection process. If the needs of these groups are ignored, the program will not meet its goals.

Future rounds of new teams should factor in these particular needs in selecting which areas of the province to next build in. This should include considering what already exists for different groups in communities across the province, and how equitable access can be best supported, including different models and, possibly, virtual care.

Recommendation 3: Who new teams are

Who those teams are – their diversity and their commitments to equity – offers another opportunity to ensure groups most in need of access do not fall further behind. Based on Wellesley Institute research, we recommend the requests for interest for new primary care teams include factors such as community engagement, representation of local communities in the staff of the prospective providers, commitment to include multicultural workers on their teams, and the ability of those providers to offer services in languages needed by local communities. This should include consideration of the providers' proposed commitments to equity-focused frameworks such as anti-discrimination, anti-Black racism, gender-affirming, and others, where relevant, to their communities.

Our research has indicated that models such as Community Health Centres are well-positioned to provide excellent care in underserved communities and in areas with significant representation of equity-deserving communities. Particular consideration should be given to ensuring that Community Health Centres or other team-based models with especially strong plans for engaging community and other community services are prioritized for the areas identified under the preceding recommendation.

Recommendation 4: Health equity impact assessments

Health equity for providers must be a cycle of thoughtful external engagement and internal review that drives change to build the health system we all want. To ensure our new primary care teams can meet this promise, the process to select the new health teams should require health equity impact assessments in advance. Those teams, once selected, should be required to regularly and meaningfully update and make public these assessments – with an emphasis on action.

Recommendation 5: Travel barriers

Our research indicated travel can be a significant barrier to care. Locations that reduce travel barriers for equity-deserving communities in the catchment areas should be taken into account in evaluating applications.

Recommendation 6: Opportunity for new, world-class approaches

These new primary care teams represent a significant new investment in Ontario's healthcare system. Unfortunately, they will be joining a system that is fragmented and difficult to navigate. We urge the government of Ontario to seize on the opportunity to make this network of new providers a model for the change in the rest of the system that could deliver fairness, and the enormous systemic benefits of health equity.

To that end, we urge the government to consider putting in place new approaches that leap beyond the issues of the past, and that the rest of the primary care system could join in coming years.

In particular, the government should consider putting in place new approaches around:

1. **Translation**. There is an opportunity here to pilot a new province-wide translation model that ensures providers' time is used wisely and that those accessing the system are not harmed by poor translation. Poor care due to translation issues worsens health and costs the system down the line through repeat visits and emergency or tertiary care that could have been avoided.

2. **Booking**. Differing policies and approaches, provider by provider, make the system difficult to navigate and waste provider time and money. The government should consider putting in place a central system for these new providers that eases access and reduces red tape and expensive missed appointments. This should include ensuring unnecessary fees around booking and penalties for cancellation are eliminated.

3. **Training for equitable care**. These new providers offer an opportunity to get professional development right. We must ensure providers are equipped to efficiently and effectively work with the communities they serve. This training should educate providers about the impacts of the social determinants of health on access, quality of care and health outcomes. It should ensure providers have the skills, tools and procedures in place to offer equitable care to the populations they serve. The Ministry of Health, Ontario Health, Ontario Health Teams, and these providers should work together to ensure additional supports are in place that mean healthcare teams can provide equitable access and outcomes.

   Ontario can become a model for reform to the world by launching a process of community and professional engagement, then delivering a system that prepares and continues to aid workers at these new clinics to help their patients how they need to be helped.

4. **Community engagement**. To supplement the Health Equity Impact Assessments proposed above, the government should develop and implement a new model for community engagement that brings the people of Ontario into their system. Providers and patients alike will benefit from the partnership this would bring to these new teams and their communities.

Other opportunities for improved systems that our research also raised might include addressing electronic health records (access, simplicity, and transfers) and referrals.

Finally, these new teams will be taking on a significant number of new patients who desperately need primary care attachment. For that attachment to maximally benefit them, their access to the social determinants of health should be considered. The best global thinking on how our health system (and specifically these new clinics) can help ensure these patients can access what they need, including healthy jobs, housing and transportation, should be considered.

Ontario is taking the right next step in healthcare by moving to deliver primary care access for all. By taking into account the needs of everyone in Ontario, we have an incredible opportunity to improve our healthcare system, save lives, and deliver on the promise of fairness for all.

References

1. Kiran T, E. A., Mangin D, et al. . (2022). Brief on Primary Care Part 1: The roles of primary care clinicians and practices in the first two years of the COVID-19 pandemic in Ontario. *Science Briefs of the Ontario COVID-19 Science Advisory Table, 3*(67). https://doi.org/10.47326/ocsat.2022.03.67.1.0
2. Ontario College of Family Physicians. (July 11, 2024). New Data Shows There Are Now 2.5 Million Ontarians Without a Family Doctor https://ontariofamilyphysicians.ca/news/new-data-shows-there-are-now-2-5-million-ontarians-without-a-family-doctor/
3. Sundareswaran, M., Martignetti, L., & Purkey, E. (2024). Barriers to primary care among immigrants and refugees in Peterborough, Ontario: a qualitative study of provider perspectives. *BMC Primary Care, 25*(1), 199. https://doi.org/10.1186/s12875-024-02453-x
4. Howard, M., Wu, F., Kiran, T., Frymire, E., Lapointe-Shaw, L., Jaakkimainen, L., Glazier, R., & Green, M. (2023). The Impact of the COVID 19 Pandemic on Continuity of Care with Ontario Family Physicians. *The Annals of Family Medicine, 21*(Supplement 1), 3671 https://doi.org/10.1370/afm.21.s1.3671
5. Szymczak, J. E., Fiks, A. G., Craig, S., Mendez, D. D., & Ray, K. N. (2023). Access to What for Whom? How Care Delivery Innovations Impact Health Equity. *Journal of General Internal Medicine, 38*(5), 1282-1287. https://doi.org/10.1007/s11606-022-07987-3
6. Levesque, J.-F., Harris, M. F., & Russell, G. (2013). Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *International journal for equity in health, 12*(1), 18. https://doi.org/10.1186/1475-9276-12-18
7. Jindal, M., Chaiyachati, K. H., Fung, V., Manson, S. M., & Mortensen, K. (2023). Eliminating health care inequities through strengthening access to care. *Health Services Research, 58*(S3), 300-310. https://doi.org/10.1111/1475-6773.14202
8. Sanford, S., Yin, Y., & Sheppard, C. L. (2024). *Barriers and Enablers to Primary Care Access for Equity-Deserving Populations in Ontario: A Scoping Review*. https://www.wellesleyinstitute.com/wp-content/uploads/2024/09/Barriers-and-Enablers-to-Primary-Care-Access-for-Equity-Deserving-Populations-in-Ontario-A-Scoping-Review.pdf

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