Social Prescribing Needs of Older Adults in Canada

SFU

CISP Canadian Institute *for* Social Prescribing

CASCH Canadian Alliance for Social Connection and Health

GENWELL PROJECT
HUMAN CONNECTION MOVEMENT

About this Report

This report provides preliminary findings from a patient-oriented research project aiming to understand the social prescribing needs of older adults, aged 55+, living in Canada. The purpose of this report is to provide an overview of key themes that emerged from our analyses of the data, with specific attention to equity-considerations that can help inform the development and implementation of social prescribing programs. In fulfilling this purpose, results from the study were analyzed to identify differences in social prescribing needs and attitudes by age, gender, income, ethnicity, residential status, geographic location, sexual orientation, and disability status.

Findings highlight widespread health and social needs, diverse barriers to healthcare access and utilization, and a generally positive perception of the holistic health care supported by social prescribing programs. Furthermore, we highlight systematic inequities and individualized needs of individuals across demographic groups – reflecting broader challenges to health equity experienced by individuals who are socially marginalized and structurally disadvantaged.

As the results of this report are exploratory, they should be interpreted with caution. However, it is our hope that our results will provide preliminary insights that can be helpful for those engaged in front line implementation of social prescribing programs.

Acknowledgements

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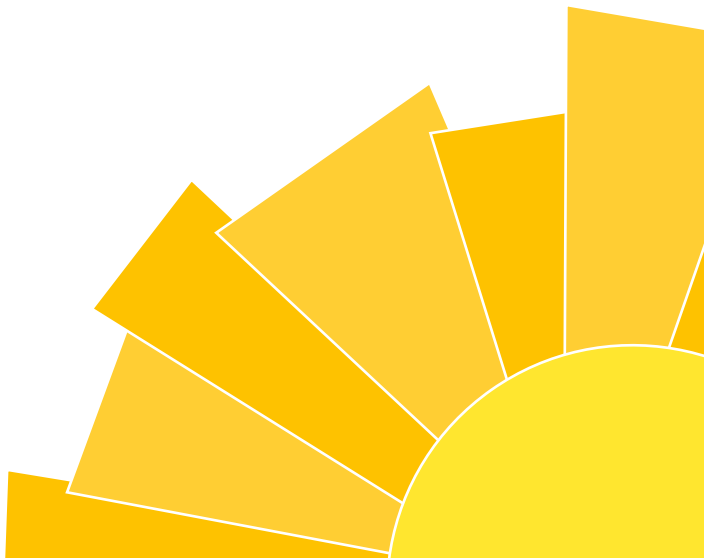

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Background

What is social prescribing?

Social prescribing, also referred to as community referral, is a way of linking patients with non-medical sources of support within the community. These programs connect people with various community services and activities, such as volunteering, arts activities, group learning, gardening, befriending, cookery, healthy eating advice, and a range of sports, to promote their well-being and tackle social isolation.

Social prescribing comes in many forms, and it can vary widely in its implementation, reflecting the diversity of communities and individuals' needs. However, some key elements are commonly seen in most social prescribing programs:

1. Link Workers or Social Prescribers: These are the individuals who facilitate the social prescribing process. They might be employed by a medical practice, a community organization, or a health system. They work closely with patients, get to know them, understand their needs and aspirations, and then refer them to relevant local, non-clinical services.

2. Local Community Resources: A key part of any social prescribing program is the availability of local community resources. These might include social clubs, volunteering opportunities, exercise groups, learning classes, self-help groups, or community gardening projects, among others.

3. Personalized Care and Support Plan: Each individual's needs and preferences are different, so social prescribing programs typically involve creating a personalized care and support plan. This plan might include several different types of support, reflecting the fact that a person's health is influenced by a range of social, economic, and environmental factors.

4. Collaboration and Partnership: Social prescribing programs usually involve partnerships between different types of organizations, such as healthcare providers, community groups, and social services. This collaboration is essential to ensure that people can access the support they need and that different services are coordinated effectively.

5. Monitoring and Evaluation: To ensure that social prescribing programs are effective, it's important to monitor outcomes and evaluate the impact of the service. This might involve tracking changes in individuals' health and well-being, or evaluating whether the program is successful in reducing healthcare use.

Overall, social prescribing represents a holistic approach to health and well-being, recognizing that people's health is influenced by a range of factors beyond traditional medical care. Its primary aim is to address people's needs in a broader context, targeting social determinants of health like isolation, stress, inactivity, and lack of social interaction.

Why is understanding older adult's social prescribing needs important?

Understanding older adults' social prescribing needs is important for several reasons:

1. Age-Related Health Concerns: As people age, they are more likely to experience health problems, many of which are chronic or complex. These conditions may be exacerbated by isolation, stress, poor nutrition, and lack of physical activity. Social prescribing can help address these factors, potentially reducing the severity of health problems and improving older adults' quality of life.

2. Loneliness and Isolation: Older adults, especially those living alone or in rural areas, can experience significant loneliness and social isolation, which can negatively impact both mental and physical health. Social prescribing can provide opportunities for social interaction and community involvement, helping to mitigate these issues.

3. Holistic Approach to Health: Traditional medical interventions might not fully address the health and well-being needs of older adults. Social prescribing can provide a more holistic approach, tackling not just the physical, but also the social, emotional, and psychological aspects of health.

4. Prevention and Early Intervention: Social prescribing can play a key role in preventing health problems or intervening early before conditions worsen. For example, encouraging an older adult to join a walking group can help improve physical health, while also providing opportunities for social interaction.

5. Empowerment and Autonomy: Social prescribing enables older adults to take an active role in their own health and well-being. Through activities and services that they enjoy and are interested in, they can feel more engaged, which can contribute to a better quality of life.

6. Reduced Pressure on Health Services: By addressing the social determinants of health, social prescribing can potentially reduce demand for healthcare services, such as GP appointments and hospital admissions. This is particularly important given the pressures many health systems face due to aging populations.

In summary, understanding the social prescribing needs of older adults can contribute to more effective, personalized care that improves overall health outcomes and well-being for this population.

Why is it necessary to take an equity-oriented approach to assessing social prescribing needs?

Taking an equity-oriented approach to assessing social prescribing needs is crucial because it helps ensure that all individuals, regardless of their social, economic, or cultural backgrounds, have the opportunity to benefit from these services. Health inequities, which can be based on factors such as income, race, gender, or geographical location, can significantly affect an individual's access to health-promoting resources and activities. Thus, by assessing social prescribing needs through an equity lens, programs can be designed to reach and support those who are most marginalized or disadvantaged.

Social determinants of health - conditions in the environments in which people are born, live, learn, work, play, and age - often lead to health disparities. Social prescribing has the potential to address some of these determinants by connecting individuals with community resources that can support health and well-being. But for this potential to be realized, it is necessary to understand and address the unique challenges that different groups may face in accessing these resources. An equity-oriented approach takes into account these unique challenges, making the program more inclusive, effective, and fair.

Additionally, an equity-oriented approach can also help address systemic barriers to health and well-being. For example, some groups may be less likely to access social prescribing programs due to stigma, lack of information, or lack of culturally appropriate services. By identifying and addressing these barriers, social prescribing programs can be made more accessible and welcoming to all, contributing to better health outcomes for the entire community.

Lastly, it's important to remember that an equity-oriented approach involves not just identifying and addressing disparities, but also empowering individuals and communities to take control of their own health and well-being. This can involve providing opportunities for individuals to participate in the design and implementation of social prescribing programs, ensuring that these programs are responsive to the unique needs and preferences of different communities.

What were the aims of this report?

Recognizing the importance of taking an equity-oriented approach to assessing older adult's social prescribing needs, the present study aimed to:

1. Assess the social prescribing needs of older adults by analyzing their needs and preferences for social prescribing programs, and
2. Assess whether key demographic groups differ with respect to their needs and preferences for social prescribing programs.

Methodology

Participants were invited to participate in an online survey in the Summer 2022, promoted with paid advertisements on Facebook, Instagram, Twitter, Google ads, and through front-line healthcare services to increase distribution amongst older adults across Canada. Additional paid ads and community e-mail outreach were performed to increase demographic diversity of participants.

Inclusion criteria for the online study included:

1. 55 years of age or older;
2. Resided in Canada; and
3. Agreed to participate (informed consent).

Participation in the online survey enrolled participants in a prize draw of $200 CAD cash, with a 1 in 100 odds in winning. All responses were collected via Qualtrics, and required informed consent.

The results from the social prescribing data comes from a survey of over 4100 participants. This large sample size was needed to recruit a sufficient number of people across demographic factors of interest. To adjust for the non-representativeness of this sample, data was weighted by income, age, gender, living arrangement, disability status, and ethnicity using iterative proportional fitting with raking ratio estimation. With this method, the data points reported by individuals from over represented populations are down-weighted and the data points reported by individuals from under-represented populations are up-weighted.

The weighted data is then compared by strata that include age, gender, disability status, income groups, rural or urban community type, living arrangement, sexual orientation, and ethnicity. The groups are compared based on the type of data. Where the data is categorical, the counts and percentages are compared with chi-squared test. When the data is numeric, the means are compared by the groups with a t-test.

Participant Demographics

The following section provides a brief overview of the demographic characteristics of included participants.

Age

The average (weighted) age of our sample was 68.1 years old (SD: 9.4).

Age Groups	N	Unweighted %	Weighted %
55-59	388	9.4	21.6
60-64	604	14.6	21.0
65-69	904	21.9	18.1
70-74	836	20.2	15.1
75-79	742	17.9	10.3
80-84	443	10.7	6.9
85-89	156	3.8	4.3
90-94	53	1.3	2.1
95-99	10	0.2	0.6

Gender

There were approximately equal parts men and women in our sample, with approximately 1% of participants who were non-binary.

Gender	N	Unweighted %	Weighted %
Man	784	24.3	48.8
Non-binary	24	0.7	1.0
Woman	2415	74.9	50.2

Income

The majority of participants were currently unemployed with a smaller percentage of participants still working full-time or part-time. The majority of participants made under $59,000 yearly, 20% made between $60,000-99,000 yearly, and 10.8% made over $100,000 yearly.

Income Group	N	Unweighted %	Weighted %
<$30,000	895	31.7	36.0
$30,000 - $59,999	964	34.1	33.2
$60,000 - $99,999	592	20.9	20.0
$100,000+	375	13.3	10.8

Geographic Location

The majority of participants lived in a large urban centre or medium-sized city or town with fewer participants living in a small town or a rural area.

Geographic Location	N	Unweighted %	Weighted %
Large urban centre (100,000+ people)	1325	40.7	42.1
Medium city/town (30,000-99,999 people)	658	20.2	19.9
Small city/town (1,000-29,999 people)	799	24.6	23.6
Rural area (Less than 1000 people)	470	14.5	14.5

Living Arrangement

Most participants did not live alone.

Living Arrangement	N	Unweighted %	Weighted %
Alone	1201	37.1	14.5
Not alone	2033	62.9	85.5

Sexual Orientation

Most participants identified as straight.

Sexual Orientation	N	Unweighted %	Weighted %
Straight	2799	89.9	87.1
2SLGBTQ+	315	10.1	12.9

Ethnicity

The majority of participants were Canadian-born and primarily white. A smaller proportion of the participants were Indigenous or of a visible minority.

Ethnicity	N	Unweighted %	Weighted %
Black African (e.g. Ghana, Kenya, Somalia)	4	0.12	0.43
Black Canadian or African-American	23	0.69	2.02
East Asian (e.g. China, Japan, Korea, Taiwan)	35	1.0	3.4
Indigenous (First Nations, Metis or Inuit)	111	3.3	4.9
Indo-Caribbean (e.g. Guyanese with origins in India)	4	0.12	0.35
Latin American (e.g. Argentina, Mexico, Nicaragua)	24	0.72	2.67
Middle Eastern (e.g. Egypt, Iran, Israel, Saudi Arabia)	20	0.60	1.88
South Asian (e.g. India, Sri Lanka, Pakistan)	34	1.0	3.5
South East Asian (e.g. Vietnam, Malaysia, Philippines)	39	1.2	4.7
White	2928	87.4	67.5
Another ethnicity not listed above.	130	3.9	9.2

Note: Participants were able to choose multiple ethnicities.

Disability

The majority of participants self-reported some type of disability, with the most common disabilities being mobility disability, difficulty hearing, visual impairment, and chronic illness. And the majority of participants indicated they could leave home without assistance.

Disability	N	Unweighted %	Weighted %
Blind, low vision or visual impairment	418	6.4	6.5
Deafness, or difficulty hearing	823	12.6	12.8
Communication disability (use of augmentative or alternative communication)	30	0.46	0.56
Physical or mobility disability	1209	18.4	18.4
Chronic illness	1086	16.6	17.1
Mental health disability (including depression)	761	11.6	11.9
Labelled with an intellectual disability	22	0.34	0.43
Learning disability	55	0.84	1.26
Autism, Aspergers or neuro-diverse spectrum	42	0.64	0.94
Chronic pain	1281	19.5	19.4
None of the above	829	12.6	10.7

Note: Participants were able to choose multiple disabilities.

Relationship Status

Approximately half of participants indicated they were in a monogamous relationship, with other participants indicating they were widowed, divorced, or single.

Relationship Status	N	Unweighted %	Weighted %
Dating	27	0.85	0.65
Divorced	469	14.8	10.1
Relationship (Monogamous)	1496	47.2	60.0
Relationship (Open)	29	0.92	1.7
Relationship (Polyamorous)	5	0.16	0.15
Separated	118	3.7	3.7
Single	426	13.5	13.1
Widowed	598	18.9	10.8

Physical and Mental Health

Participants were asked to report on their self-rated physical and mental health, whether they currently have any chronic health conditions or disabilities, and answer questions to score on potential for anxiety and depression.

Self-Rated Physical and Mental Health

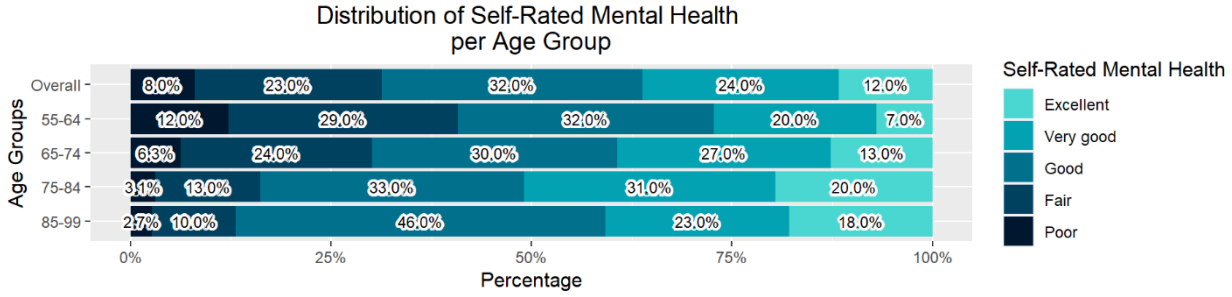
Participants were asked to rate your perceived physical and mental health on a scale of "Poor" to Excellent". Overall, the majority of participants indicated their physical health was "Fair" or "Good", and anywhere between "Fair" and "Very Good" for mental health.

Physical Health	N	Unweighted %	Weighted %
Excellent	151	4.6	3.8
Very good	708	21.4	18.8
Good	1123	34.0	32.1
Fair	975	29.5	31.8
Poor	346	10.5	13.5

Mental Health	N	Unweighted %	Weighted %
Excellent	435	13.2	11.7
Very good	896	27.1	24.4
Good	1042	31.5	32.5
Fair	725	21.9	23.3
Poor	205	6.2	8.0

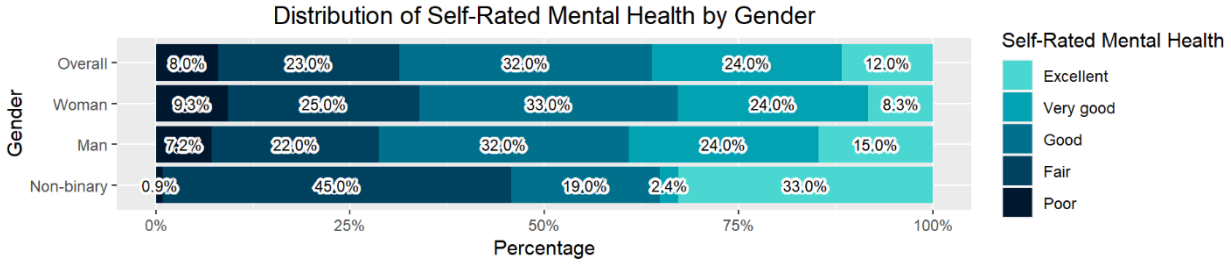
Differences by Age

It was important to identify whether there were differences in self-rated physical or mental health based on age groups. For physical health, there was no statistically significant difference by age group ($p = 0.16$); however, there was for mental health by age group ($p < 0.001$). For instance, a higher proportion of older adults in the age bracket of 85-99 years old rated their mental health as "Excellent" or "Good" compared to the overall sample of older adults, as well as fewer rating "Poor" mental health.



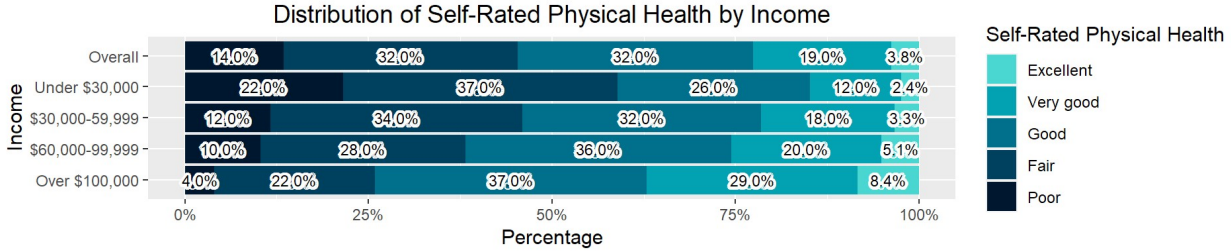
Differences by Gender

There was no statistically significant differences in self-reported physical health by gender (p = 0.512). In self-reported mental health, however, there was a statistically significant difference by gender (p <0.001). Men were more likely to rate their mental health as “Excellent” compared to the overall sample; comparatively, women were slightly less likely to rate their mental health as “Excellent” compared to the overall sample. Non-binary participants were less likely to rate their mental health as “Poor” and more likely to rate it “Excellent”; however, the sample size of the present study’s non-binary population is small (24 participants, weighted 1.0%) and may be provide little generalizability and reliability.

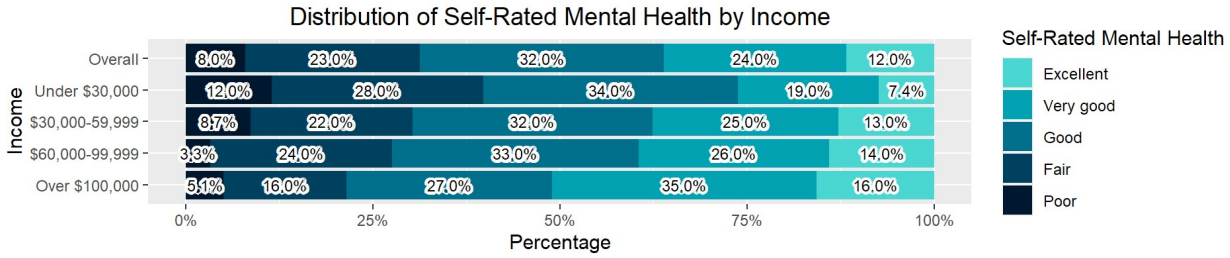


Differences by Income

Both self-reported physical and mental health were statistically significant by differences in income. For self-rated physical health by income (p <0.001), participants in lower income brackets were more likely to rate their physical health as poor compared to the overall study sample, and participants in higher income brackets were less likely to rate their physical health as poor. The general trends by income group indicate that lower income is associated with poorer self-rated physical health.



A similar trend was observed for self-rated mental health by income (p <0.001); participants indicating their income was over $100,000 were also more likely to rate their mental health as "Excellent" or "Very good" compared to the overall study sample, and participants who's income was under $30,000 were less likely to report this. In combination, the results show a clear positive relationship between self-rated physical and mental health and income.

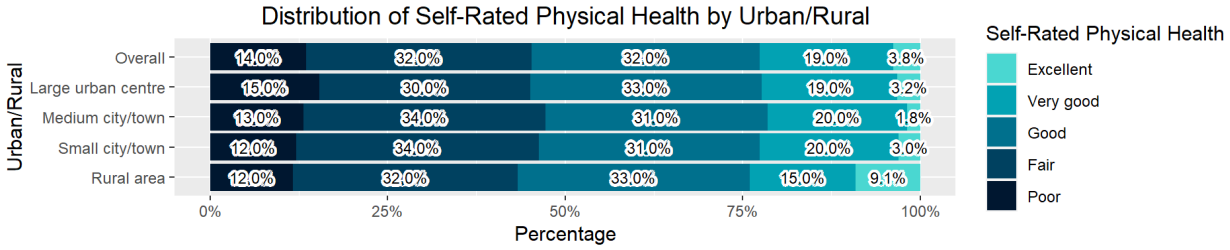


Differences by Urban/Rural

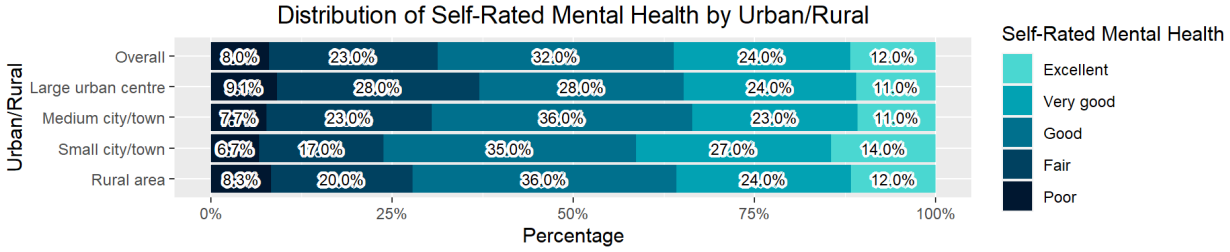
Participants were asked to identify the general size of the area they reside in; this information was used to determine differences in effect by urban/rural Canadian regions. Specifically, the four options were described as:

- Large urban centre (100,000+ people)
- Medium city/town (30,000-99,999 people)
- Small city/town (1,000-29,999 people)
- Rural area (Less than 1000 people)

There was a statistically significant difference for both self-rated physical and mental health by urban/rural location. For self-rated physical health by urbanicity (p = 0.008), participants who resided in rural areas were more likely to rate their physical health as "Excellent" compared to the overall study sample. Since the majority of participants making up the overall study sample reside from large urban centres (unweighted 40.7%), it can be inferred that participants in rural areas had better physical health than their urban counterparts.

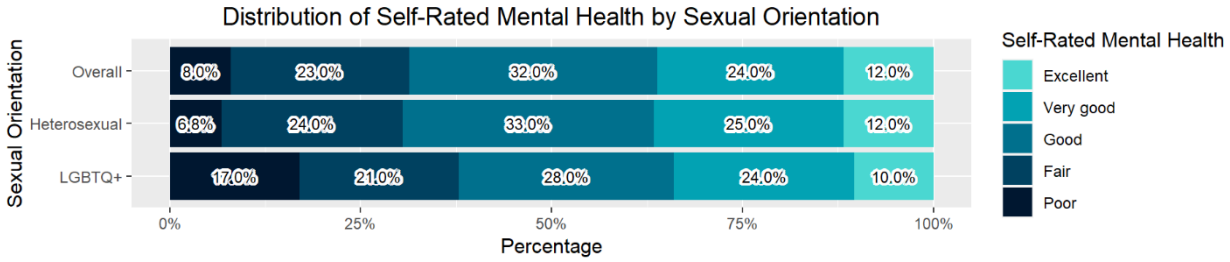


For self-rated mental health by urbanicity (p = 0.024), the differences were slighter. There is a slight trend; as one moves from urban to rural residence, a greater number of participants rate their mental-health as “Good”. Those living in a small city/town rated their mental health the best overall (as “Excellent”, “Very Good”, and “Good”) compared to the overall study sample.



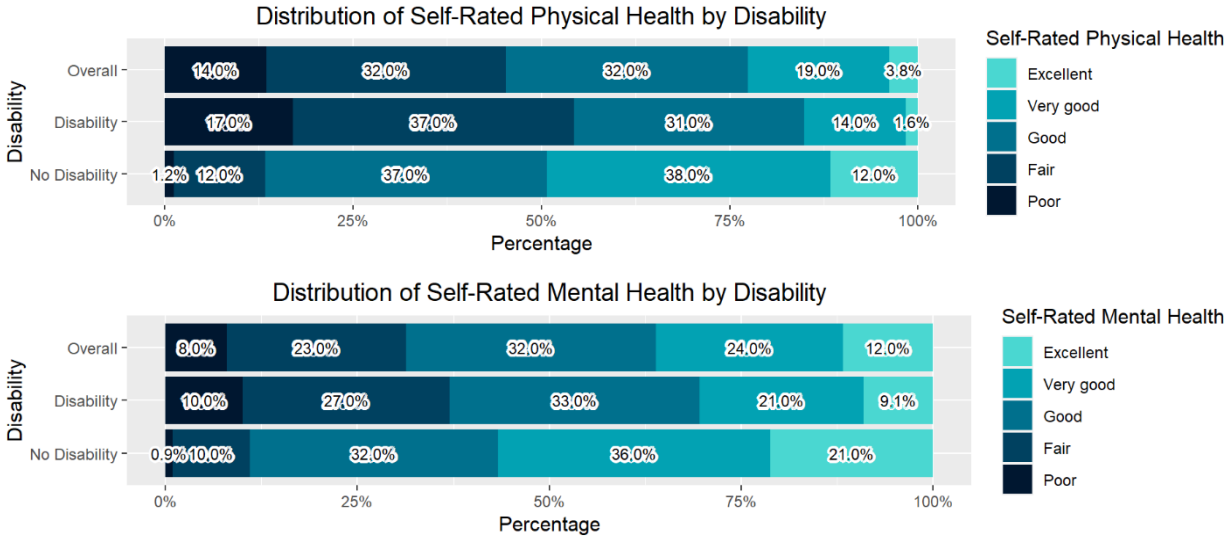
Differences by Sexual Orientation

Although there was no statistically significant difference in self-rated physical health by sexual orientation (p = 0.88), there was a statistically significant difference by sexual orientation for mental health (p = 0.001). 2SLGBTQ+ participants were more likely to rate their mental health as “Poor” compared to the overall study sample. However, as was the case with results for non-binary participants under “Differences by Gender”, the total number of 2SLGBTQ+ participants in the study was small (315, weighted 12.2%) and thus may lack generalizability. Conclusions must be considered with caution.



Differences by Disability

There were statistically significant differences in both self-rated physical and mental health by disability status (both at $p < 0.001$). Expectedly, participants who reported having no disability were more likely to perceive their physical health as positive ("Good", "Very Good", "Excellent"). Interestingly, similar trends were evident for self-rated mental health; participants without any disabilities were also more likely to perceive their mental health as positive. Such results suggest that disability not only effects the physical body, but the mind as well, in our study of older adults.



Chronic Health Conditions and Disabilities

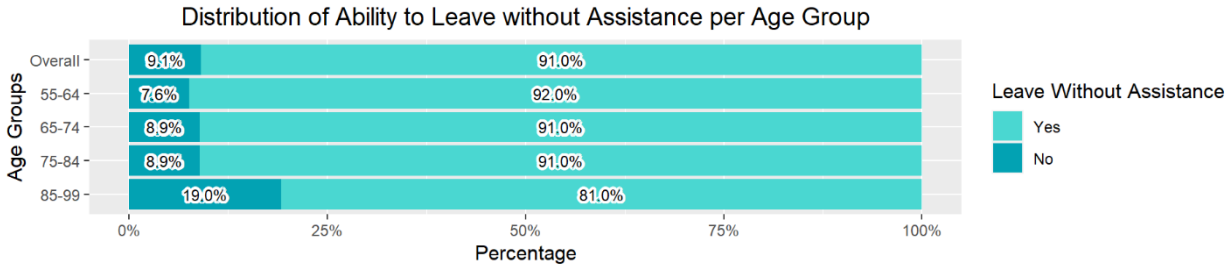
Participants were asked to identify any and all disabilities that they face. Specific disabilities are listed under "Participant Demographics" in an earlier section. For the purposes of the following analyses, disability was treated as a dichotomous variable, in which participants with any disability formed one group, and those without any disability formed the other. Participants were also asked to indicate whether they are currently able to leave their home without assistance. The majority of participants reported that they had a disability (78%) but also that the majority of participants could leave their home without assistance (90.9%).

Any Disability	N	Unweighted %	Weighted %
Disability	2471	75.1	78.0
No disability	818	24.9	22.0

Leave without Assistance	N	Unweighted %	Weighted %
Cannot leave without assistance	259	7.9	9.1
Can leave without assistance	3039	92.1	90.9

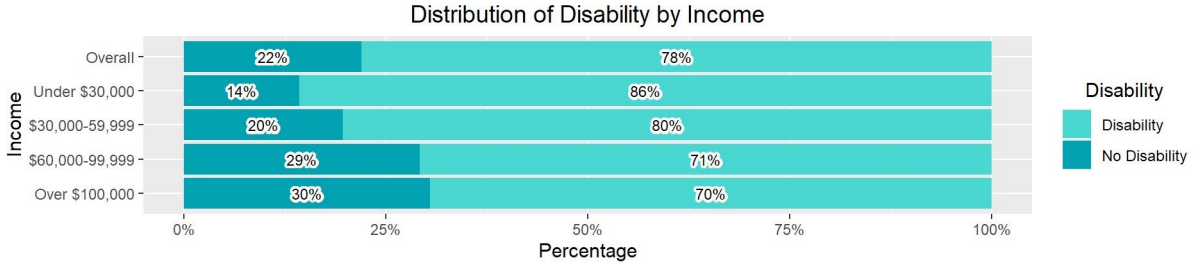
Differences by Age

There was no statistically significant difference in disability status by age (p = 0.313). For the ability to leave home without assistance (p = 0.011), as expected, participants in the age group 85-99 were more likely to be unable to leave home without assistance compared to the overall study sample.

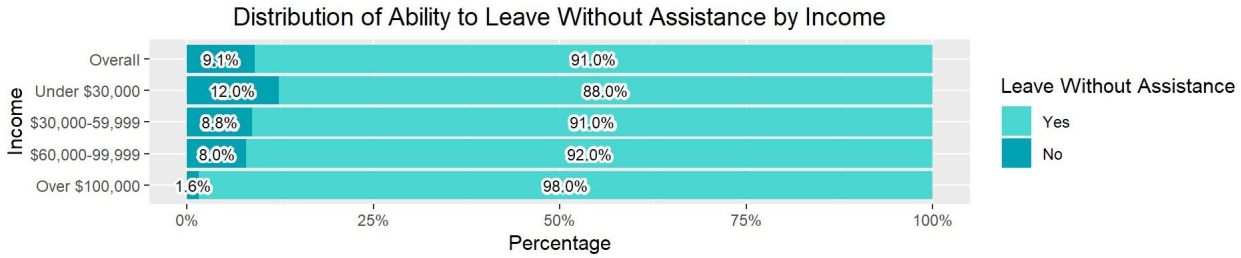


Differences by Income

Differences by income was statistically significant for disability status (p <0.001). Participants in income brackets $60,000-99,000 and over $100,000 were less likely to report having any disability. In contrast, participants in income brackets $30,000-59,000 and under $30,000 were more likely to report having a disability.

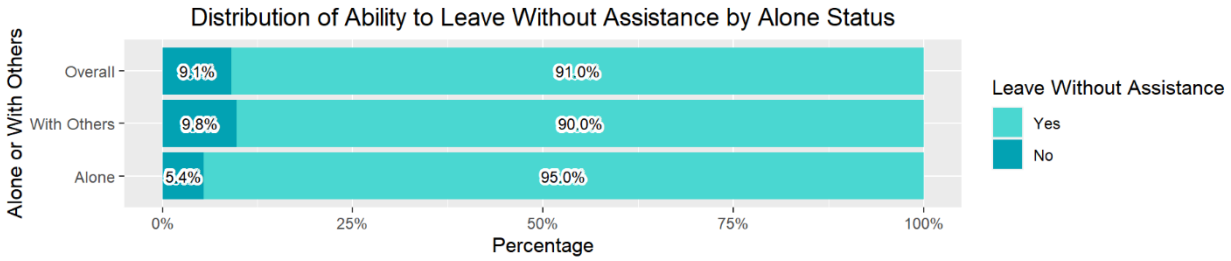


Differences by income was statistically significant for ability to leave home without assistance (p = 0.002). Similar to disability status participants in higher income brackets were more likely to indicate they had the ability to leave home without assistance.



Differences by Living Arrangement

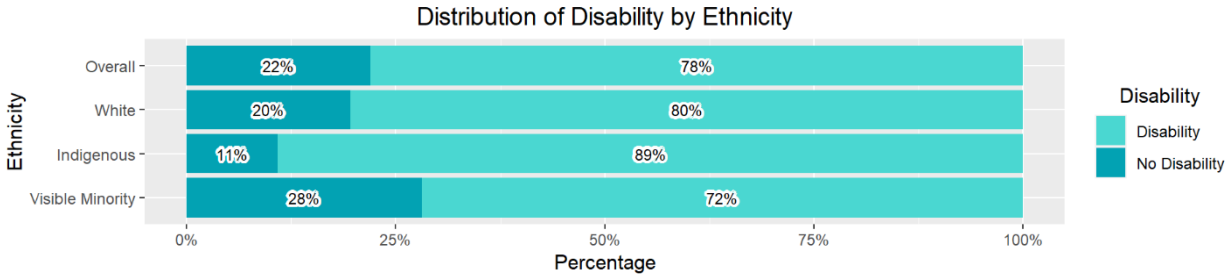
There was no statistically significant difference in disability status by live arrangement (p = 0.161). For the ability to leave home without assistance (p = 0.002), participants who lived alone were slightly more likely to report being able to leave home without assistance. Intuitively, older adults who were able to live alone, by necessity, must also be able to leave without assistance, the results reflect that.



Differences by Ethnicity

For disability status (p = 0.001), visible minority participants were less likely to have any disability compared to the overall study sample, and Indigenous participants were more likely to. It is unclear whether visible minorities lead healthier lifestyles, for example, and thus have less reported disabilities, or that culturally visible minorities were less likely to report illness or seek help for issues, and thus diagnoses.

There was no statistically significant difference in ability to leave home without assistance by ethnicity (p = 0.378).



Anxiety and Depression

Participants were asked four questions on symptoms relating to anxiety and depression and scored using the GAD-2 and PHQ-2 scores for anxiety and depression, respectively (Kroenke et al., 2003, 2007).

And questions on symptoms of anxiety:

- Feeling nervous, anxious or on edge
- Not being able to stop or control worrying

Participants were asked to answer questions on symptoms of depression:

- Little interest or pleasure in doing things
- Feeling down, depressed or hopeless

Specifically, participants were asked to answer the above questions on symptoms in regards to over the past 2 weeks, and the frequency as “Not at all”, “Several days”, “More than half the days”, or “Nearly every day”.

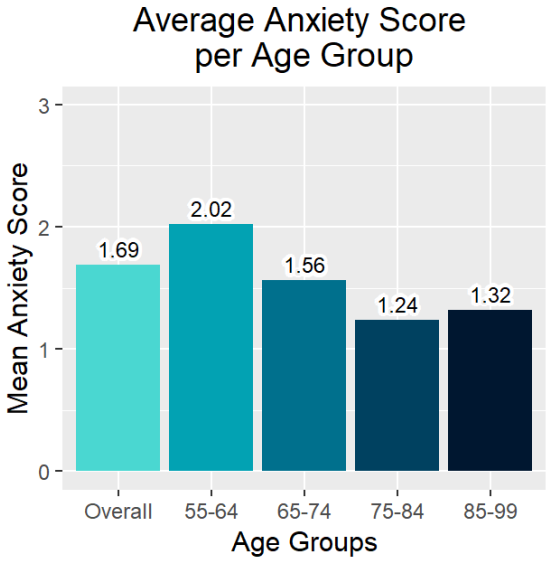
Results from these questions were combined and scored out of 6. A score of 3 or greater out of 6 was considered an indication that major depressive disorder was likely. A score of 3 or greater out of 6 was considered as higher potential for general anxiety disorder. Score out of 6, with 3 or greater indicating major depressive disorder is likely, and that further diagnostic evaluation for general anxiety disorder is warranted.

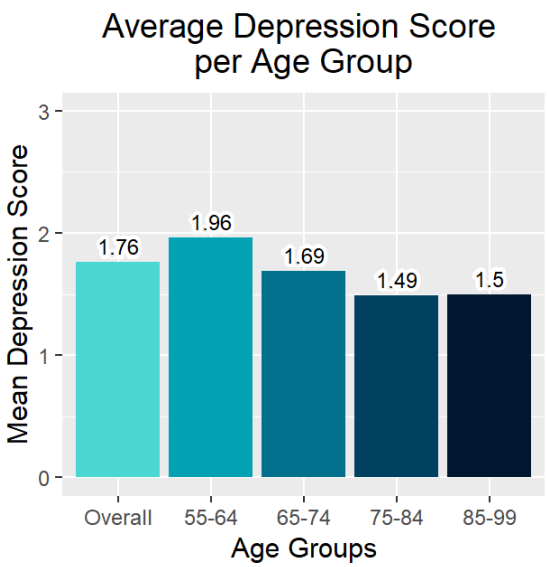
On average, participants scored 1.76 on the depression score, and 1.69 on the anxiety score; both are indications of some depressive and anxiety symptoms, but no strong indication of clinical major depressive disorder or generalized anxiety disorder.

Anxiety and Depression	Weighted Mean (SD)
Depression Score (0 – 6)	1.76 (1.80)
Anxiety Score (0 – 6)	1.69 (1.81)

Differences by Age

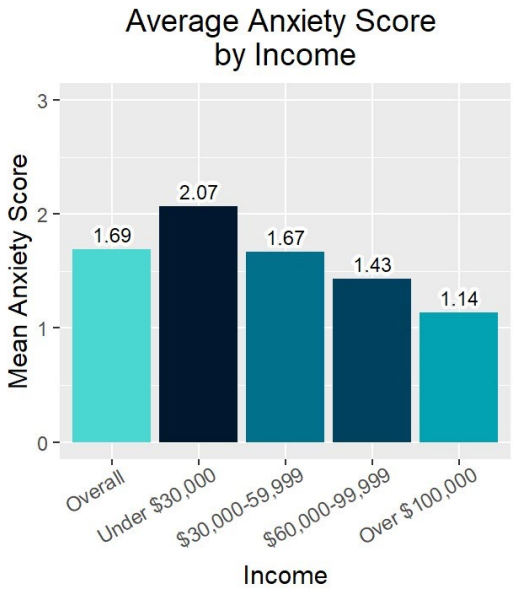
There were some differences in average depression and anxiety scores by age. For depression ($p = 0.003$), the younger older adults (aged 55-64) scored slightly higher (i.e. worse) on the depression score compared to the overall study sample, and the older age brackets scored slightly lower (i.e. better). Similarly trends by age for evident for anxiety ($p < 0.001$) as well.

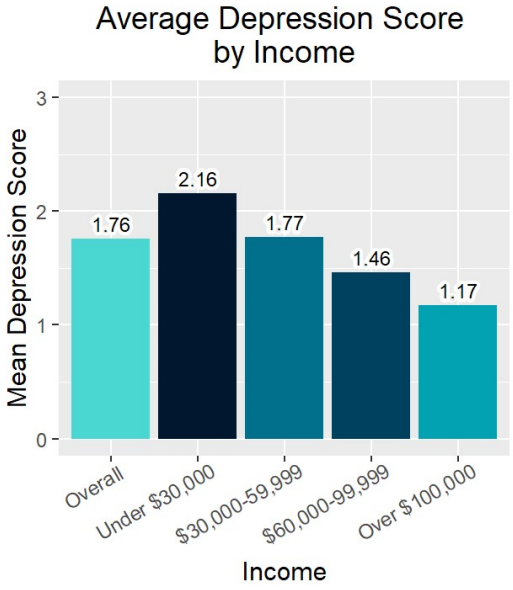




Differences by Income

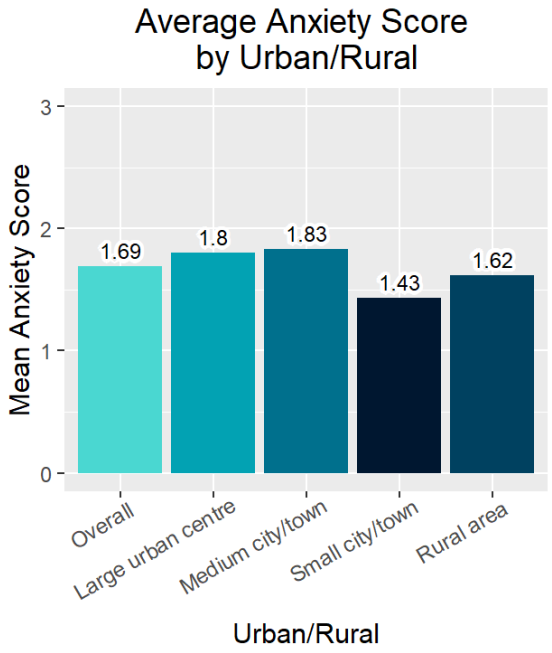
Participants in the under $30,000 income bracket scored higher on the depression score, with trends of decreasing average depression scores with increasing income ($p < 0.001$). Similar trends were found between average income scores and income as well ($p < 0.001$).





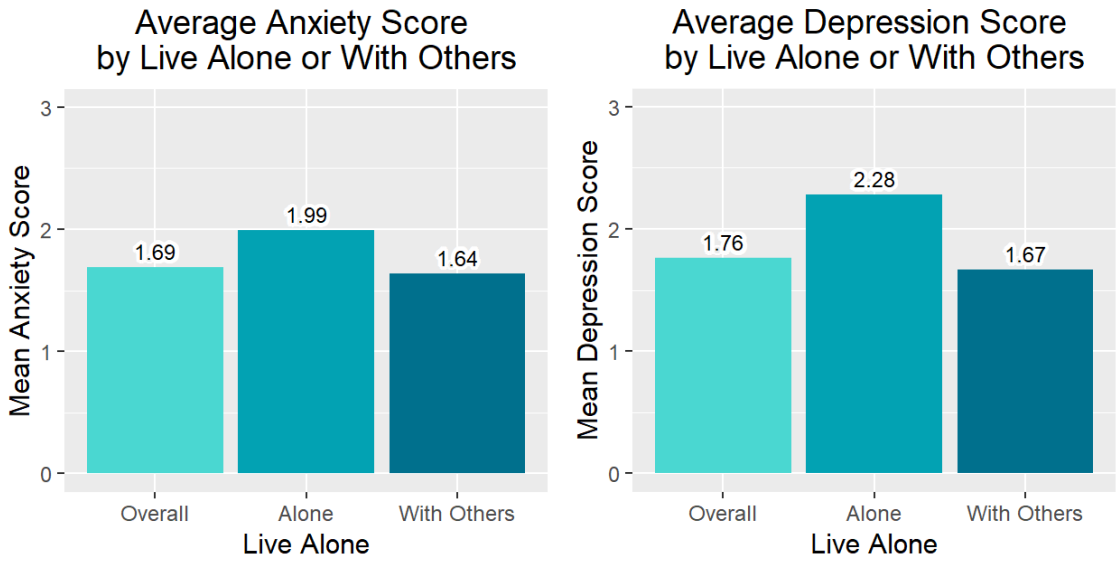
Differences by Urban/Rural

There was no statistically significant difference in average depression scores by urban/rural residence (p = 0.468). Participants in small city/town scored lower on the anxiety score compared to the overall study sample, whereas those living in a large urban centre or a medium city/town scored on average, higher on the anxiety score (p = 0.013).



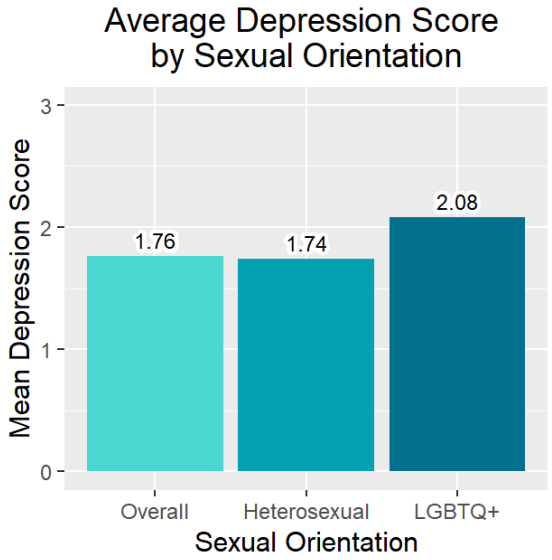
Differences by Living Arrangement

Participants who lived alone had higher depression (p < 0.001) and anxiety scores (p = 0.01). Uniquely, participants who lived alone scored the highest depression score (2.28) which was the highest and closest to the cut-off for clinical depression (3.0) amongst all stratified analyses, suggesting the importance in supporting older adults who live alone.



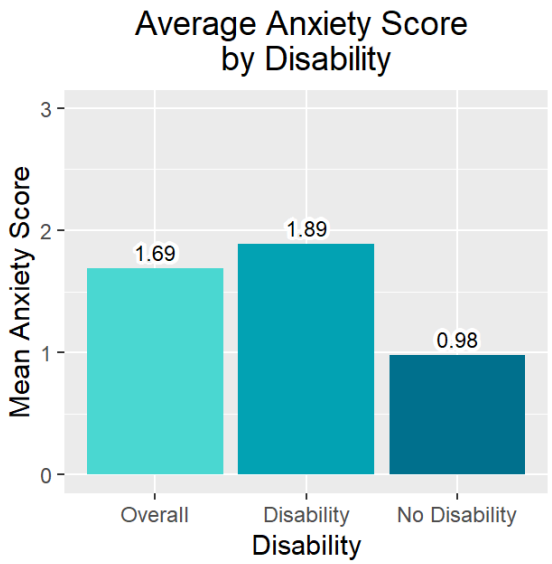
Differences by Sexual Orientation

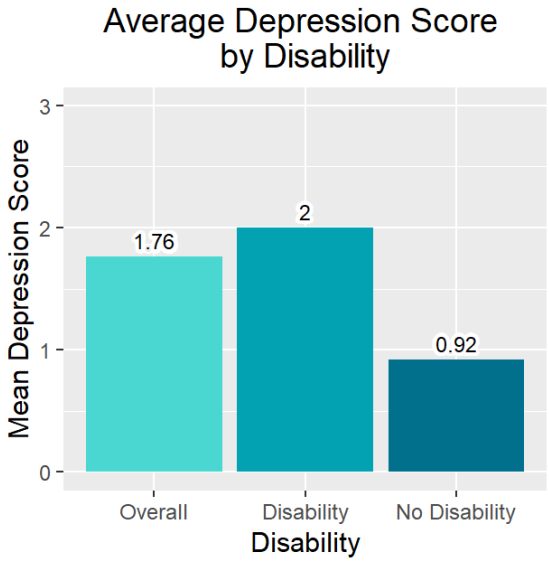
2SLGBTQ+ participants scored higher average depression scores compared to the general study sample ($p = 0.037$). There was no statistically significant difference in average anxiety scores by sexual orientation ($p = 0.075$).



Differences by Disability

Differences in average depression and anxiety scores by disability were both statistically significant (both at $p < 0.001$) with similar trends. Participants with no reported disability had lower average depression and anxiety scores compared to the overall study population.





Social Connectedness and Wellbeing

Social connectedness and wellbeing of participants was evaluated by using the DeJong Overall Loneliness Score (Gierveld & Tilburg, 2006). In summary, participants were asked to answer how true 6 statements were to them, by answering “Yes”, “More or less”, or “No”, based on the on either emotional loneliness or social loneliness.

The three statements on Emotional Loneliness were:

1. I experience a general sense of emptiness
2. I miss having people around
3. I often feel rejected

The three statements on Social Loneliness were:

1. There are plenty of people I can rely on when I have problems
2. There are many people I can trust completely
3. There are enough people I feel close to

DeJong Overall Loneliness Score is made of a combination of all 6 statements, and the score is out of 6, from 0 being least lonely, and 6 being most lonely. The Overall Score is made up of two subscales, DeJong Emotional Loneliness and DeJong Social Loneliness Scores, both out of 3, with 0 being least emotionally or socially lonely, and 3 being most.

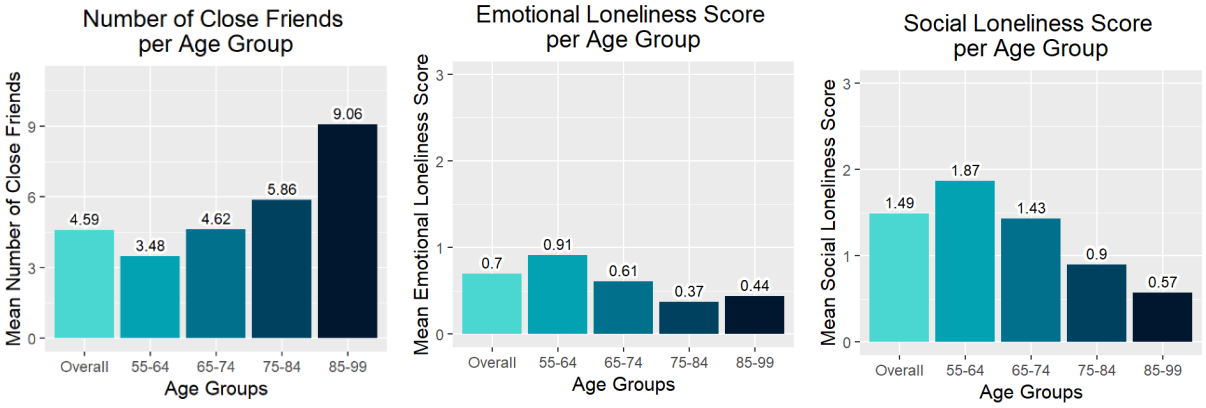
Participants were also asked to identify the number of close friends they had, as another measure of social connectedness.

In the study population, participants had an average of 5 close friends, 1.94 out of 6 on the Overall Loneliness Score, 0.70 out of 3 on the Emotional Loneliness Subscale, and 1.49 on the Social Loneliness Subscale. Even from the overall study population, it is evident that social loneliness is prevalent amongst this cohort of older adults in Canada.

Social Connectedness	Weighted Mean (SD)
Number of Close Friends	4.59 (7.83)
DeJong Overall Loneliness Score (0 – 6)	1.94 (2.35)
DeJong Emotional Loneliness Subscale (0 – 3)	0.70 (1.07)
DeJong Social Loneliness Subscale (0 – 3)	1.49 (1.43)

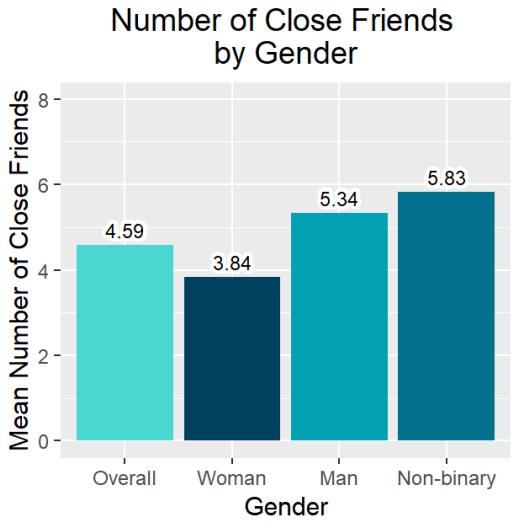
Differences by Age

Perhaps unexpectedly, participants in the older age brackets (specifically 85-99) reported the highest number of close friends (approximately 9) compared to the overall study sample ($p < 0.001$). For overall loneliness ($p < 0.001$), participants in older age brackets had lower overall loneliness scores and participants in the younger age brackets had higher overall loneliness scores compared to the overall study sample. The trend of age being negatively associated with loneliness (greater age with less loneliness) appears strongly for overall loneliness as well as for the emotional loneliness ($p < 0.001$) and social loneliness subscales ($p < 0.001$).



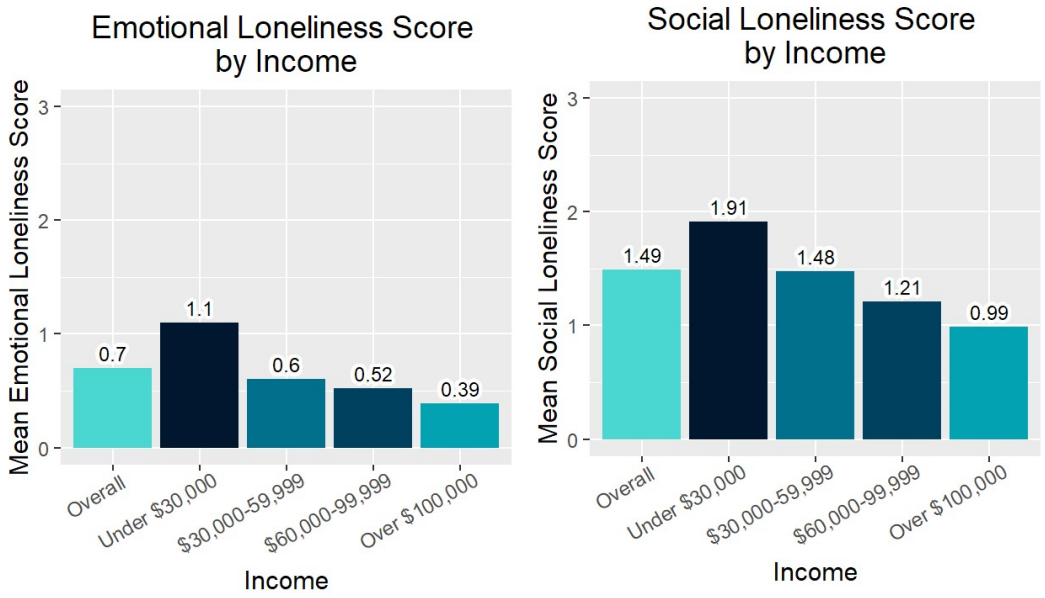
Differences by Gender

Compared to the overall sample, non-binary individuals and men reported having more close friends on average, at 5.83 and 5.34, respectively ($p = 0.016$). For the overall loneliness score, the sample size for non-binary was insufficient, but between men and women, men scored on average slightly higher on mean overall loneliness, at 2.29, vs. 1.61 for women ($p < 0.001$). There were no statistically significant differences by gender for the emotional loneliness and social loneliness subscales.



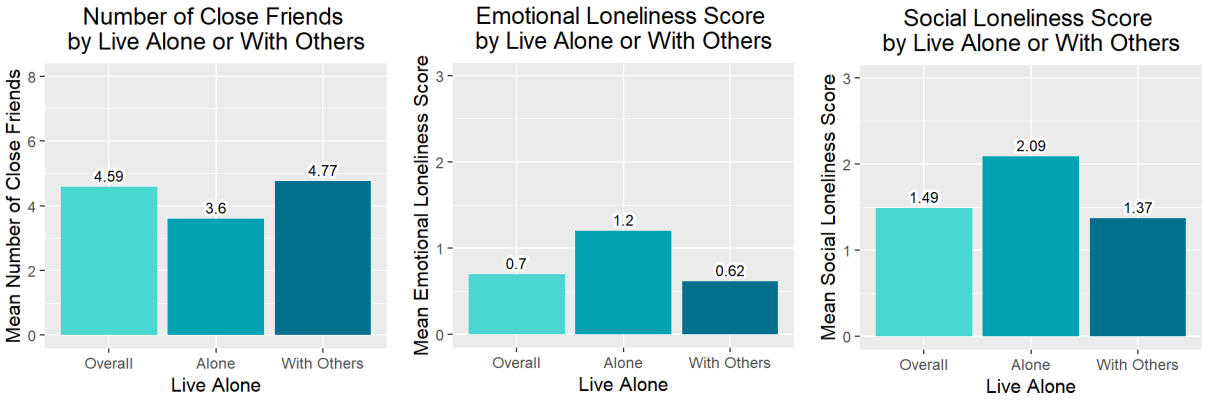
Differences by Income

There were no statistically significant differences in number of close friends by income level. Participants reporting income under $30,000 had a higher average overall loneliness score (at 2.92) compared to the total sample, whereas each high income bracket ($30,000-59,000, $60,000-99,000, and over $100,000) had slightly lower average overall loneliness scores than the total ($p < 0.001$). Similar trends were suggested in the results of the emotional loneliness sub-scale score ($p < 0.001$) and social loneliness sub-scale score ($p < 0.001$), in which participants reported the lowest income (under $30,000) had high levels of loneliness compared to counterparts in higher income brackets.



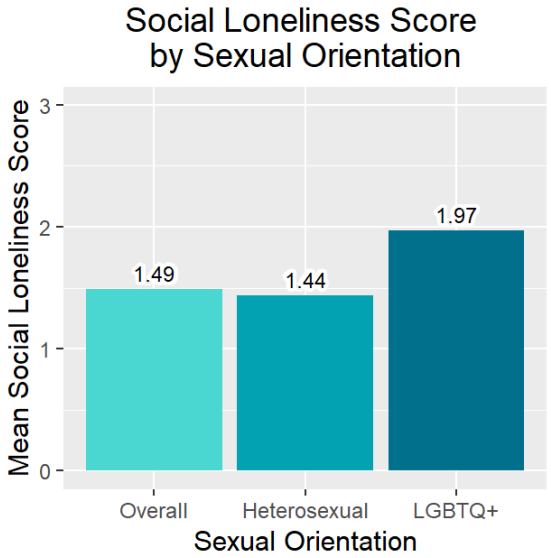
Differences by Living Arrangement

Participants who lived alone reported fewer close friends on average (3.6 vs. 4.59; $p = 0.003$). The average overall loneliness score, emotional loneliness subscale, and social loneliness subscale were all higher and statistically significant ($p < 0.001$) amongst participants who lived alone. Specifically, on average, participants living alone scored 3.35 on the overall loneliness scare, 1.20 on the emotional loneliness scale, and 2.09 on the social loneliness scale. Such findings suggest the clear implication of living alone on loneliness, particularly social isolation.



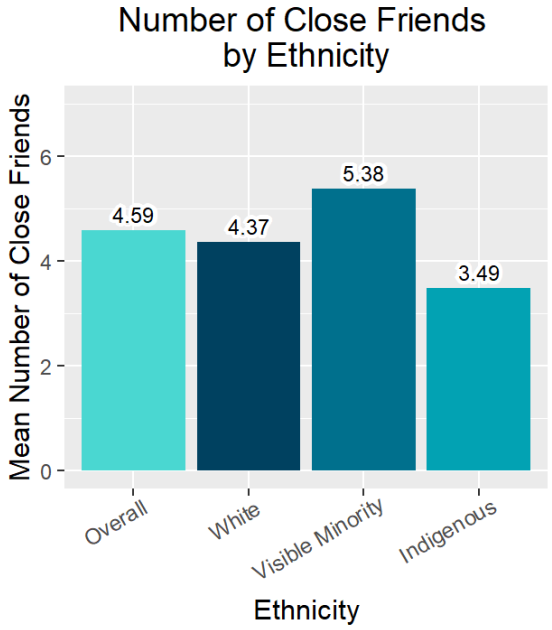
Differences by Sexual Orientation

There were no statistically significant differences in number of close friends, average overall loneliness score, or emotional loneliness subscale by sexual orientation. There was a statistically significant different (p = 0.001) in social loneliness subscale by sexual orientation; older adult participants who identified as 2SLGBTQ+ scored high on the social loneliness scale than the overall population at 1.97.



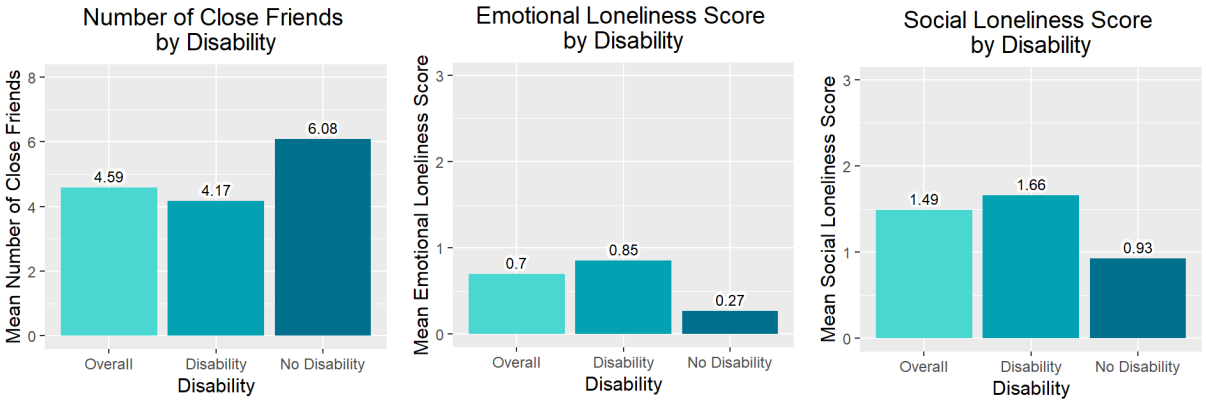
Differences by Ethnicity

Visible minorities reported having a higher number of close friends than both White and Indigenous participants, at 5.38 (p = 0.046). There was no statistically significant difference in overall loneliness scale, emotional loneliness subscale or social loneliness subscale by ethnicity.



Differences by Disability

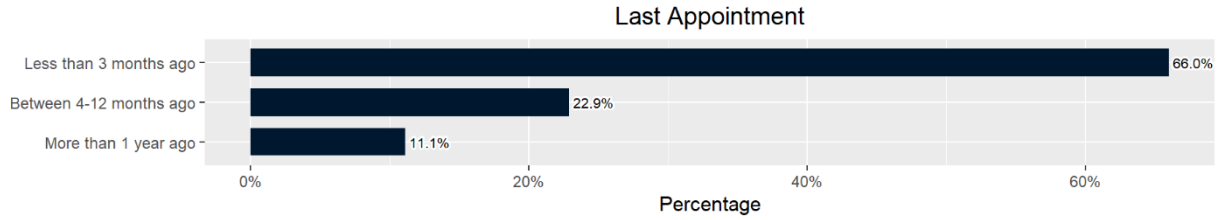
Participants without a disability reported higher number of close friends, at 6.08 compared to the overall sample (p = 0.024). Participants without a disability were also more likely to report lower overall loneliness scores, emotional loneliness subscales, and social loneliness subscales (all p <0.001), at 0.68, 0.27, and 0.93, respectively. This finding suggests that participants with disabilities were in particular need of social prescribing interventions for loneliness compared to participants without disabilities.



Health Services

Time Since Last Appointment

Participants were asked, “When was the last time you had an appointment with a healthcare provider?” The majority of participants (66.0%) indicated that had been to see their healthcare provider in the last 3 months. Approximately 22.9% and 11.1% of participants indicated they had been to see their healthcare provider within the last 4-12 months, or more than a year ago, respectively.



Differences by Age

There was statistically significant difference in time since last appointment by age (p = 0.002). Participants aged 55-64 were more likely than average to have had an appointment more than 1 year ago, whereas older participants aged 85-99 were less likely.

	Overall	55-64	65-74	75-84	85-99	p
Less than 3 months ago	2649.1 (66.0)	1091.8 (63.5)	897.6 (67.4)	478.7 (69.6)	181.0 (66.2)	0.002
4-12 months ago	917.9 (22.9)	377.9 (22.0)	304.3 (22.9)	162.4 (23.6)	73.3 (26.8)	
More than 1 year ago	444.4 (11.1)	248.7 (14.5)	129.7 (9.7)	46.6 (6.8)	19.3 (7.1)	

Differences by Urban/Rural

There was a slight difference in time since last appointment by urban/rural status. Participants living in large urban centres were more likely than the overall sample to have had an appointment in the last 3 months, and participants living in rural areas were more likely than the overall sample to have an appointment in the last 4-12 months.

	Overall	Large urban centre	Medium city/town	Small city/town	Rural area	p
Less than 3 months ago	2649.1 (66.0)	948.2 (71.6)	396.7 (63.3)	512.3 (69.2)	292.0 (63.9)	0.032
4-12 months ago	917.9 (22.9)	262.2 (19.8)	154.8 (24.7)	142.2 (19.2)	128.6 (28.2)	
More than 1 year ago	444.4 (11.1)	114.4 (8.6)	75.7 (12.1)	85.8 (11.6)	36.0 (7.9)	

Note*:* Large urban centre (100,000+ people), Medium city/town (30,000-99,999 people), Rural area (Less than 1000 people), and Small city/town (1,000-29,999 people).

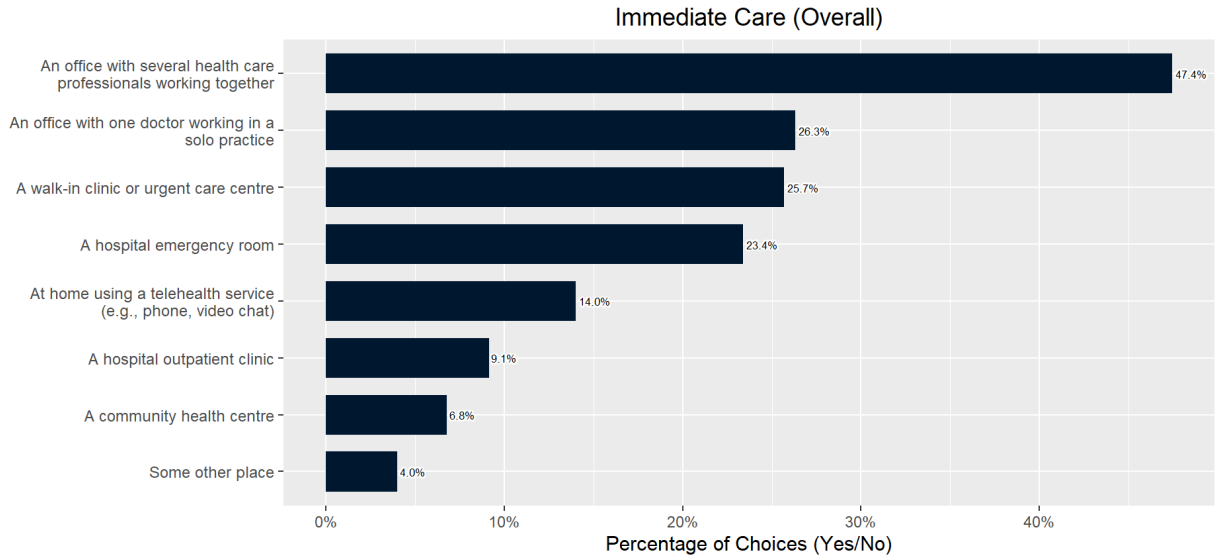
Differences by Disability

Participants with a disability were more likely than the overall population to have had an appointment within the last 3 months, whereas participants without a disability were more likely to have an appointment within the last 4-12 months or more than a year ago than the average study sample ($p < 0.001$).

	Overall	Disability	No disability	p
Less than 3 months ago	2649.1 (66.0)	1792.2 (71.7)	392.2 (55.5)	<0.001
4-12 months ago	917.9 (22.9)	496.6 (19.9)	206.6 (29.2)	
More than 1 year ago	444.4 (11.1)	209.9 (8.4)	107.8 (15.3)	

Experience with Immediate Healthcare

Participants were asked to identify all that apply to the question: In the PAST FIVE YEARS, where have you gone when you needed immediate healthcare for a non-urgent health problem? Participants were allowed to answer multiple options. The majority of choices selected were for seeking immediate healthcare from an office with several health care professionals working together (47.4%). A close second was tied between an office with one doctor working in a solo practice (26.3%), a walk-in clinic or urgent care centre (25.7%), or a hospital emergency room (23.4%). The popularity of seeking immediate healthcare for a non-urgent health problem at a walk-in clinic or urgent care centre, or a hospital emergency room, suggests perhaps the need of some participants to seek treatment without family physician.



Differences by Age

Of each option, four choices for places to go to when in need of immediate healthcare for a non-urgent health problem were statistically significantly different from the overall study sample by age group and were provided in the following table. Participants aged 65-74 were more likely to indicate they would go to an office with several healthcare professionals working together (50.2%), and participants aged 85-99 were least likely (30.9%). Although a community health centre was not as popular (overall 6.8%), participants aged 55-64 or 85-99 were slightly more likely to indicate this option, at 8.4 and 8.7%, respectively. For a walk-in clinic or urgent care centre, participants aged 75-84 were much less likely (16.0%) to access this service, whereas participants aged 55-64 were more likely (31.7%). An finally, an at home telehealth service was most popular amongst the younger participants aged 55-64 (18.9%) vs. the overall study sample (14.0%).

	Overall	55-64	65-74	75-84	85-99	p
An office with several health care professionals working together	1916.6 (47.4)	834.1 (48.3)	673.2 (50.2)	323.4 (46.5)	85.9 (30.9)	0.001
A community health centre	273.7 (6.8)	144.3 (8.4)	70.3 (5.2)	35.0 (5.0)	24.1 (8.7)	0.046
A walk-in clinic or urgent care centre	1037.7 (25.7)	546.5 (31.7)	322.6 (24.1)	111.3 (16.0)	57.3 (20.6)	<0.001
At home using a telehealth service (e.g., phone, video chat)	565.2 (14.0)	325.6 (18.9)	140.9 (10.5)	68.4 (9.8)	30.3 (10.9)	<0.001

Note: Number of weighted participants (percentage chose answer)

Differences by Gender

All four choices for immediate healthcare had a statistically significant difference from the overall study sample by gender. The majority of participants of all genders indicated that they would prefer to use an office with several healthcare professionals, even though for non-binary participants the lead with the next category is slight (29.7% vs 29%). Out of the three gender categories non-binary participants were more likely to use a hospital outpatient clinic than other participants (29%). Female participants were least likely to use a hospital outpatient clinic (7.3%). Male participants were the least likely (4.3%) to use a hospital emergency room in comparison to non-binary and female participants. A similar picture was with the use of telehealth services where male participants were the least likely to use these services (4.8%). Non-binary participants were the most likely to use a telehealth service than other gender groups (18.8%).

	Overall	Man	Non-binary	Woman	p
An office with several health care professionals working together	1916.6 (47.4)	687.4 (45.1)	9.3 (29.7)	822.4 (52.4)	0.017
A hospital outpatient clinic	369.2 (9.1)	189.2 (12.4)	9.1 (29.0)	115.0 (7.3)	0.006
A hospital emergency room	420.1 (27.6)	1.4 (4.3)	338.4 (21.6)	420.1 (27.6)	0.003
At home using a telehealth service (e.g., phone, video chat)	181.5 (11.9)	1.5 (4.8)	293.4 (18.8)	181.5 (11.9)	0.001

Note: Number of weighted participants (percentage chose answer)

Differences by Income

There was a statistically significant difference in the use of community health centres and walk-in clinics or urgent care centres by income groups. Out of all income groups, participants in the lowest income group were the most likely to use a community health centre (12%), whereas participants in the highest income group were the least likely (3.5%). A walk-in clinic or urgent care centre was still a more popular choice among the participants across all income groups (25.7%).

	Overall	< 30k	$30,000 - $59,999	$60,000 - $99,999	$100,000+	p
A community health centre	273.7 (6.8)	119.1 (12.0)	65.3 (7.1)	37.6 (6.8)	10.4 (3.5)	0.004
A walk-in clinic or urgent care centre	1037.7 (25.7)	237.1 (23.9)	296.0 (32.3)	139.0 (25.2)	80.2 (26.9)	0.04

Note: Number of weighted participants (percentage chose answer)

Differences by Urban/Rural

In differences among urban/rural areas, there was a statistically significant differences among four categories. An office with several health care professionals working together was overall the most likely chosen option (47.4%). A hospital emergency room was a more likely choice for participants in rural area (29.1%) and (28.8%). A walk-in clinic or urgent care centre was the most likely choice for participants in large urban centres (33.9%).

	Overall	Large urban centre	Medium city/ town	Small city/ town	Rural area	p
An office with several health care professionals working together	1916.6 (47.4)	699.2 (52.6)	280.3 (44.5)	354.7 (47.6)	197.9 (43.3)	0.048
A community health centre	273.7 (6.8)	96.3 (7.2)	30.6 (4.9)	55.9 (7.5)	63.0 (13.8)	0.01
A walk-in clinic or urgent care centre	1037.7 (25.7)	451.2 (33.9)	173.4 (27.6)	142.9 (19.2)	75.6 (16.5)	<0.001
A hospital emergency room	944.9 (23.4)	276.1 (20.8)	144.6 (23.0)	214.2 (28.8)	133.1 (29.1)	0.021

Note: Number of weighted participants (percentage chose answer). Large urban centre (100,000+ people), Medium city/town (30,000-99,999 people), Rural area (Less than 1000 people), and Small city/town (1,000-29,999 people).

Differences by Ethnicity

A community health centre and hospital emergency rooms had a statistically significant difference among different ethnic groups. Indigenous participants were both more likely to use a community health centre (19.3%) and hospital emergency room (42.4%). All groups were more likely to use a hospital emergency room than a community health centre (23.4%).

	Overall	Indigenous	Visible Minority	White	p
A community health centre	273.7 (6.8)	30.1 (19.3)	37.6 (4.5)	176.0 (8.2)	0.003
A hospital emergency room	944.9 (23.4)	66.1 (42.4)	164.8 (19.8)	533.4 (24.9)	0.003

Note: Number of weighted participants (percentage chose answer)

Differences by Disability

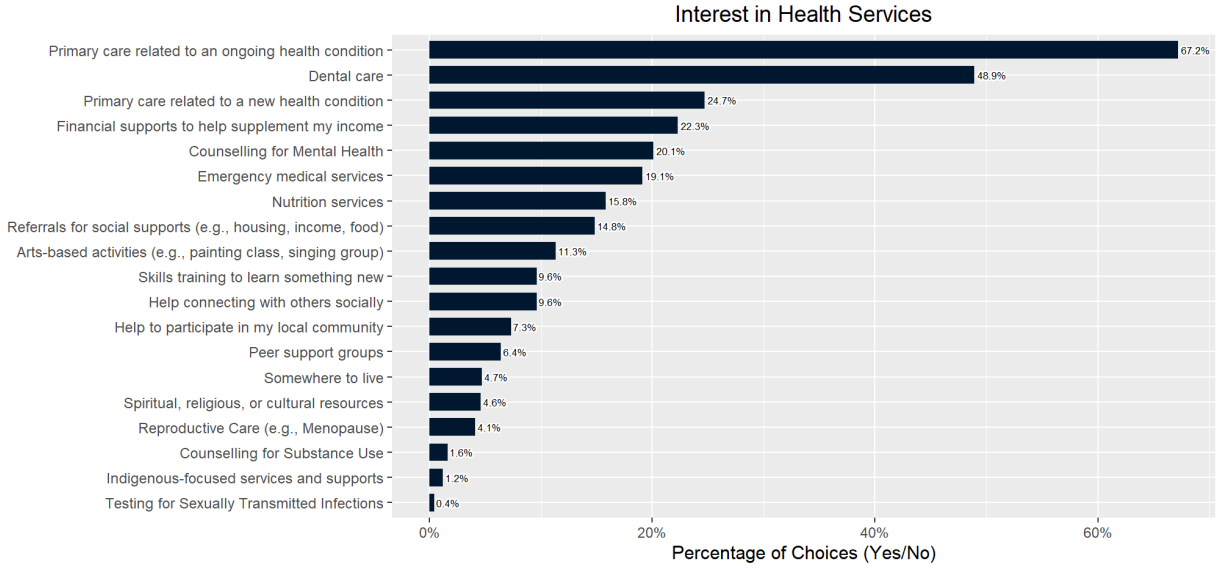
Three categories that have statistically significant difference by disability. A hospital emergency room is the most likely choice among both participants with and without disabilities (23.4%). Participants with disabilities were the most likely to use a hospital emergency room (26.2%). Participants without disabilities were less likely to use any immediate healthcare services than participants with disabilities.

	Overall	Disability	No disability	p
A hospital outpatient clinic	369.2 (9.1)	281.1 (11.2)	38.0 (5.4)	0.007
A community health centre	273.7 (6.8)	214.9 (8.6)	33.4 (4.7)	0.014
A hospital emergency room	944.9 (23.4)	657.2 (26.2)	128.7 (18.2)	0.005

Note: Number of weighted participants (percentage chose answer)

Interest in Specific Health Services, Supports, Resources

Participants were asked: “Which of the following services, supports, or resources are you interested in accessing? (Check all that apply.)” Participants were allowed to answer multiple options. The majority of choices selected were for primary care related to an ongoing health condition (67.2%) and dental care (48.9%). Options of primary care related to a new health condition, financial supports to help supplement my income, and counselling for mental health, were the next most popular choices of specific health services, supports, and resources of interest, at 24.7%, 22.3%, and 20.1%, respectively. Approximately 27% were interested in at least one service. The average number of services someone was interested in was 0.84.



Differences by Age

Based on the data, it is evident that primary care related to a new health condition has the lowest percentage overall, with the highest percentage belonging to dental care. There were significant differences between age groups, with the 55-64 age group having the highest percentage of utilization for primary care, and the 85-99 age group having the lowest percentage. Reproductive care had the lowest overall utilization, with the highest utilization among the 65-74 age group. Counselling for mental health had the second-highest overall utilization, with the highest utilization among the 55-64 age group. Referrals for social supports had the fourth-highest overall utilization, with the highest utilization among the 55-64 age group. Financial supports to help supplement income had the third-highest overall utilization, with the highest utilization among the 55-64 age group. Overall, there were statistically significant differences in utilization across age groups and services, highlighting the importance of tailoring healthcare services to specific age groups and needs.

	Overall	55-64	65-74	75-84	85-99	p
Primary care related to a new health condition	316.3 (24.7)	158.0 (29.7)	108.7 (23.8)	42.8 (20.5)	6.8 (8.0)	0.005
Dental care	627.5 (48.9)	296.2 (55.7)	226.6 (49.5)	74.8 (36.0)	29.8 (34.8)	0.003
Reproductive Care (e.g., Menopause)	52.2 (4.1)	46.4 (8.7)	4.8 (1.1)	1.0 (0.5)	0.0 (0.0)	<0.001
Counselling for Mental Health	258.5 (20.1)	170.1 (32.0)	68.8 (15.0)	18.3 (8.8)	1.2 (1.4)	<0.001
Nutrition services	202.4 (15.8)	111.6 (21.0)	61.2 (13.4)	19.8 (9.5)	9.9 (11.6)	0.032
Referrals for social supports (e.g., housing, income, food)	189.5 (14.8)	114.0 (21.4)	68.9 (15.1)	5.1 (2.5)	1.4 (1.6)	<0.001
Help to participate in my local community	93.5 (7.3)	56.6 (10.6)	32.3 (7.1)	4.6 (2.2)	0.0 (0.0)	0.007
Help connecting with others socially	122.7 (9.6)	76.0 (14.3)	30.8 (6.7)	12.4 (5.9)	3.5 (4.1)	<0.001
Spiritual, religious, or cultural resources	59.2 (4.6)	38.2 (7.2)	18.2 (4.0)	1.7 (0.8)	1.1 (1.3)	0.015
Peer support groups	81.9 (6.4)	59.0 (11.1)	15.8 (3.4)	6.1 (2.9)	1.0 (1.2)	<0.001
Financial supports to help supplement my income	286.2 (22.3)	151.7 (28.5)	116.7 (25.5)	12.7 (6.1)	5.0 (5.8)	<0.001
Somewhere to live	60.7 (4.7)	36.4 (6.9)	20.5 (4.5)	2.5 (1.2)	1.3 (1.5)	0.019

Skills training to learn something new	123.2 (9.6)	90.3 (17.0)	20.6 (4.5)	9.1 (4.4)	3.2 (3.7)	<0.001
Arts-based activities (e.g., painting class, singing group)	145.1 (11.3)	77.5 (14.6)	51.7 (11.3)	12.0 (5.8)	3.7 (4.4)	0.025

Note: Number of weighted participants (percentage chose answer)

Differences by Gender

Among the statistically significant differences among genders, a notable difference is that women were more likely to use mental health counselling than men or non-binary. Women were also more likely to seek help connecting with others socially and arts-based activities.

	Overall	Man	Non-binary	Woman	p
Reproductive Care (e.g., Menopause)	52.2 (4.1)	2.2 (0.4)	0.0 (0.0)	42.7 (7.9)	<0.001
Counselling for Mental Health	258.5 (20.1)	80.7 (15.7)	0.6 (21.4)	146.0 (26.9)	0.005
Help to participate in my local community	93.5 (7.3)	21.2 (4.1)	0.0 (0.0)	58.6 (10.8)	0.011
Help connecting with others socially	122.7 (9.6)	18.9 (3.7)	0.3 (9.2)	78.9 (14.5)	<0.001
Skills training to learn something new	123.2 (9.6)	33.0 (6.4)	0.0 (0.0)	79.6 (14.7)	0.012
Arts-based activities (e.g., painting class, singing group)	145.1 (11.3)	30.5 (5.9)	0.0 (0.0)	94.6 (17.4)	<0.001

Note: Number of weighted participants (percentage chose answer)

Differences by Income

From the differences by income, it is evident that financial supports were more likely to be needed by the lower income groups 4.3% for $100,000+ and 35.8% for <$30,000, for instance. A similar picture is for referrals for social supports 3.5% for $100,000+ and 29.1% for <$30,000. Reproductive care is more sought out by higher income groups like $100,000+ and $60,000 - $99,999, which is higher than <$30,000.

	Overall	<$30,000	$30,000 - $59,999	$60,000 - $99,999	$100,000+	p
Reproductive Care (e.g., Menopause)	52.2 (4.1)	1.2 (0.4)	14.4 (4.6)	21.6 (9.9)	6.4 (6.5)	0.007
Referrals for social supports (e.g., housing, income, food)	189.5 (14.8)	86.6 (29.1)	44.8 (14.3)	16.4 (7.5)	3.4 (3.5)	<0.001
Peer support groups	81.9 (6.4)	27.9 (9.4)	29.2 (9.3)	3.0 (1.4)	8.0 (8.1)	0.028
Financial supports to help supplement my income	286.2 (22.3)	106.5 (35.8)	84.5 (26.9)	33.0 (15.2)	4.3 (4.3)	<0.001

Note: Number of weighted participants (percentage chose answer)

Differences by Urban/Rural

Based on urban/rural differences, several significant findings can be noted. Firstly, counselling for mental health services is the most sought after by all participants, with a higher proportion in large urban centers compared to other areas. Participants in rural areas and small cities/towns were found to have significantly lower proportions seeking counseling. Secondly, helping connecting with others socially was also found to have significant differences in usage by location, with participants in medium city/towns and large urban centers using it more often compared to those in rural areas. Finally, spiritual, religious, or cultural resources were found to be less commonly used overall, but participants in large urban centers and medium city/towns were found to use these resources more than those in rural areas.

	Overall	Large urban centre	Medium city/town	Small city/town	Rural area	p
Counselling for Mental Health	258.5 (20.1)	113.3 (25.2)	48.7 (23.7)	24.9 (9.6)	40.8 (26.6)	0.004
Help to participate in my local community	93.5 (7.3)	51.2 (11.4)	12.0 (5.8)	6.4 (2.5)	10.1 (6.6)	0.013
Help connecting with others socially	122.7 (9.6)	49.2 (11.0)	30.2 (14.7)	9.7 (3.7)	9.0 (5.9)	0.003
Spiritual, religious, or cultural resources	59.2 (4.6)	41.0 (9.1)	10.7 (5.2)	4.8 (1.8)	0.3 (0.2)	0.003
Skills training to learn something new	123.2 (9.6)	69.9 (15.6)	20.2 (9.8)	15.2 (5.9)	10.5 (6.8)	0.033
Arts-based activities (e.g., painting class, singing group)	145.1 (11.3)	65.6 (14.6)	32.9 (16.0)	15.6 (6.0)	11.0 (7.1)	0.026

Note: Number of weighted participants (percentage chose answer). Large urban centre (100,000+ people), Medium city/town (30,000-99,999 people), Rural area (Less than 1000 people), and Small city/town (1,000-29,999 people).

Differences by Living Arrangement

Based on the differences of people living alone or with others, the differences show that people living alone were more likely to seek counselling for mental health. Moreover, help connecting with others socially also has higher proportion among people living alone as well as peer support groups.

	Overall	Alone	Not alone	p
Reproductive Care (e.g., Menopause)	52.2 (4.1)	2.7 (1.9)	42.2 (4.6)	0.049
Counselling for Mental Health	258.5 (20.1)	48.0 (33.1)	178.3 (19.5)	0.005
Help connecting with others socially	122.7 (9.6)	31.8 (21.9)	66.4 (7.3)	<0.001
Peer support groups	81.9 (6.4)	21.3 (14.7)	53.1 (5.8)	0.005

Note: Number of weighted participants (percentage chose answer)

Differences by Ethnicity

In terms of ethnicity differences, the most significant one is in financial supports for indigenous visible minorities, white. Counselling for substance use is also the highest among indigenous survey participants.

	Overall	Indigenous	Visible Minority	White	p
Counselling for Substance Use	20.8 (1.6)	4.8 (11.1)	5.0 (1.7)	7.2 (1.0)	0.016
Spiritual, religious, or cultural resources	59.2 (4.6)	4.5 (10.5)	27.2 (9.3)	20.1 (2.8)	0.034
Indigenous-focused services and supports	15.6 (1.2)	11.4 (26.5)	0.0 (0.0)	3.3 (0.5)	<0.001
Financial supports to help supplement my income	286.2 (22.3)	21.8 (50.6)	48.4 (16.6)	175.2 (24.2)	0.016
Skills training to learn something new	123.2 (9.6)	1.4 (3.3)	49.6 (17.0)	64.7 (9.0)	0.022

Note: Number of weighted participants (percentage chose answer)

Differences by Disability

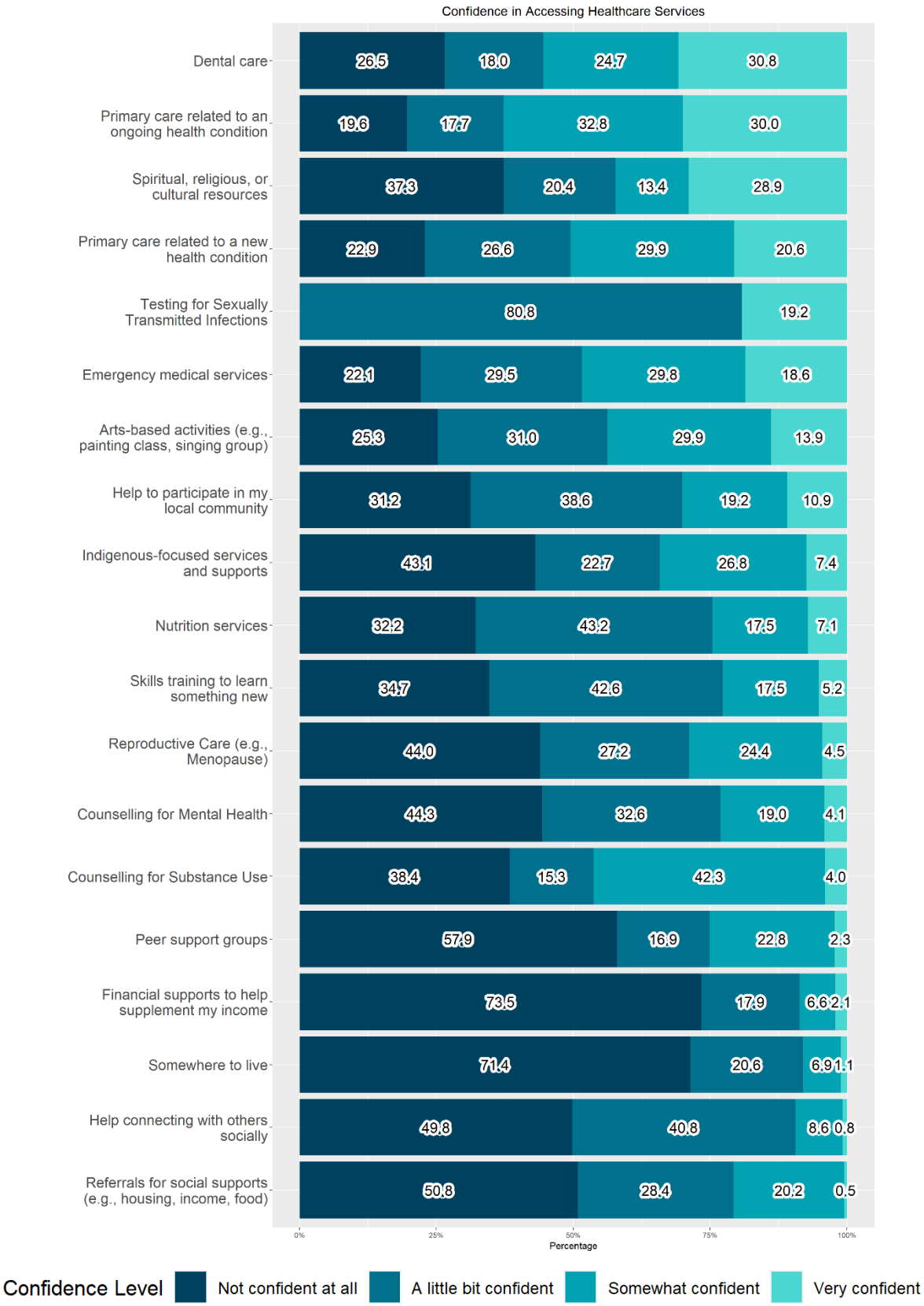
In differences by disability, counselling for mental health, referrals for social supports, and emergency medical services were more prevalent for people with disabilities.

	Overall	Disability	No disability	p
Primary care related to an ongoing health condition	861.9 (67.2)	636.3 (74.2)	108.7 (46.5)	<0.001
Counselling for Mental Health	258.5 (20.1)	209.3 (24.4)	21.5 (9.2)	<0.001
Counselling for Substance Use	20.8 (1.6)	16.5 (1.9)	0.5 (0.2)	0.012
Referrals for social supports (e.g., housing, income, food)	189.5 (14.8)	153.7 (17.9)	10.8 (4.6)	<0.001
Help connecting with others socially	122.7 (9.6)	93.6 (10.9)	9.4 (4.0)	0.007
Spiritual, religious, or cultural resources	59.2 (4.6)	53.0 (6.2)	3.9 (1.7)	0.011
Peer support groups	81.9 (6.4)	74.0 (8.6)	2.3 (1.0)	<0.001
Emergency medical services	245.1 (19.1)	190.9 (22.3)	26.0 (11.1)	0.002
Financial supports to help supplement my income	286.2 (22.3)	223.5 (26.1)	31.7 (13.6)	0.022

Note: Number of weighted participants (percentage chose answer)

Confidence in Ability to Access Health Services, Supports, Resources

Participants were asked to rate their confidence in their personal ability to access different health services, supports, and resources on a scale of not confident at all, a little bit confident, somewhat confident, and very confident. Results in red suggest participants were on average, not confident at all in accessing services, supports, and resources related to somewhere to live (71.4%), financial supports to help supplement their income (73.5%), peer support groups (57.9%), and help connecting with others socially (49.8%). Overall, very few healthcare services were rated ones they were confident in accessing (in turquoise and white for somewhat confident and very confident, respectively), suggesting a clear barrier of access and confidence for older adults.


Confidence in Accessing Healthcare Services
Dental care
26.5
18.0
24.7
30.8
Primary care related to an ongoing health condition
19.6
17.7
32.8
30.0
Spiritual, religious, or cultural resources
37.3
20.4
13.4
28.9
Primary care related to a new health condition
22.9
26.6
29.9
20.6
Testing for Sexually Transmitted Infections
80.8
19.2
Emergency medical services
22.1
29.5
29.8
18.6
Arts-based activities (e.g., painting class, singing group)
25.3
31.0
29.9
13.9
Help to participate in my local community
31.2
38.6
19.2
10.9
Indigenous-focused services and supports
43.1
22.7
26.8
7.4
Nutrition services
32.2
43.2
17.5
7.1
Skills training to learn something new
34.7
42.6
17.5
5.2
Reproductive Care (e.g., Menopause)
44.0
27.2
24.4
4.5
Counselling for Mental Health
44.3
32.6
19.0
4.1
Counselling for Substance Use
38.4
15.3
42.3
4.0
Peer support groups
57.9
16.9
22.8
2.3
Financial supports to help supplement my income
73.5
17.9
6.6
2.1
Somewhere to live
71.4
20.6
6.9
1.1
Help connecting with others socially
49.8
40.8
8.6
0.8
Referrals for social supports (e.g., housing, income, food)
50.8
28.4
20.2
0.5
0%
25%
50%
75%
100%
Percentage
Confidence Level
Not confident at all
A little bit confident
Somewhat confident
Very confident

Differences by Age

The highest confidence is in ability is in dental care for 85–99-year-olds, which is the highest average among all age groups. Overall, the highest average is for primary care related to an ongoing health condition.

	Overall	55-64	65-74	75-84	85-99	p
Primary care related to an ongoing health condition	1.73 (1.09)	1.65 (1.08)	1.64 (1.13)	2.13 (0.99)	1.87 (0.91)	0.002
Dental care	1.60 (1.18)	1.54 (1.17)	1.50 (1.21)	1.89 (1.14)	2.31 (0.57)	<0.001
Counselling for Mental Health	0.83 (0.88)	0.71 (0.82)	1.01 (0.96)	1.28 (0.86)	1.22 (0.41)	0.006
Counselling for Substance Use	1.12 (0.98)	0.47 (0.92)	1.54 (0.75)	0.00 (0.00)	0.00 (0.00)	0.053
Help connecting with others socially	0.60 (0.68)	0.48 (0.58)	0.76 (0.82)	0.71 (0.61)	1.25 (0.58)	0.01
Peer support groups	0.70 (0.90)	0.75 (0.92)	0.55 (0.82)	0.48 (0.75)	0.00 (0.00)	<0.001
Financial supports to help supplement my income	0.37 (0.70)	0.40 (0.71)	0.34 (0.68)	0.48 (0.83)	0.00 (0.00)	<0.001

Note: Average confidence in ability to access health services or supports on a scale from 0 to 4. Where 0 is not confident at all and 4 is very confident.

Differences by Gender

In gender differences, the highest average overall is in accessing primary care related to ongoing health condition and the highest average is among non-binary participants. The lowest confidence overall is in help connecting others socially.

	Overall	Man	Non-binary	Woman	p
Primary care related to an ongoing health condition	1.73 (1.09)	1.82 (1.06)	2.00 (0.00)	1.64 (1.12)	0.006
Primary care related to a new health condition	1.49 (1.05)	1.52 (1.02)	1.00 (0.00)	1.46 (1.08)	<0.001
Counselling for Mental Health	0.81 (0.86)	0.87 (0.80)	0.00 (0.00)	0.78 (0.89)	<0.001
Referrals for social supports (e.g., housing, income, food)	0.73 (0.81)	1.09 (0.83)	0.32 (0.75)	0.51 (0.72)	0.015
Help connecting with others socially	0.58 (0.66)	0.70 (0.70)	0.00 (0.00)	0.55 (0.65)	<0.001
Somewhere to live	0.40 (0.71)	0.20 (0.56)	2.00 (0.00)	0.47 (0.73)	<0.001

Note: Average confidence in ability to access health services or supports on a scale from 0 to 4. Where 0 is not confident at all and 4 is very confident.

Differences by Income

Participants with higher income are on average more confident in accessing dental care than other income groups. The lowest average is for peer support groups overall. Also, lower income individuals are generally less confident on average in receiving most of the services.

	Overall	<$30,000	$30,000 - $59,999	$60,000 - $99,999	$100,000+	p
Primary care related to a new health condition	1.36 (1.03)	1.00 (1.06)	1.63 (1.02)	1.34 (0.92)	1.60 (0.94)	0.06
Dental care	1.55 (1.19)	1.05 (1.06)	1.65 (1.15)	1.90 (1.20)	2.14 (1.04)	<0.001
Reproductive Care (e.g., Menopause)	0.86 (0.92)	1.10 (0.81)	1.29 (0.86)	0.74 (0.89)	0.27 (0.68)	0.063
Nutrition services	0.98 (0.84)	0.62 (0.77)	1.03 (0.82)	0.95 (0.70)	1.68 (0.89)	0.005
Spiritual, religious, or cultural resources	1.34 (1.26)	0.69 (1.09)	1.63 (1.45)	2.02 (0.58)	1.28 (1.06)	0.003
Peer support groups	0.64 (0.86)	0.18 (0.53)	0.98 (0.91)	1.18 (0.78)	0.79 (0.86)	<0.001
Somewhere to live	0.42 (0.72)	0.43 (0.72)	0.46 (0.83)	0.00 (0.00)	0.80 (0.40)	0.001
Arts-based activities (e.g., painting class, singing group)	1.19 (0.94)	0.60 (0.88)	1.34 (0.84)	1.31 (0.73)	1.97 (0.99)	0.008

Note: Average confidence in ability to access health services or supports on a scale from 0 to 4. Where 0 is not confident at all and 4 is very confident.

Differences by Urban/Rural

People in rural areas seem to have less confidence in accessing health services and supports.

	Overall	Large urban centre	Medium city/town	Small city/town	Rural area	p
Primary care related to a new health condition	1.48 (1.06)	1.74 (0.99)	1.11 (1.10)	1.50 (1.00)	0.96 (0.99)	0.012
Dental care	1.57 (1.18)	1.58 (1.17)	1.74 (1.20)	1.68 (1.16)	1.02 (1.07)	0.007
Counselling for Substance Use	1.18 (0.97)	1.15 (1.08)	2.00 (0.00)	0.76 (0.43)	0.00 (0.00)	<0.001
Help to participate in my local community	1.02 (0.94)	1.34 (0.94)	0.09 (0.33)	0.65 (0.65)	0.79 (0.65)	<0.001
Spiritual, religious, or cultural resources	1.34 (1.26)	1.32 (1.20)	1.53 (1.41)	1.14 (1.36)	0.00 (0.00)	<0.001
Indigenous-focused services and supports	0.98 (1.00)	1.10 (0.97)	0.00 (0.00)	1.40 (1.38)	1.17 (0.56)	<0.001
Peer support groups	0.63 (0.84)	0.68 (0.84)	0.23 (0.48)	1.40 (0.90)	0.19 (0.44)	0.03

Note: Large urban centre (100,000+ people), Medium city/town (30,000-99,999 people), Rural area (Less than 1000 people), and Small city/town (1,000-29,999 people). Average confidence in ability to access health services or supports on a scale from 0 to 4. Where 0 is not confident at all and 4 is very confident.

Differences by Living Arrangement

Respondents who indicated that they do not live alone are on average more confident in accessing most of the health services and supports except for primary care related to an ongoing health condition.

	Overall	Alone	Not alone	p
Primary care related to an ongoing health condition	1.72 (1.09)	1.95 (0.98)	1.68 (1.11)	0.046
Counselling for Substance Use	1.18 (0.97)	0.36 (0.98)	1.60 (0.63)	0.048
Nutrition services	0.98 (0.85)	0.56 (0.78)	1.06 (0.84)	0.011
Spiritual, religious, or cultural resources	1.34 (1.26)	0.63 (0.99)	1.58 (1.25)	0.047
Peer support groups	0.63 (0.84)	0.18 (0.50)	0.82 (0.88)	0.005
Arts-based activities (e.g., painting class, singing group)	1.27 (0.99)	0.80 (0.90)	1.36 (0.98)	0.025

Note: Average confidence in ability to access health services or supports on a scale from 0 to 4. Where 0 is not confident at all and 4 is very confident.

Differences by Ethnicity

The most confidence in accessing primary care related to ongoing health condition, overall. For visible minorities, the least confidence is in accessing services related to connecting with others.

	Overall	Indigenous	Visible Minority	White	p
Primary care related to a new health condition	1.49 (1.06)	0.17 (0.70)	1.57 (0.98)	1.50 (1.09)	<0.001
Referrals for social supports (e.g., housing, income, food)	0.72 (0.82)	1.31 (0.47)	0.42 (0.67)	0.76 (0.85)	0.003
Help connecting with others socially	0.58 (0.66)	2.00 (0.00)	0.34 (0.51)	0.66 (0.68)	<0.001
Spiritual, religious, or cultural resources	1.27 (1.30)	0.09 (0.51)	1.11 (1.27)	1.76 (1.24)	<0.001
Indigenous-focused services and supports	0.98 (1.00)	1.20 (0.98)	0.00 (0.00)	0.24 (0.65)	0.039
Peer support groups	0.63 (0.84)	0.00 (0.00)	0.63 (0.93)	0.65 (0.81)	<0.001
Financial supports to help supplement my income	0.35 (0.69)	0.01 (0.16)	0.63 (0.87)	0.31 (0.65)	<0.001
Somewhere to live	0.40 (0.71)	0.00 (0.00)	0.79 (0.41)	0.32 (0.74)	<0.001
Skills training to learn something new	0.90 (0.80)	0.28 (0.88)	0.86 (0.83)	0.95 (0.77)	0.038
Arts-based activities (e.g., painting class, singing group)	1.27 (0.99)	0.07 (0.45)	1.54 (0.96)	1.21 (0.96)	<0.001

Note: Average confidence in ability to access health services or supports on a scale from 0 to 4. Where 0 is not confident at all and 4 is very confident.

Differences by Sexual Orientation

In general, Straight participants seem to be more confident in accessing most of the health services or supports, except for primary care, reproductive care, arts-based activities, and somewhere to live.

	Overall	Straight	2SLGBTQ+	p
Primary care related to a new health condition	1.49 (1.06)	1.48 (1.07)	1.70 (0.92)	<0.001
Reproductive Care (e.g., Menopause)	0.88 (0.92)	0.87 (0.92)	2.00 (0.00)	<0.001
Counselling for Mental Health	0.81 (0.86)	0.86 (0.85)	0.45 (0.82)	0.043
Nutrition services	1.00 (0.85)	1.03 (0.85)	0.68 (0.85)	<0.001
Referrals for social supports (e.g., housing, income, food)	0.74 (0.81)	0.77 (0.82)	0.55 (0.76)	<0.001
Spiritual, religious, or cultural resources	1.34 (1.26)	1.41 (1.27)	1.23 (1.16)	0.002
Peer support groups	0.63 (0.84)	0.68 (0.84)	0.33 (0.75)	<0.001
Emergency medical services	1.43 (1.03)	1.42 (1.05)	1.42 (0.80)	<0.001
Somewhere to live	0.35 (0.71)	0.30 (0.63)	2.66 (0.48)	<0.001
Arts-based activities (e.g., painting class, singing group)	1.26 (0.99)	1.26 (1.00)	1.52 (0.83)	0.024

Note: Average confidence in ability to access health services or supports on a scale from 0 to 4. Where 0 is not confident at all and 4 is very confident.

Differences by Disability

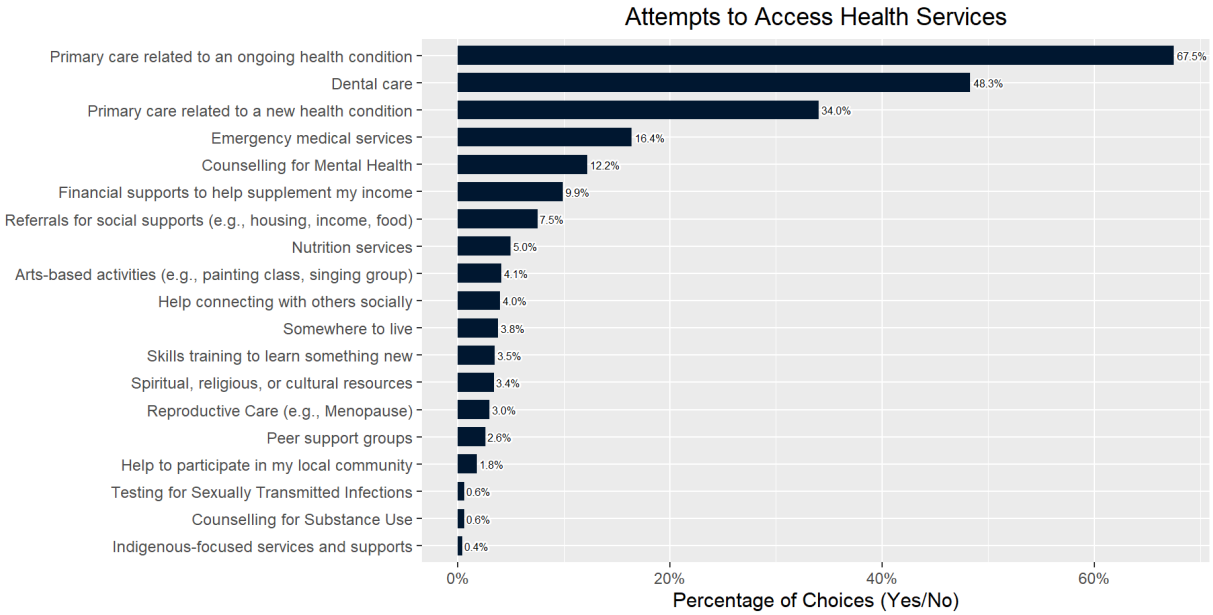
Participants without disabilities on average are more confident in accessing health services and supports that those with disabilities.

	Overall	Disability	No disability	p
Primary care related to an ongoing health condition	1.73 (1.09)	1.68 (1.09)	2.03 (1.02)	0.021
Dental care	1.59 (1.18)	1.51 (1.19)	1.88 (1.11)	0.028
Spiritual, religious, or cultural resources	1.34 (1.26)	1.27 (1.25)	2.34 (0.94)	0.033
Emergency medical services	1.44 (1.02)	1.38 (1.02)	1.87 (0.88)	0.03
Arts-based activities (e.g., painting class, singing group)	1.29 (1.00)	1.22 (1.01)	1.70 (0.78)	0.035

Note: Average confidence in ability to access health services or supports on a scale from 0 to 4. Where 0 is not confident at all and 4 is very confident.

Attempts to Access Health Services

Participants were asked, “Which of the following services, supports, and resources have you tried to access in the PAST 12 MONTHS? (Check all that apply)” and given a list of various health services, supports, and resources. Participants were allowed to answer multiple options. The most popular choice was attempts to access primary care related to an ongoing health condition (67.5%), followed by dental care (48.3%) and primary care related to a new health condition (34.0%). These most commonly selected choices align with participants’ self-reported interest in health services, supports, and resources. Such results suggest older adults are generally attempting to access services, supports, and resources, that they also are interested in.



Differences by Age

Compared to the overall population, there were seem differences in health services of most interest amongst participants by age. For instance, the majority of choices were weighted most heavily amongst older adults aged 55-64 vs. older age groups in all categories of statistical significance.

	Overall	55-64	65-74	75-84	85-99	p
Primary care related to a new health condition	423.8 (34.0)	207.0 (39.3)	141.1 (33.0)	62.5 (29.0)	13.2 (17.1)	0.012
Reproductive Care (e.g., Menopause)	37.4 (3.0)	27.5 (5.2)	5.7 (1.3)	1.5 (0.7)	2.6 (3.4)	0.016
Counselling for Mental Health	152.6 (12.2)	106.0 (20.1)	40.8 (9.5)	5.8 (2.7)	0.0 (0.0)	<0.001
Nutrition services	62.0 (5.0)	40.5 (7.7)	16.5 (3.9)	3.7 (1.7)	1.3 (1.7)	0.001
Referrals for social supports (e.g., housing, income, food)	92.9 (7.5)	65.8 (12.5)	20.6 (4.8)	6.5 (3.0)	0.0 (0.0)	<0.001
Somewhere to live	46.9 (3.8)	32.5 (6.2)	11.4 (2.7)	2.2 (1.0)	0.8 (1.0)	0.006
Skills training to learn something new	43.6 (3.5)	29.5 (5.6)	10.6 (2.5)	1.8 (0.8)	1.8 (2.3)	0.015

Note: Number of weighted participants (percentage chose answer)

Differences by Gender

There were some differences in attempts to access healthcare services by gender, see the table below.

	Overall	Man	Non-binary	Woman	p
Reproductive Care (e.g., Menopause)	37.4 (3.0)	4.2 (0.8)	0.0 (0.0)	29.1 (5.7)	0.016
Nutrition services	62.0 (5.0)	11.9 (2.3)	0.5 (4.2)	40.8 (8.0)	0.02
Help connecting with others socially	49.9 (4.0)	9.5 (1.8)	2.2 (17.3)	31.6 (6.2)	0.024
Emergency medical services	204.0 (16.4)	83.5 (16.2)	9.3 (73.4)	89.6 (17.5)	0.001
Arts-based activities (e.g., painting class, singing group)	50.8 (4.1)	7.4 (1.4)	2.2 (17.3)	34.4 (6.7)	0.01

Note: Number of weighted participants (percentage chose answer)

Differences by Income

Dental care is the most sought-after health service with overall attempt to access at 48.3%. $100,000+ category has the most attempts at 70.5%. Respondents with income <$30,000 were more likely to attempt to access financial supports (20.4%) and referrals for social supports (17.4%).

	Overall	<$30,000	$30,000 - $59,999	$60,000 - $99,999	$100,000+	p
Dental care	602.2 (48.3)	156.7 (43.0)	142.0 (47.2)	97.9 (60.0)	57.7 (70.5)	0.006
Referrals for social supports (e.g., housing, income, food)	92.9 (7.5)	63.3 (17.4)	20.2 (6.7)	1.5 (0.9)	0.0 (0.0)	<0.001
Help connecting with others socially	49.9 (4.0)	26.1 (7.2)	4.8 (1.6)	3.7 (2.3)	0.4 (0.5)	<0.001
Spiritual, religious, or cultural resources	42.9 (3.4)	13.4 (3.7)	13.4 (4.5)	0.7 (0.4)	0.4 (0.5)	0.022
Financial supports to help supplement my income	124.0 (9.9)	74.2 (20.4)	32.1 (10.7)	3.7 (2.3)	0.4 (0.5)	<0.001
Somewhere to live	46.9 (3.8)	35.9 (9.9)	6.3 (2.1)	1.8 (1.1)	0.4 (0.5)	<0.001
Arts-based activities (e.g., painting class, singing group)	50.8 (4.1)	9.4 (2.6)	8.3 (2.8)	9.2 (5.6)	8.5 (10.4)	0.044

Note: Number of weighted participants (percentage chose answer)

Differences by Urban/Rural

The majority of respondents from different type of urban/rural categories sought primary care with respondents from rural areas attempting to access it more than others (46.3%).

	Overall	Large urban centre	Medium city/town	Small city/town	Rural area	p
Primary care related to a new health condition	423.8 (34.0)	176.1 (38.8)	54.9 (27.6)	68.9 (29.5)	78.1 (46.3)	0.033
Reproductive Care (e.g., Menopause)	37.4 (3.0)	22.7 (5.0)	0.9 (0.5)	5.8 (2.5)	3.9 (2.3)	0.038
Somewhere to live	46.9 (3.8)	30.5 (6.7)	2.5 (1.2)	10.2 (4.4)	1.4 (0.8)	0.011

Note: Number of weighted participants (percentage chose answer). Large urban centre (100,000+ people), Medium city/town (30,000-99,999 people), Rural area (Less than 1000 people), and Small city/town (1,000-29,999 people).

Differences by Living Arrangement

Respondents living alone were more likely to attempt to access referrals for social supports (18.3%) and financial supports (20.4%).

	Overall	Alone	Not alone	p
Counselling for Substance Use	8.0 (0.6)	4.0 (2.7)	1.4 (0.2)	<0.001
Referrals for social supports (e.g., housing, income, food)	92.9 (7.5)	27.4 (18.3)	59.7 (6.6)	0.001
Spiritual, religious, or cultural resources	42.9 (3.4)	14.0 (9.4)	21.7 (2.4)	0.001
Financial supports to help supplement my income	124.0 (9.9)	30.6 (20.4)	83.6 (9.3)	0.003
Somewhere to live	46.9 (3.8)	13.4 (8.9)	30.6 (3.4)	0.029

Note: Number of weighted participants (percentage chose answer)

Differences by Sexual Orientation

Participants identifying as 2SLGBTQ+ were more likely to seek referrals for social supports than the overall population.

	Overall	Straight	2SLGBTQ+	p
Referrals for social supports (e.g., housing, income, food)	92.9 (7.5)	63.0 (7.1)	21.2 (15.7)	0.031

Note: Number of weighted participants (percentage chose answer)

Differences by Ethnicity

White participants were more likely to see counselling for mental health compared to the overall population.

	Overall	Indigenous	Visible Minority	White	p
Counselling for Mental Health	152.6 (12.2)	4.6 (9.3)	14.6 (5.6)	118.2 (16.0)	0.047

Note: Number of weighted participants (percentage chose answer)

Differences by Disability

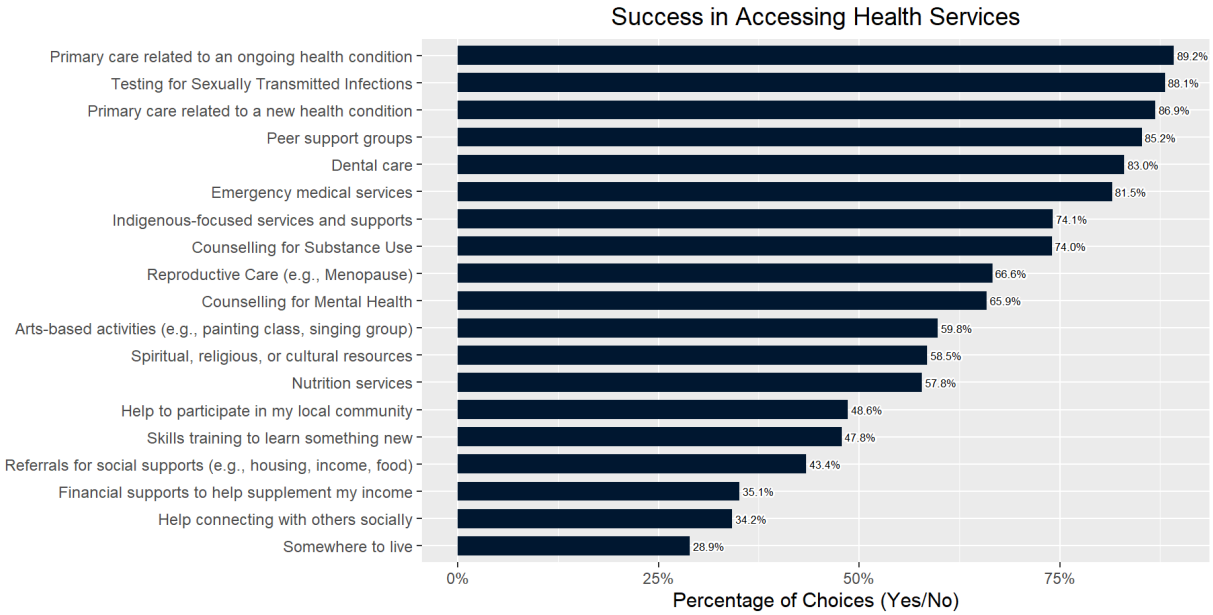
Primary care for both ongoing and new health conditions is the most sought-after service among both respondents with and without disabilities. Respondents with disabilities were more likely to access emergency medical services (16.4%). In addition, respondents with disabilities were more likely to attempt to access counselling for mental health (14.8%).

	Overall	Disability	No disability	p
Primary care related to an ongoing health condition	842.1 (67.5)	617.8 (74.3)	123.5 (52.3)	<0.001
Primary care related to a new health condition	423.8 (34.0)	317.0 (38.1)	62.0 (26.2)	0.016
Counselling for Mental Health	152.6 (12.2)	123.2 (14.8)	13.1 (5.6)	0.012
Nutrition services	62.0 (5.0)	49.9 (6.0)	5.7 (2.4)	0.039
Referrals for social supports (e.g., housing, income, food)	92.9 (7.5)	82.3 (9.9)	5.4 (2.3)	0.002
Help connecting with others socially	49.9 (4.0)	41.1 (4.9)	3.2 (1.3)	0.02
Emergency medical services	204.0 (16.4)	172.4 (20.7)	12.8 (5.4)	<0.001
Financial supports to help supplement my income	124.0 (9.9)	102.0 (12.3)	12.2 (5.1)	0.018
Somewhere to live	46.9 (3.8)	44.0 (5.3)	0.5 (0.2)	<0.001

Note: Number of weighted participants (percentage chose answer)

Success in Accessing Health Services

Participants were asked “Of the services you tried to access in the PAST 12 MONTHS, which services were you able to access? (Check all that apply)” and given a list of various health services, supports, and resources. Participants were allowed to answer multiple options. Overall, there appeared to be general success in accessing most health services, with a good number of services successfully accessed 74.0 % to 89.2%. Some health services had less success in access, such as somewhere to live (28.9%), help connecting with others socially (34.2%), and financial supports to help with income (35.1%).



Differences by Income

Success in access of dental care is higher among higher income groups. For instance, $100,000+ is at 98.5%, while <$30,000 is at 70%. A similar picture is in spiritual/religious resources with $100,000+ at 100% and <$30,000 at 42.1%.

	Overall	<$30,000	$30,000 - $59,999	$60,000 - $99,999	$100,000+	p
Dental care	495.6 (83.0)	109.6 (70.0)	122.7 (86.4)	81.7 (83.5)	56.8 (98.5)	0.008
Spiritual, religious, or cultural resources	24.8 (58.5)	5.6 (42.1)	12.8 (95.9)	0.7 (100.0)	0.4 (100.0)	<0.001
Financial supports to help supplement my income	43.5 (35.1)	33.9 (45.7)	5.7 (17.6)	0.3 (9.5)	0.0 (0.0)	0.035

Note: Number of weighted participants (percentage chose answer)

Differences by Urban/Rural

The success in access of skills training is spread out. In large urban centres its at 43.8%, in medium cities 17.2%, rural area 10.4%, and small city 83.9%.

	Overall	Large urban centre	Medium city/town	Small city/town	Rural area	p
Spiritual, religious, or cultural resources	24.8 (58.5)	6.7 (35.2)	7.5 (100.0)	0.7 (30.2)	6.8 (96.2)	<0.001
Indigenous-focused services and supports	3.7 (74.1)	1.0 (91.1)	0.2 (100.0)	2.5 (100.0)	0.0 (0.0)	0.001
Skills training to learn something new	20.8 (47.8)	6.7 (43.8)	1.4 (17.2)	10.3 (83.9)	0.5 (10.4)	0.027

Note: Number of weighted participants (percentage chose answer). Large urban centre (100,000+ people), Medium city/town (30,000-99,999 people), Rural area (Less than 1000 people), and Small city/town (1,000-29,999 people).

Differences by Disability

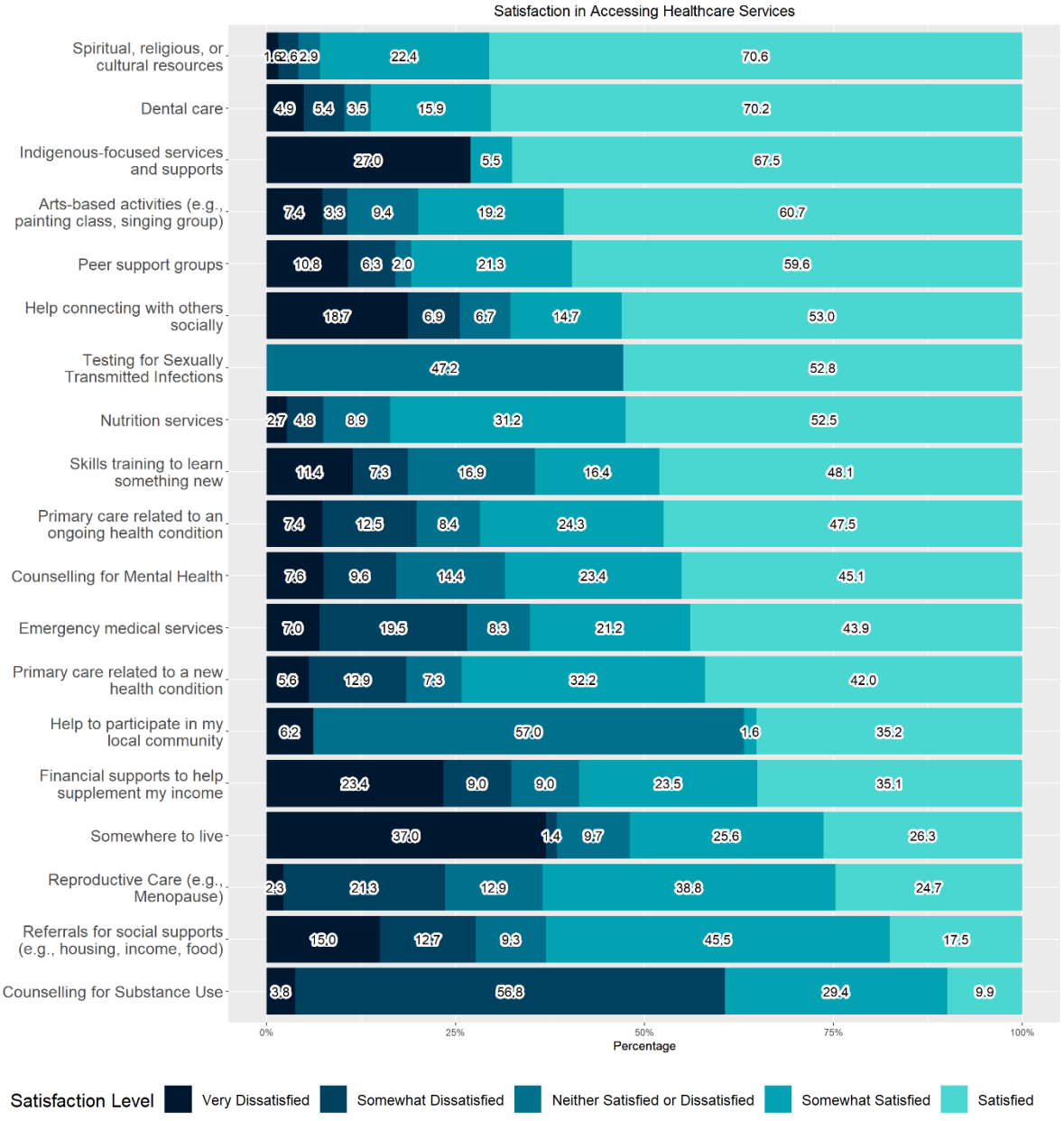
Respondents without disabilities generally have higher success chances in accessing health services. For example, dental care difference for respondents with disabilities is 79.6% vs 92.7% for respondents without disabilities. For nutrition services, 51.4% vs 97%. Spiritual and religious services 52.6% vs 100%.

	Overall	Disability	No disability	p
Dental care	495.6 (83.0)	328.4 (79.6)	108.6 (92.7)	0.029
Nutrition services	35.8 (57.8)	25.7 (51.4)	5.5 (97.0)	<0.001
Referrals for social supports (e.g., housing, income, food)	40.3 (43.4)	36.3 (44.1)	0.5 (9.7)	0.017
Help to participate in my local community	11.0 (48.6)	3.2 (27.5)	7.7 (92.4)	0.001
Spiritual, religious, or cultural resources	24.8 (58.5)	15.6 (52.6)	6.0 (100.0)	0.041

Note: Number of weighted participants (percentage chose answer)

Satisfaction in Health Services

Participants were asked to rank their level of satisfaction with the services or supports they accessed in the past 12 months. Possible rankings include: very dissatisfied, somewhat dissatisfied, neither satisfied or dissatisfied, somewhat satisfied, or satisfied. The majority of services were deemed generally satisfied, somewhat satisfied, or neither satisfied or dissatisfied (neutral). Some trends were the opposite however, for somewhere to live and counselling for substance use. For somewhere to live, 37.0% were very dissatisfied, and counselling for substance use, 56.8% were somewhat dissatisfied.



Differences by Age

Overall, the highest satisfaction is with nutrition services. Generally, the 75-84 age groups is more satisfied with health services and supports than the younger age groups.

	Overall	55-64	65-74	75-84	85-99	p
Nutrition services	3.26 (0.99)	3.56 (0.59)	2.76 (1.25)	3.17 (0.86)	1.50 (1.50)	0.038
Help connecting with others socially	2.76 (1.58)	0.58 (1.18)	3.09 (1.18)	3.63 (0.48)	4.00 (0.00)	<0.001
Somewhere to live	2.03 (1.67)	1.93 (1.67)	1.45 (1.40)	2.41 (1.70)	4.00 (0.00)	0.001
Skills training to learn something new	2.83 (1.39)	3.17 (1.04)	1.94 (2.00)	2.44 (0.61)	0.00 (0.00)	<0.001
Arts-based activities (e.g., painting class, singing group)	3.22 (1.20)	2.72 (1.29)	3.81 (0.42)	2.92 (1.42)	2.78 (1.84)	0.036

Note: Average satisfaction in health services or supports on a scale from 0 to 5. Where 0 is very dissatisfied and 5 is satisfied.

Differences by Gender

In gender differences, the highest overall satisfaction is with spiritual or religious services, across most services men are more satisfied on average than women and non-binary.

	Overall	Man	Non-binary	Woman	p
Testing for Sexually Transmitted Infections	3.06 (1.00)	4.00 (0.00)	0.00 (0.00)	2.13 (0.49)	0.058
Help connecting with others socially	2.71 (1.59)	3.85 (0.36)	4.00 (0.00)	2.12 (1.65)	0.025
Spiritual, religious, or cultural resources	3.60 (0.83)	3.46 (0.80)	4.00 (0.00)	3.70 (0.84)	0.018
Peer support groups	3.13 (1.35)	3.97 (0.18)	3.00 (0.00)	2.60 (1.51)	<0.001
Emergency medical services	2.77 (1.33)	2.76 (1.34)	1.11 (0.58)	2.96 (1.25)	<0.001
Somewhere to live	1.60 (1.54)	3.00 (0.00)	0.00 (0.00)	1.52 (1.55)	0.033
Arts-based activities (e.g., painting class, singing group)	3.23 (1.17)	4.00 (0.00)	2.09 (1.02)	3.26 (1.16)	<0.001

Note: Average satisfaction in health services or supports on a scale from 0 to 5. Where 0 is very dissatisfied and 5 is satisfied.

Differences by Income

The highest satisfaction is among the $60,000 - $99,999 income bracket for most services and supports.

	Overall	<$30,000	$30,000 - $59,999	$60,000 - $99,999	$100,000+	p
Testing for Sexually Transmitted Infections	3.06 (1.00)	2.13 (0.49)	0.00 (0.00)	4.00 (0.00)	0.00 (0.00)	0.058
Referrals for social supports (e.g., housing, income, food)	2.38 (1.40)	2.41 (1.42)	2.27 (1.30)	1.00 (0.00)	0.00 (0.00)	0.001
Help to participate in my local community	2.77 (0.96)	2.03 (0.17)	3.64 (0.77)	4.00 (0.00)	0.00 (0.00)	<0.001
Help connecting with others socially	2.51 (1.63)	2.02 (1.77)	2.33 (1.18)	4.00 (0.00)	0.00 (0.00)	0.002
Spiritual, religious, or cultural resources	3.56 (0.86)	3.24 (1.04)	3.74 (0.56)	2.50 (1.94)	4.00 (0.00)	0.024
Financial supports to help supplement my income	2.50 (1.54)	2.48 (1.46)	2.52 (1.93)	4.00 (0.00)	0.00 (0.00)	<0.001
Somewhere to live	1.60 (1.54)	1.44 (1.45)	3.47 (1.35)	0.00 (0.00)	0.00 (0.00)	0.058
Skills training to learn something new	3.00 (1.17)	2.95 (0.87)	3.52 (1.22)	1.19 (0.74)	3.00 (0.00)	0.008

Note: Average satisfaction in health services or supports on a scale from 0 to 5. Where 0 is very dissatisfied and 5 is satisfied.

Differences by Urban/Rural

Overall the highest satisfaction by location is with dental care.

	Overall	Large urban centre	Medium city/town	Small city/town	Rural area	p
Dental care	3.43 (1.11)	3.46 (1.08)	3.19 (1.24)	3.35 (1.09)	3.63 (1.01)	0.014
Reproductive Care (e.g., Menopause)	2.62 (1.14)	2.40 (1.09)	2.95 (1.76)	3.85 (0.36)	2.59 (0.95)	0.004
Counselling for Mental Health	2.89 (1.29)	2.73 (1.45)	2.64 (1.01)	3.65 (0.65)	3.18 (1.07)	0.023
Referrals for social supports (e.g., housing, income, food)	2.37 (1.37)	2.42 (1.39)	1.19 (0.99)	3.73 (0.45)	2.89 (1.07)	<0.001
Help to participate in my local community	2.77 (0.96)	3.31 (0.95)	2.21 (0.61)	4.00 (0.00)	3.87 (0.34)	0.011
Spiritual, religious, or cultural resources	3.60 (0.83)	3.70 (0.65)	3.14 (1.10)	4.00 (0.00)	3.71 (0.45)	0.013
Indigenous-focused services and supports	2.87 (1.76)	0.00 (0.00)	3.00 (0.00)	0.00 (0.00)	4.00 (0.00)	<0.001
Peer support groups	3.13 (1.35)	2.89 (1.65)	3.70 (0.46)	3.00 (0.00)	3.67 (0.47)	0.004
Arts-based activities (e.g., painting class, singing group)	3.23 (1.17)	3.24 (0.99)	3.95 (0.23)	2.63 (1.80)	3.26 (1.20)	0.018

Note: Large urban centre (100,000+ people), Medium city/town (30,000-99,999 people), Rural area (Less than 1000 people), and Small city/town (1,000-29,999 people). Average satisfaction in health services or supports on a scale from 0 to 5. Where 0 is very dissatisfied and 5 is satisfied.

Differences by Living Arrangement

People living alone are more satisfied on average with help in participating in a local community than people not living alone.

	Overall	Alone	Not alone	p
Help to participate in my local community	2.77 (0.96)	3.88 (0.32)	2.58 (0.91)	0.023

Note: Average satisfaction in health services or supports on a scale from 0 to 5. Where 0 is very dissatisfied and 5 is satisfied.

Differences by Sexual Orientation

Straight participants are on average more satisfied with services than 2SLGBTQ+ participants.

	Overall	Straight	2SLGBTQ+	p
Reproductive Care (e.g., Menopause)	2.62 (1.14)	2.92 (1.02)	1.48 (0.88)	0.001
Counselling for Mental Health	2.89 (1.29)	2.91 (1.33)	2.72 (1.13)	<0.001
Nutrition services	3.18 (1.04)	3.13 (1.17)	3.69 (0.92)	<0.001
Help connecting with others socially	2.71 (1.59)	2.60 (1.61)	0.00 (0.00)	0.025
Spiritual, religious, or cultural resources	3.60 (0.83)	3.56 (0.86)	4.00 (0.00)	0.009
Peer support groups	3.13 (1.35)	3.28 (1.30)	1.28 (0.69)	<0.001
Emergency medical services	2.79 (1.33)	2.77 (1.35)	2.47 (1.22)	<0.001

Note: Average satisfaction in health services or supports on a scale from 0 to 5. Where 0 is very dissatisfied and 5 is satisfied.

Differences by Ethnicity

Overall, the highest average satisfaction is with spiritual, religious, or cultural services across all ethnic categories. For most of the categories visible minority participants seem to be slightly more satisfied in the majority of health services or supports.

	Overall	Indigenous	Visible Minority	White	p
Dental care	3.42 (1.11)	2.81 (1.21)	3.78 (0.54)	3.32 (1.22)	0.001
Reproductive Care (e.g., Menopause)	2.62 (1.14)	2.00 (0.00)	3.24 (0.43)	2.37 (1.29)	0.001
Counselling for Mental Health	2.89 (1.29)	3.23 (0.74)	2.34 (0.48)	2.98 (1.40)	0.006
Counselling for Substance Use	1.37 (1.09)	4.00 (0.00)	0.00 (0.00)	0.94 (0.24)	0.002
Nutrition services	3.18 (1.04)	3.02 (1.00)	3.00 (0.00)	3.24 (1.15)	0.016
Referrals for social supports (e.g., housing, income, food)	2.37 (1.37)	0.43 (0.50)	3.00 (0.00)	2.44 (1.39)	<0.001
Help connecting with others socially	2.71 (1.59)	0.00 (0.00)	4.00 (0.00)	2.54 (1.62)	0.021
Spiritual, religious, or cultural resources	3.60 (0.83)	4.00 (0.00)	0.00 (0.00)	3.58 (0.84)	0.01
Financial supports to help supplement my income	2.46 (1.55)	4.00 (0.00)	3.55 (0.50)	2.25 (1.60)	<0.001
Arts-based activities (e.g., painting class, singing group)	3.23 (1.17)	2.67 (0.95)	4.00 (0.00)	3.24 (1.21)	<0.001

Note: Average satisfaction in health services or supports on a scale from 0 to 5. Where 0 is very dissatisfied and 5 is satisfied.

Differences by Disability

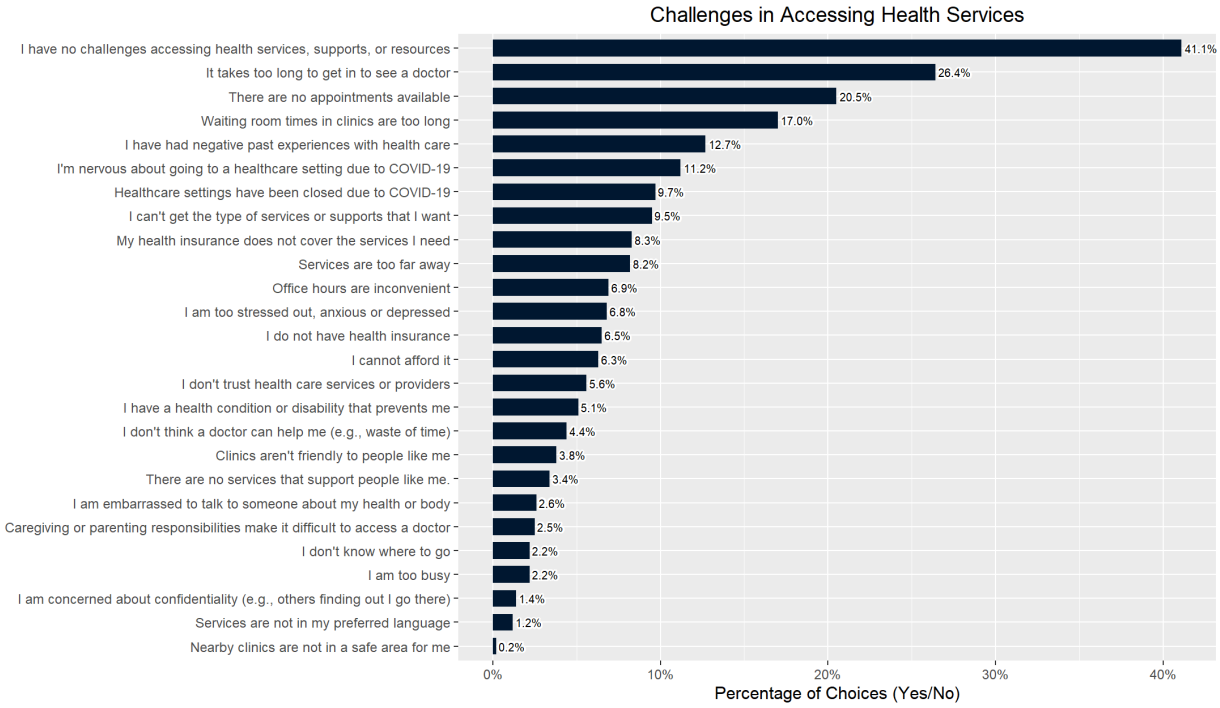
Participants without disabilities have higher satisfaction with most of the health services and supports than those without disabilities. Except for help to participate in one's local community.

	Overall	Disability	No disability	p
Primary care related to an ongoing health condition	2.94 (1.30)	2.82 (1.33)	3.56 (0.96)	<0.001
Primary care related to a new health condition	2.94 (1.23)	2.86 (1.24)	3.35 (1.11)	0.003
Dental care	3.43 (1.11)	3.37 (1.12)	3.58 (1.06)	0.015
Reproductive Care (e.g., Menopause)	2.62 (1.14)	2.36 (1.00)	3.36 (1.18)	0.033
Counselling for Substance Use	1.37 (1.09)	1.45 (1.07)	0.00 (0.00)	0.047
Referrals for social supports (e.g., housing, income, food)	2.37 (1.37)	2.35 (1.37)	3.44 (0.96)	0.06
Help to participate in my local community	2.60 (1.15)	3.61 (0.76)	2.09 (0.96)	0.015
Somewhere to live	1.60 (1.54)	1.62 (1.54)	0.00 (0.00)	0.026

Note: Average satisfaction in health services or supports on a scale from 0 to 5. Where 0 is very dissatisfied and 5 is satisfied.

Healthcare Challenges

Participants were asked to identify any challenges they may face in accessing healthcare services, supports, and resources. Participants were allowed to answer multiple options. The majority, at 41.1% indicated they had no challenges accessing health services, supports, or resources. For those who did have challenges in access, the second most popular selections were that it takes too long to get in to see a doctor (26.4%), there were no appointments available (20.5%), waiting room times were too long (17.0%), or they had negative past experiences with health care (12.7%). The average number of barriers reported by a participant was 1.6 (SD: 2.1).



Differences by Age

The most significant finding is that across all age groups, the top reason for not accessing healthcare is due to there being no available appointments, with a percentage range of 20.5% to 26.8%. The second most common reason is that people were nervous about going to a healthcare setting due to COVID-19, ranging from 11.2% to 14.6%. Other significant factors include services being too far away, inconvenient office hours, negative past experiences with healthcare, and cost-related issues such as affordability and lack of coverage by health insurance. The percentage ranges for these factors vary from 3.4% to 12.7%. Lastly, it's worth noting that people aged 75-84 and 85-99 face more challenges in accessing healthcare due to their age, with the highest percentages for most factors being in these age groups.

	Overall	55-64	65-74	75-84	85-99	p
I have no challenges accessing health services, supports, or resources	1607.3 (41.1)	578.2 (34.8)	536.8 (41.2)	362.8 (53.3)	129.6 (48.5)	<0.001
I'm nervous about going to a healthcare setting due to COVID-19	437.6 (11.2)	243.3 (14.6)	135.1 (10.4)	40.8 (6.0)	18.4 (6.9)	0.001
There are no appointments available	803.6 (20.5)	445.3 (26.8)	231.9 (17.8)	98.6 (14.5)	27.7 (10.4)	<0.001
I am too busy	85.3 (2.2)	74.8 (4.5)	7.2 (0.6)	0.6 (0.1)	2.6 (1.0)	<0.001
Services are too far away	321.3 (8.2)	183.4 (11.0)	100.1 (7.7)	33.3 (4.9)	4.5 (1.7)	<0.001
Office hours are inconvenient	268.6 (6.9)	173.0 (10.4)	55.1 (4.2)	21.9 (3.2)	18.6 (7.0)	<0.001
Caregiving or parenting responsibilities make it difficult to access a doctor	97.3 (2.5)	43.2 (2.6)	28.3 (2.2)	8.7 (1.3)	17.0 (6.4)	0.048
I don’t trust health care services or providers	217.3 (5.6)	137.5 (8.3)	59.8 (4.6)	10.1 (1.5)	9.8 (3.7)	<0.001
I have had negative past experiences with health care	496.6 (12.7)	283.2 (17.0)	140.8 (10.8)	50.7 (7.4)	21.9 (8.2)	<0.001
There are no services that support people like me.	132.2 (3.4)	86.8 (5.2)	31.1 (2.4)	8.5 (1.3)	5.8 (2.2)	0.011

I don't think a doctor can help me (e.g., waste of time)	170.4 (4.4)	105.1 (6.3)	37.3 (2.9)	19.7 (2.9)	8.3 (3.1)	0.012
I can't get the type of services or supports that I want	371.4 (9.5)	202.9 (12.2)	114.9 (8.8)	42.4 (6.2)	11.2 (4.2)	0.003
I am too stressed out, anxious or depressed	267.0 (6.8)	181.2 (10.9)	70.7 (5.4)	13.6 (2.0)	1.5 (0.6)	<0.001
I cannot afford it	246.6 (6.3)	172.7 (10.4)	65.5 (5.0)	6.9 (1.0)	1.5 (0.6)	<0.001
My health insurance does not cover the services I need	323.6 (8.3)	196.7 (11.8)	100.8 (7.7)	22.6 (3.3)	3.5 (1.3)	<0.001
It takes too long to get in to see a doctor	1033.9 (26.4)	477.0 (28.7)	376.3 (28.9)	137.0 (20.1)	43.6 (16.3)	0.001
I have a health condition or disability that prevents me	199.2 (5.1)	126.2 (7.6)	51.1 (3.9)	11.5 (1.7)	10.4 (3.9)	0.001
I am embarrassed to talk to someone about my health or body	100.1 (2.6)	66.3 (4.0)	24.3 (1.9)	6.6 (1.0)	2.9 (1.1)	0.001

Note: Number of weighted participants (percentage chose answer)

Differences by Gender

Overall, women reported facing more challenges than men or non-binary individuals. For instance, women were more likely to be nervous about going to a healthcare setting due to COVID-19 (15.2% compared to 9.3% for men and 19.2% for non-binary individuals). They were also more likely to experience negative past experiences with healthcare (15.3% vs 11.2% for men and 32.1% for non-binary individuals). Additionally, women were more likely to feel embarrassed to talk to someone about their health or body (3.8% vs 1.1% for men and 16.9% for non-binary individuals). On the other hand, men were more likely to report that they have no challenges accessing health services, supports, or resources (45.0% vs 38.1% for women and 6.5% for non-binary individuals). Overall, these findings suggest that gender plays a significant role in determining the barriers individuals face when accessing healthcare, and that healthcare providers should consider these differences when designing interventions to improve access and utilization of services.

	Overall	Man	Non-binary	Woman	p
I have no challenges accessing health services, supports, or resources	1607.3 (41.1)	685.5 (45.0)	2.0 (6.5)	597.9 (38.1)	<0.001
I'm nervous about going to a healthcare setting due to COVID-19	437.6 (11.2)	142.0 (9.3)	6.0 (19.2)	237.8 (15.2)	0.025
There are no appointments available	803.6 (20.5)	269.9 (17.7)	10.7 (34.2)	373.5 (23.8)	0.028
I am too busy	85.3 (2.2)	14.0 (0.9)	0.0 (0.0)	51.3 (3.3)	0.049
Clinics aren’t friendly to people like me	149.9 (3.8)	43.3 (2.8)	6.2 (19.8)	71.8 (4.6)	0.018
I have had negative past experiences with health care	496.6 (12.7)	170.8 (11.2)	10.0 (32.1)	240.7 (15.3)	0.036
I can’t get the type of services or supports that I want	371.4 (9.5)	106.5 (7.0)	3.1 (10.0)	198.9 (12.7)	0.001
My health insurance does not cover the services I need	323.6 (8.3)	102.5 (6.7)	2.4 (7.6)	165.8 (10.6)	0.032
I am embarrassed to talk to someone about my health or body	100.1 (2.6)	16.3 (1.1)	5.3 (16.9)	59.3 (3.8)	0.002

Note: Number of weighted participants (percentage chose answer)

Differences by Income

First, the most commonly reported barrier to accessing healthcare services was the lack of available appointments, with 20.5% of respondents reporting this issue. This barrier was more prevalent among individuals with lower incomes, with 24.9% of those earning <$30,000 reporting it as a barrier. Second, a significant proportion of respondents (12.7%) reported negative past experiences with healthcare, with individuals in the $100,000+ income bracket being less likely to report this barrier compared to those in other income brackets. Third, a sizable number of respondents (6.8%) reported feeling too stressed, anxious, or depressed to access healthcare services. This barrier was more common among individuals with lower incomes, with 12.2% of those earning <$30,000 reporting it as a barrier. Fourth, 5.1% of respondents reported having a health condition or disability that prevented them from accessing healthcare services, with individuals with lower incomes being more likely to report this barrier. Lastly, 3.8% of respondents reported that clinics were not friendly to people like them, with individuals earning <$30,000 being the most likely to report this barrier.

	Overall	<$30,000	$30,000 - $59,999	$60,000 - $99,999	$100,000+	p
There are no appointments available	803.6 (20.5)	208.1 (20.9)	170.7 (18.6)	137.7 (24.9)	89.1 (29.9)	0.04
Clinics aren't friendly to people like me	149.9 (3.8)	63.1 (6.4)	27.5 (3.0)	17.4 (3.2)	1.4 (0.5)	0.002
I have had negative past experiences with health care	496.6 (12.7)	172.1 (17.3)	117.2 (12.8)	69.4 (12.6)	17.9 (6.0)	0.015
There are no services that support people like me.	132.2 (3.4)	58.6 (5.9)	18.3 (2.0)	21.7 (3.9)	5.1 (1.7)	0.024
I am too stressed out, anxious or depressed	267.0 (6.8)	120.9 (12.2)	76.4 (8.3)	20.0 (3.6)	4.5 (1.5)	<0.001
I do not have health insurance	255.9 (6.5)	104.8 (10.5)	47.1 (5.1)	39.7 (7.2)	7.4 (2.5)	0.015
I have a health condition or disability that prevents me	199.2 (5.1)	95.3 (9.6)	35.1 (3.8)	12.6 (2.3)	2.1 (0.7)	<0.001
I am embarrassed to talk to someone about my health or body	100.1 (2.6)	27.2 (2.7)	16.6 (1.8)	30.2 (5.5)	0.8 (0.3)	0.011

Note: Number of weighted participants (percentage chose answer)

Differences by Urban/Rural

The most significant challenge is the lack of appointments across all types of areas at overall 20.5%. The highest proportion of respondents who indicated this challenge were in rural areas (27.4%). For rural areas, another big issue is services being too far away 18.7%.

	Overall	Large urban centre	Medium city/town	Small city/town	Rural area	p
I'm nervous about going to a healthcare setting due to COVID-19	437.6 (11.2)	201.1 (15.1)	68.1 (10.8)	77.5 (10.4)	39.1 (8.5)	0.048
There are no appointments available	803.6 (20.5)	284.3 (21.4)	104.5 (16.6)	148.8 (20.0)	125.1 (27.4)	0.042
Services are too far away	321.3 (8.2)	89.6 (6.7)	34.1 (5.4)	79.9 (10.7)	85.6 (18.7)	<0.001
Caregiving or parenting responsibilities make it difficult to access a doctor	97.3 (2.5)	49.4 (3.7)	23.6 (3.8)	7.4 (1.0)	5.4 (1.2)	0.036
I cannot afford it	246.6 (6.3)	119.5 (9.0)	20.6 (3.3)	45.1 (6.1)	34.1 (7.5)	0.032
I am embarrassed to talk to someone about my health or body	100.1 (2.6)	52.7 (4.0)	13.0 (2.1)	8.3 (1.1)	6.8 (1.5)	0.005

Note: Number of weighted participants (percentage chose answer). Large urban centre (100,000+ people), Medium city/town (30,000-99,999 people), Rural area (Less than 1000 people), and Small city/town (1,000-29,999 people).

Differences by Living Arrangement

In differences by living alone or with others, respondents living alone were more stressed out (11.9%) and another challenge is a belief that there were no services that support people like them.

	Overall	Alone	Not alone	p
There are no appointments available	803.6 (20.5)	75.9 (16.7)	587.1 (21.9)	0.029
I am too busy	85.3 (2.2)	3.2 (0.7)	62.1 (2.3)	0.003
Caregiving or parenting responsibilities make it difficult to access a doctor	97.3 (2.5)	2.4 (0.5)	82.8 (3.1)	<0.001
There are no services that support people like me.	132.2 (3.4)	30.4 (6.7)	82.7 (3.1)	0.018
I am too stressed out, anxious or depressed	267.0 (6.8)	51.4 (11.3)	184.5 (6.9)	0.026
It takes too long to get in to see a doctor	1033.9 (26.4)	95.5 (21.0)	754.6 (28.1)	0.003

Note: Number of weighted participants (percentage chose answer)

Differences by Sexual Orientation

The most significant findings include that 2SLGBTQ+ individuals face additional barriers compared to Straight individuals. For example, 2SLGBTQ+ individuals were more likely to be nervous about going to healthcare settings due to COVID-19, feel that there were no services that support people like them, and cannot get the type of services or supports that they want. Additionally, 2SLGBTQ+ individuals were more likely to be too stressed out, anxious, or depressed to seek help and cannot afford the services they need. The findings suggest that there is a need for targeted interventions to address the specific challenges faced by 2SLGBTQ+ individuals in accessing healthcare services and supports.

	Overall	Straight	2SLGBTQ+	p
I have no challenges accessing health services, supports, or resources	1607.3 (41.1)	1113.9 (42.5)	128.1 (33.1)	0.026
I'm nervous about going to a healthcare setting due to COVID-19	437.6 (11.2)	301.5 (11.5)	70.9 (18.3)	0.02
There are no services that support people like me.	132.2 (3.4)	78.7 (3.0)	26.5 (6.9)	0.026
I don’t think a doctor can help me (e.g., waste of time)	170.4 (4.4)	99.0 (3.8)	31.5 (8.1)	0.024
I can’t get the type of services or supports that I want	371.4 (9.5)	222.2 (8.5)	70.3 (18.2)	<0.001
I am too stressed out, anxious or depressed	267.0 (6.8)	175.1 (6.7)	57.1 (14.8)	0.001
I cannot afford it	246.6 (6.3)	151.2 (5.8)	59.2 (15.3)	<0.001
It takes too long to get in to see a doctor	1033.9 (26.4)	737.4 (28.1)	73.2 (18.9)	0.018

Note: Number of weighted participants (percentage chose answer)

Differences by Ethnicity

One significant finding is that Indigenous respondents were more likely to report not trusting healthcare services or providers compared to visible minority and white respondents. Additionally, negative past experiences with healthcare were more prevalent among Indigenous and visible minority respondents compared to white respondents. Another notable finding is that visible minority respondents were more likely to report that healthcare services were not available in their preferred language compared to Indigenous and white respondents. Interestingly, only a small percentage of respondents overall reported feeling unsafe accessing healthcare services due to potential dangers in the area, with Indigenous respondents being the most likely to report this concern. Overall, these findings highlight the importance of considering diverse perspectives and experiences when addressing healthcare access and trust issues.

	Overall	Indigenous	Visible Minority	White	p
I don't trust health care services or providers	217.3 (5.6)	15.4 (9.9)	67.4 (8.1)	93.4 (4.4)	0.04
I have had negative past experiences with health care	496.6 (12.7)	39.2 (25.1)	124.6 (15.0)	259.2 (12.1)	0.024
I don't think a doctor can help me (e.g., waste of time)	170.4 (4.4)	5.0 (3.2)	66.7 (8.0)	73.2 (3.4)	0.005
Nearby clinics are not in a safe area for me (e.g., afraid to run into enemies, perpetrators, ex'es, or other dangers)	7.1 (0.2)	2.7 (1.7)	0.0 (0.0)	1.8 (0.1)	<0.001
Services are not in my preferred language	47.2 (1.2)	3.5 (2.3)	22.0 (2.7)	14.6 (0.7)	0.047

Note: Number of weighted participants (percentage chose answer)

Differences by Disability

The most significant findings from this dataset suggest that individuals with disabilities face more challenges accessing health services, supports, or resources than those without disabilities. Specifically, those with disabilities were more likely to have negative past experiences with health care, feel that doctors cannot help them, and have difficulty accessing the type of services or supports they need. Additionally, individuals without health insurance or with limited coverage were more likely to report not being able to afford health services or that their insurance does not cover the services they need. Finally, waiting times and access to appointments were also significant barriers for some individuals, with those with disabilities being more likely to face these challenges. These findings highlight the importance of addressing barriers to health care access for marginalized populations, particularly those with disabilities and limited financial resources.

	Overall	Disability	No disability	p
I have no challenges accessing health services, supports, or resources	1607.3 (41.1)	947.5 (37.8)	384.4 (54.3)	<0.001
There are no appointments available	803.6 (20.5)	567.3 (22.6)	100.7 (14.2)	0.001
Services are too far away	321.3 (8.2)	250.1 (10.0)	37.5 (5.3)	0.021
Clinics aren't friendly to people like me	149.9 (3.8)	118.3 (4.7)	9.3 (1.3)	0.005
I have had negative past experiences with health care	496.6 (12.7)	405.4 (16.2)	30.6 (4.3)	<0.001
There are no services that support people like me.	132.2 (3.4)	106.4 (4.2)	7.6 (1.1)	0.003
I don't think a doctor can help me (e.g., waste of time)	170.4 (4.4)	134.5 (5.4)	12.4 (1.8)	0.021
I can't get the type of services or supports that I want	371.4 (9.5)	279.7 (11.1)	33.8 (4.8)	0.001
I am too stressed out, anxious or depressed	267.0 (6.8)	230.5 (9.2)	11.7 (1.7)	0.001
I cannot afford it	246.6 (6.3)	213.8 (8.5)	7.2 (1.0)	<0.001

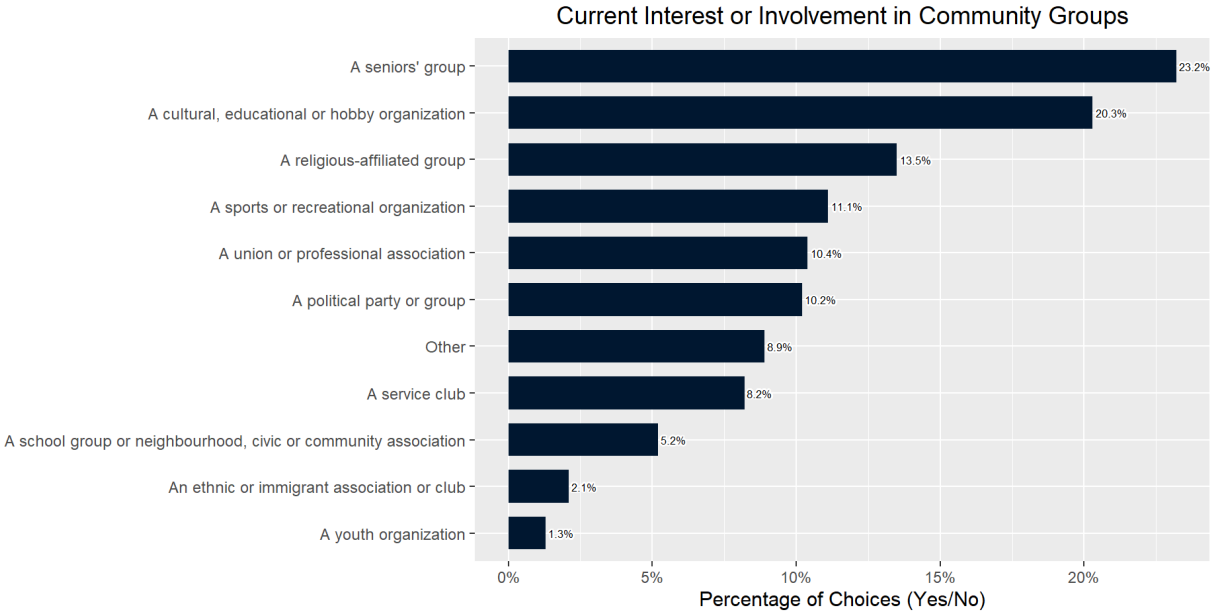
I do not have health insurance	255.9 (6.5)	195.9 (7.8)	24.8 (3.5)	0.012
My health insurance does not cover the services I need	323.6 (8.3)	246.0 (9.8)	27.5 (3.9)	0.003
Waiting room times in clinics are too long	664.2 (17.0)	476.1 (19.0)	97.5 (13.8)	0.034
It takes too long to get in to see a doctor	1033.9 (26.4)	730.6 (29.1)	130.4 (18.4)	<0.001
I have a health condition or disability that prevents me	199.2 (5.1)	163.5 (6.5)	0.0 (0.0)	<0.001

Note: Number of weighted participants (percentage chose answer)

Social Prescribing

Current Interest and Involvement in Social or Community Groups

Participants were asked about their current interest or involvement in various social or community groups. There were allowed to answer multiple options. A seniors' group and a cultural, educational, or hobby organization were the most common selections, at 23.2% and 20.3%, respectively. Around 80% of people chose non of these, and the average number of participation in groups is 0.38.



Differences by Age

The majority of the respondents in differences by age were either interested in a cultural, educational or hobby organization or a senior's group with overall 20.3% and 23.2% respectively. The older participants were more likely to be involved in senior's groups (40.7% for 85-99 age group), while younger ones were more interested in hobby organizations (25.4% for 55-64 age group).

	Overall	55-64	65-74	75-84	85-99	p
A union or professional association	132.5 (10.4)	84.4 (15.2)	30.3 (7.8)	12.6 (5.1)	5.3 (5.9)	0.001
A cultural, educational or hobby organization (such as a theatre group, book club or bridge club)	258.8 (20.3)	141.1 (25.4)	64.8 (16.8)	42.3 (17.2)	10.6 (11.7)	0.014
A school group or neighbourhood, civic or community association (such as PTA, alumni, block parents or neighbourhood watch)	66.5 (5.2)	45.2 (8.1)	11.8 (3.1)	8.3 (3.4)	1.3 (1.4)	0.004
A seniors' group (such as a seniors' club, recreational association or resource centre)	295.9 (23.2)	81.3 (14.6)	94.9 (24.5)	83.1 (33.9)	36.6 (40.7)	<0.001

Note: Number of weighted participants (percentage chose answer)

Differences by Gender

In differences by gender, men were more likely to be interested to be a part of a political party than women 15.5% vs 6.3%. Similarly, men were more likely to be interested in service clubs 13.7% vs 4.5%.

	Overall	Man	Non-binary	Woman	p
A political party or group	130.6 (10.2)	76.4 (15.5)	5.0 (31.7)	32.1 (6.3)	0.015
A school group or neighbourhood, civic or community association (such as PTA, alumni, block parents or neighbourhood watch)	66.5 (5.2)	15.9 (3.2)	5.0 (31.7)	34.1 (6.6)	0.027
A service club (such as Kiwanis, Knights of Columbus or the Legion)	104.3 (8.2)	67.3 (13.7)	0.2 (1.2)	23.1 (4.5)	<0.001

Note: Number of weighted participants (percentage chose answer)

Differences by Income

Income differences show that participants with higher income were more interested or involved with unions, political parties, sports organizations, and cultural or hobby organizations than participants with lower income. For instance, union participation is at 18.4% for $100,000+ and 5.9% for <$30,000. Participation in political groups is at 26.7% for $100,000+ vs 12.3% for 30k, which is not the lowest participation rate though. Participation in sports organizations is at 22% in $100,000+ groups vs 6.2% for <$30,000. Participation in cultural or hobby organizations is at 36% for $100,000+ and 14.8% for <$30,000.

	Overall	<$30,000	$30,000 - $59,999	$60,000 - $99,999	$100,000+	p
A union or professional association	132.5 (10.4)	19.7 (5.9)	33.2 (11.0)	27.6 (16.1)	21.6 (18.4)	0.05
A political party or group	130.6 (10.2)	40.8 (12.3)	17.6 (5.8)	10.4 (6.1)	31.4 (26.7)	<0.001
A sports or recreational organization (such as a hockey league, health club or golf club)	142.1 (11.1)	20.5 (6.2)	32.9 (10.9)	31.1 (18.1)	25.8 (22.0)	0.008
A cultural, educational or hobby organization (such as a theatre group, book club or bridge club)	258.8 (20.3)	49.2 (14.8)	73.0 (24.2)	36.5 (21.3)	42.3 (36.0)	0.01

Note: Number of weighted participants (percentage chose answer)

Differences by Sexual Orientation

Participants who identified as 2SLGBTQ+ were more likely to be interested or involved in an ethnic or immigrant association or club compared to the overall population.

	Overall	Straight	2SLGBTQ+	p
An ethnic or immigrant association or club	27.2 (2.1)	13.4 (1.6)	9.1 (6.8)	0.05

Note: Number of weighted participants (percentage chose answer)

Differences by Ethnicity

Visible minority participants were more likely to be interested or involved in an ethnic or immigrant association or club compared to the overall population.

	Overall	Indigenous	Visible Minority	White	p
An ethnic or immigrant association or club	27.2 (2.1)	0.0 (0.0)	18.8 (6.8)	3.7 (0.5)	0.001

Note: Number of weighted participants (percentage chose answer)

Differences by Disability

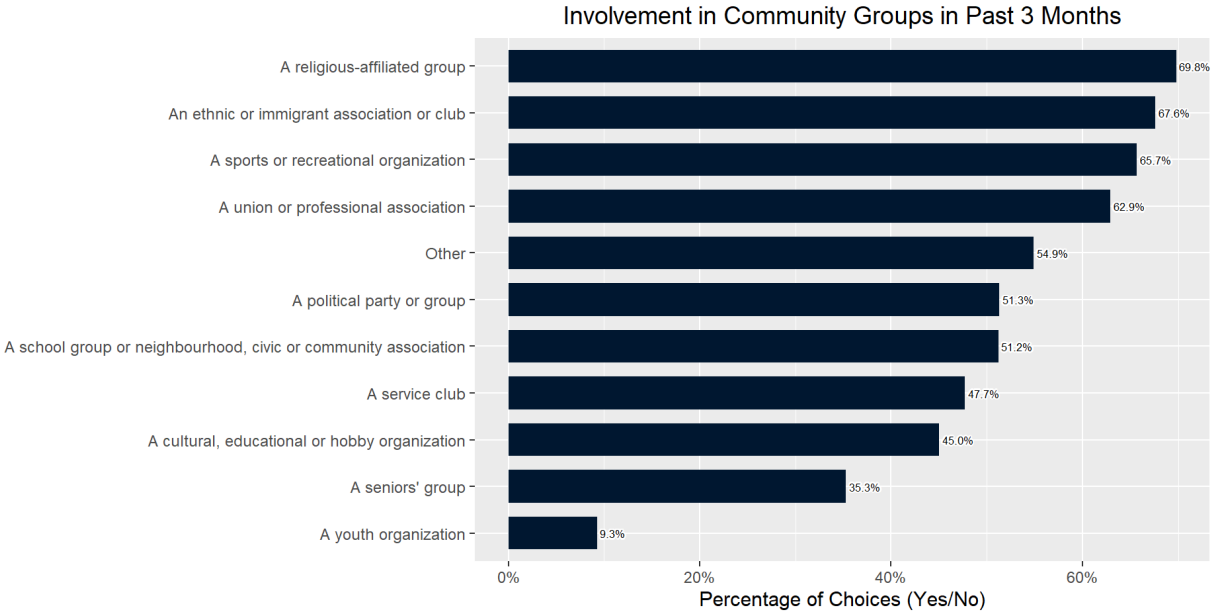
Participants who self-reported no disability were more likely to be interested or involved in an ethnic or immigrant association or club compared to the overall population.

	Overall	Disability	No disability	p
An ethnic or immigrant association or club	27.2 (2.1)	8.0 (1.0)	14.5 (6.1)	0.008

Note: Number of weighted participants (percentage chose answer)

Involvement in Community Groups Within Last 3 Months

Participants were asked to select all community groups which they have been involved with in the past 3 months. Participants were allowed to select multiple options. The most commonly selected groups included: a religious-affiliated group, an ethnic or immigrant association or club, a sports or recreational organization, and a union or professional association, at 69.8%, 67.5%, 65.7%, and 62.9%, respectively. The least likely involved was with a youth organization, at 9.3%.



Differences by Age

In differences by age for involvement in certain organizations, a younger group of 55-64 were highly involved in ethnic or immigrant associations with 93.3% indicating involvement.

	Overall	55-64	65-74	75-84	85-99	p
A service club (such as Kiwanis, Knights of Columbus or the Legion)	48.2 (47.7)	12.6 (26.7)	17.0 (64.5)	13.5 (63.8)	5.0 (80.8)	0.03
An ethnic or immigrant association or club	18.4 (67.6)	16.7 (93.3)	0.6 (13.3)	1.1 (26.8)	0.0 (0.0)	0.001

Note: Number of weighted participants (percentage chose answer)

Differences by Living Arrangement

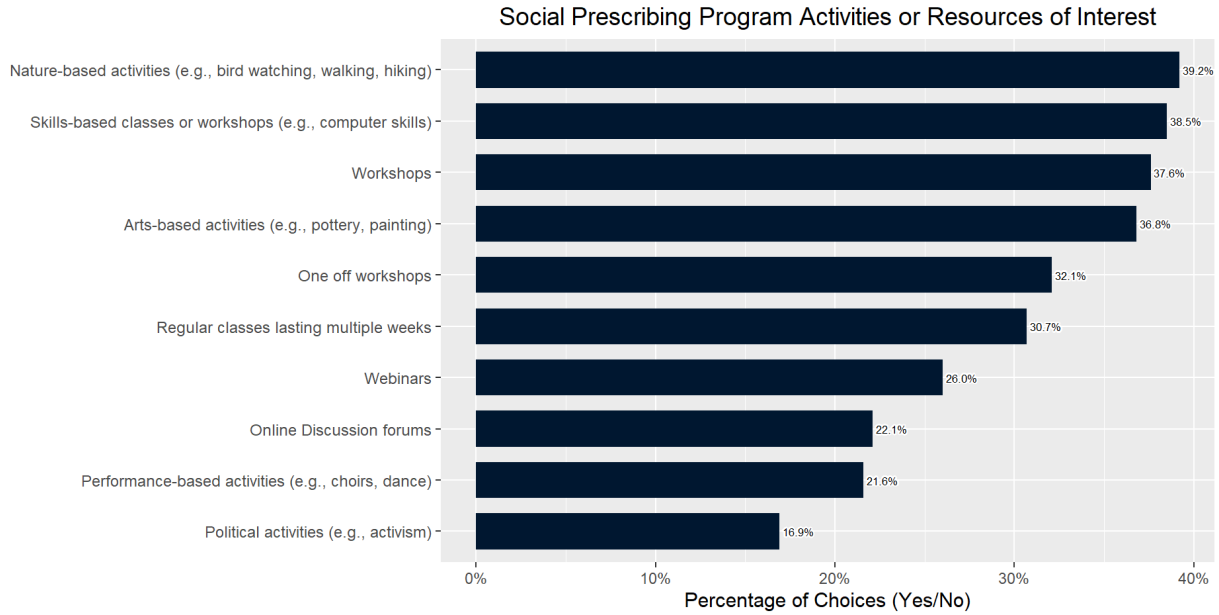
Participants who lived alone were more likely to be involved in a political party or group in the last 3 months compared to the overall population.

	Overall	Alone	Not alone	p
A political party or group	66.4 (51.3)	18.6 (74.3)	34.9 (39.6)	0.008

Note: Number of weighted participants (percentage chose answer)

Social Prescribing Activities of Interest

Participants were asked the following question "What type of activities or resources are you be interested in participating in as part of a social prescribing program? (Check all that apply)". Participants were allowed to answer multiple choices. The most common social prescribing program activities or resources of interest were nature-based activities (39.2%), skills-based classes or workshops (38.5%), workshops (37.6%), and arts-based activities (36.8%).



Differences by Age

The most popular social prescribing activity overall was nature-based activities (39.2%). Generally, participants from younger age groups were more likely to participate in any type of activities in comparison to older age groups.

	Overall	55-64	65-74	75-84	85-99	p
Webinars	407.6 (26.0)	232.7 (33.7)	105.3 (21.2)	50.4 (18.6)	19.2 (17.9)	0.001
Workshops	588.3 (37.6)	313.6 (45.4)	182.6 (36.7)	73.9 (27.4)	18.3 (17.1)	<0.001
Regular classes lasting multiple weeks	480.8 (30.7)	273.3 (39.6)	128.7 (25.9)	61.1 (22.6)	17.7 (16.5)	<0.001
One off workshops	501.9 (32.1)	270.1 (39.1)	150.1 (30.2)	60.5 (22.4)	21.3 (19.8)	0.003
Arts-based activities (e.g., pottery, painting)	576.4 (36.8)	309.4 (44.8)	173.4 (34.9)	59.2 (21.9)	34.4 (32.0)	<0.001
Performance-based activities (e.g., choirs, dance)	338.1 (21.6)	179.1 (25.9)	109.0 (21.9)	37.9 (14.0)	12.0 (11.2)	0.015
Skills-based classes or workshops (e.g., computer skills)	602.9 (38.5)	321.6 (46.6)	171.4 (34.5)	77.8 (28.8)	32.0 (29.9)	0.001
Nature-based activities (e.g., bird watching, walking, hiking)	613.9 (39.2)	327.7 (47.4)	183.9 (37.0)	76.4 (28.3)	25.9 (24.2)	<0.001

Note: Number of weighted participants (percentage chose answer)

Differences by Gender

In differences by gender, women and non-binary persons were more likely than men to participate in any types of activities.

	Overall	Man	Non-binary	Woman	p
Workshops	588.3 (37.6)	205.1 (30.4)	3.7 (22.4)	359.5 (45.6)	<0.001
Regular classes lasting multiple weeks	480.8 (30.7)	155.7 (23.1)	8.2 (50.2)	301.5 (38.2)	0.001
One off workshops	501.9 (32.1)	171.0 (25.3)	7.5 (45.7)	303.5 (38.5)	0.007
Arts-based activities (e.g., pottery, painting)	576.4 (36.8)	148.0 (21.9)	8.5 (51.9)	394.8 (50.0)	<0.001
Performance-based activities (e.g., choirs, dance)	338.1 (21.6)	103.2 (15.3)	6.9 (42.5)	213.5 (27.1)	0.004
Nature-based activities (e.g., bird watching, walking, hiking)	613.9 (39.2)	222.4 (33.0)	9.1 (55.4)	351.5 (44.6)	0.024

Note: Number of weighted participants (percentage chose answer)

Differences by Income

In differences by income, webinars and one off workshops were more likely to be attended by wealthier groups with income $100,000+ than groups with lower income such as <$30,000. 32.4% for webinars vs 22% and 44.3% for one off workshops vs 26.9%.

	Overall	<$30,000	$30,000 - $59,999	$60,000 - $99,999	$100,000+	p
Webinars	407.6 (26.0)	107.5 (22.0)	107.1 (24.4)	82.9 (36.0)	45.0 (32.4)	0.036
One off workshops	501.9 (32.1)	131.2 (26.9)	138.3 (31.5)	96.4 (41.9)	61.4 (44.3)	0.009

Note: Number of weighted participants (percentage chose answer)

Differences by Urban/Rural

The differences by urban/rural show that survey participants from large urban centres were more likely to participate in different social prescribing activities than participants from rural areas or small cities or towns.

	Overall	Large urban centre	Medium city/town	Small city/town	Rural area	p
Webinars	407.6 (26.0)	192.5 (31.0)	93.9 (29.7)	75.9 (21.9)	35.5 (16.7)	0.024
Workshops	588.3 (37.6)	284.3 (45.8)	126.9 (40.2)	96.0 (27.7)	61.6 (28.9)	<0.001
Regular classes lasting multiple weeks	480.8 (30.7)	246.5 (39.8)	100.6 (31.9)	74.3 (21.5)	45.1 (21.2)	<0.001
One off workshops	501.9 (32.1)	253.6 (40.9)	85.5 (27.1)	69.8 (20.2)	76.3 (35.8)	<0.001
Performance-based activities (e.g., choirs, dance)	338.1 (21.6)	168.0 (27.1)	63.5 (20.1)	48.5 (14.0)	46.8 (22.0)	0.013
Political activities (e.g., activism)	264.7 (16.9)	143.4 (23.1)	34.6 (11.0)	51.8 (15.0)	27.3 (12.8)	0.004

Note: Number of weighted participants (percentage chose answer). Large urban centre (100,000+ people), Medium city/town (30,000-99,999 people), Rural area (Less than 1000 people), and Small city/town (1,000-29,999 people).

Differences by Living Arrangement

The results show that participants living alone were less likely to participate in webinars (19.5%) than participants not living alone (28%).

	Overall	Alone	Not alone	p
Webinars	407.6 (26.0)	45.9 (19.5)	351.4 (28.0)	0.029

Note: Number of weighted participants (percentage chose answer)

Differences by Sexual Orientation

Participants who identified as 2SLGBTQ+ were more likely to indicate interest in performance-based activities than the overall population.

	Overall	Straight	2SLGBTQ+	p
Performance-based activities (e.g., choirs, dance)	338.1 (21.6)	251.2 (19.8)	61.4 (36.7)	0.002

Note: Number of weighted participants (percentage chose answer)

Differences by Ethnicity

Participants who were Indigenous or visible minorities were more likely to be interested in regular classes lasting multiple weeks, or arts-based activities than the general population.

	Overall	Indigenous	Visible Minority	White	p
Regular classes lasting multiple weeks	480.8 (30.7)	24.4 (41.3)	169.8 (38.0)	272.3 (27.8)	0.039
Arts-based activities (e.g., pottery, painting)	576.4 (36.8)	33.3 (56.4)	203.7 (45.6)	312.7 (31.9)	0.001

Note: Number of weighted participants (percentage chose answer)

Differences by Disability

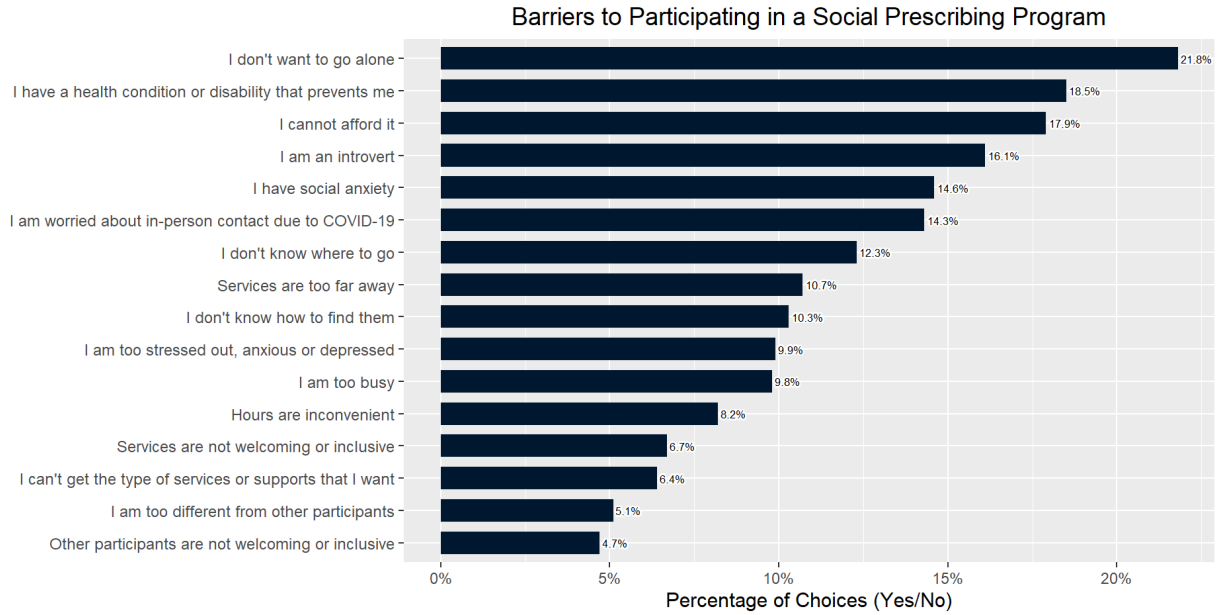
Participants with no disabilities were more likely to be interested in performance-based activities.

	Overall	Disability	No disability	p
Performance-based activities (e.g., choirs, dance)	338.1 (21.6)	227.1 (19.4)	102.3 (29.5)	0.008

Note: Number of weighted participants (percentage chose answer)

Barriers to Participating in Social Prescribing

Participants were asked to identify any and all barriers that may limit their ability to participate in a social prescribing program. Participants were allowed to answer multiple options. The most commonly selected choice was not wanting to go alone (21.8%), followed by having a health condition or disability that prevents them (18.5%), cannot afford it (17.9%), and the identify as an introvert (16.1%).



Differences by Age

For the majority of participants having a health condition or disability is the biggest barrier overall (18.5%). Social anxiety is also quite a significant barrier overall (14.6%).

	Overall	55-64	65-74	75-84	85-99	p
Services are too far away	111.0 (10.7)	65.6 (14.3)	32.1 (10.4)	10.6 (5.5)	2.8 (3.5)	0.037
Hours are inconvenient	84.7 (8.2)	63.6 (13.9)	15.0 (4.9)	3.5 (1.8)	2.6 (3.3)	0.001
I am too busy	101.9 (9.8)	70.3 (15.4)	20.7 (6.7)	8.3 (4.3)	2.6 (3.3)	0.001
I have social anxiety	151.5 (14.6)	75.6 (16.5)	62.0 (20.2)	8.7 (4.6)	5.2 (6.4)	0.001
I have a health condition or disability that prevents me	192.0 (18.5)	67.8 (14.8)	58.2 (19.0)	30.4 (15.9)	35.6 (43.9)	<0.001

Note: Number of weighted participants (percentage chose answer)

Differences by Gender

In differences by gender, the barriers such as not wanting to go alone or not being able to afford it were more likely to be experienced by women and non-binary persons. The highest chosen barrier overall was not wanting to go alone (21.8%).

	Overall	Man	Non-binary	Woman	p
Services are too far away	111.0 (10.7)	18.6 (4.9)	0.0 (0.0)	70.1 (16.0)	0.018
I am worried about in-person contact due to COVID-19	148.1 (14.3)	38.2 (10.2)	10.2 (68.5)	80.5 (18.4)	0.001
I am an introvert	166.6 (16.1)	41.6 (11.1)	9.1 (61.0)	83.1 (19.0)	0.011
I cannot afford it	186.0 (17.9)	58.3 (15.5)	10.0 (67.2)	95.0 (21.6)	0.02
I don't want to go alone	226.5 (21.8)	44.5 (11.9)	10.2 (68.5)	128.6 (29.3)	<0.001

Note: Number of weighted participants (percentage chose answer)

Differences by Income

In differences by income, the lower income groups were more likely to experience barriers such as not being able to afford it or having a health condition or disability. For a $100,000+ group, these participants were more likely to choose being too different from other participants (21.3%).

	Overall	<$30,000	$30,000 - $59,999	$60,000 - $99,999	$100,000+	p
I am too busy	101.9 (9.8)	8.6 (3.1)	17.6 (7.2)	15.6 (11.0)	13.0 (15.9)	0.024
Other participants are not welcoming or inclusive	48.7 (4.7)	13.2 (4.7)	8.6 (3.5)	7.2 (5.1)	14.9 (18.2)	0.019
I cannot afford it	186.0 (17.9)	81.4 (29.2)	54.8 (22.4)	14.8 (10.5)	1.2 (1.5)	<0.001
I am too different from other participants	53.0 (5.1)	12.3 (4.4)	11.0 (4.5)	0.4 (0.3)	17.4 (21.3)	<0.001
I have a health condition or disability that prevents me	192.0 (18.5)	76.4 (27.4)	46.1 (18.9)	16.7 (11.9)	9.0 (11.0)	0.021

Note: Number of weighted participants (percentage chose answer)

Differences by Urban/Rural

Participants in small towns were more likely to indicate having a health condition or disability was a barrier that prevented them from participating in social prescribing.

	Overall	Large urban centre	Medium city/town	Small city/town	Rural area	p
I have a health condition or disability that prevents me	192.0 (18.5)	43.0 (12.8)	32.0 (17.4)	69.9 (33.4)	24.3 (21.6)	0.001

Note: Number of weighted participants (percentage chose answer). Large urban centre (100,000+ people), Medium city/town (30,000-99,999 people), Rural area (Less than 1000 people), and Small city/town (1,000-29,999 people).

Differences by Living Arrangement

People living alone experience affordability as a barrier more than people living not alone (28.6% vs 17.8%).

	Overall	Alone	Not alone	p
Hours are inconvenient	84.7 (8.2)	3.9 (3.0)	58.4 (8.2)	0.008
I am too busy	101.9 (9.8)	5.9 (4.6)	67.4 (9.5)	0.03
I cannot afford it	186.0 (17.9)	36.8 (28.6)	126.5 (17.8)	0.035

Note: Number of weighted participants (percentage chose answer)

Differences by Sexual Orientation

In general in differences by sexual orientation, 2SLGBTQ+ are more likely to experience barriers than Straight survey participants.

	Overall	Straight	2SLGBTQ+	p
I don't know where to go	127.1 (12.3)	67.5 (10.2)	29.2 (26.5)	0.01
I don't know how to find them	106.8 (10.3)	49.7 (7.5)	22.9 (20.7)	0.014
I have social anxiety	151.5 (14.6)	90.8 (13.7)	32.8 (29.7)	0.014
Services are not welcoming or inclusive	69.8 (6.7)	42.4 (6.4)	20.1 (18.2)	0.019
Other participants are not welcoming or inclusive	48.7 (4.7)	31.2 (4.7)	15.0 (13.6)	0.035
I am too stressed out, anxious or depressed	103.1 (9.9)	53.4 (8.0)	23.8 (21.6)	0.009
I cannot afford it	186.0 (17.9)	104.6 (15.8)	37.0 (33.6)	0.012
I don't want to go alone	226.5 (21.8)	136.6 (20.6)	40.6 (36.8)	0.032

Note: Number of weighted participants (percentage chose answer)

Differences by Ethnicity

Visible minority participants were more likely to identify inconvenient hours as a barrier to participating in social prescribing.

	Overall	Indigenous	Visible Minority	White	p
Hours are inconvenient	84.7 (8.2)	0.2 (0.4)	30.1 (12.7)	32.0 (5.9)	0.033

Note: Number of weighted participants (percentage chose answer)

Differences by Disability

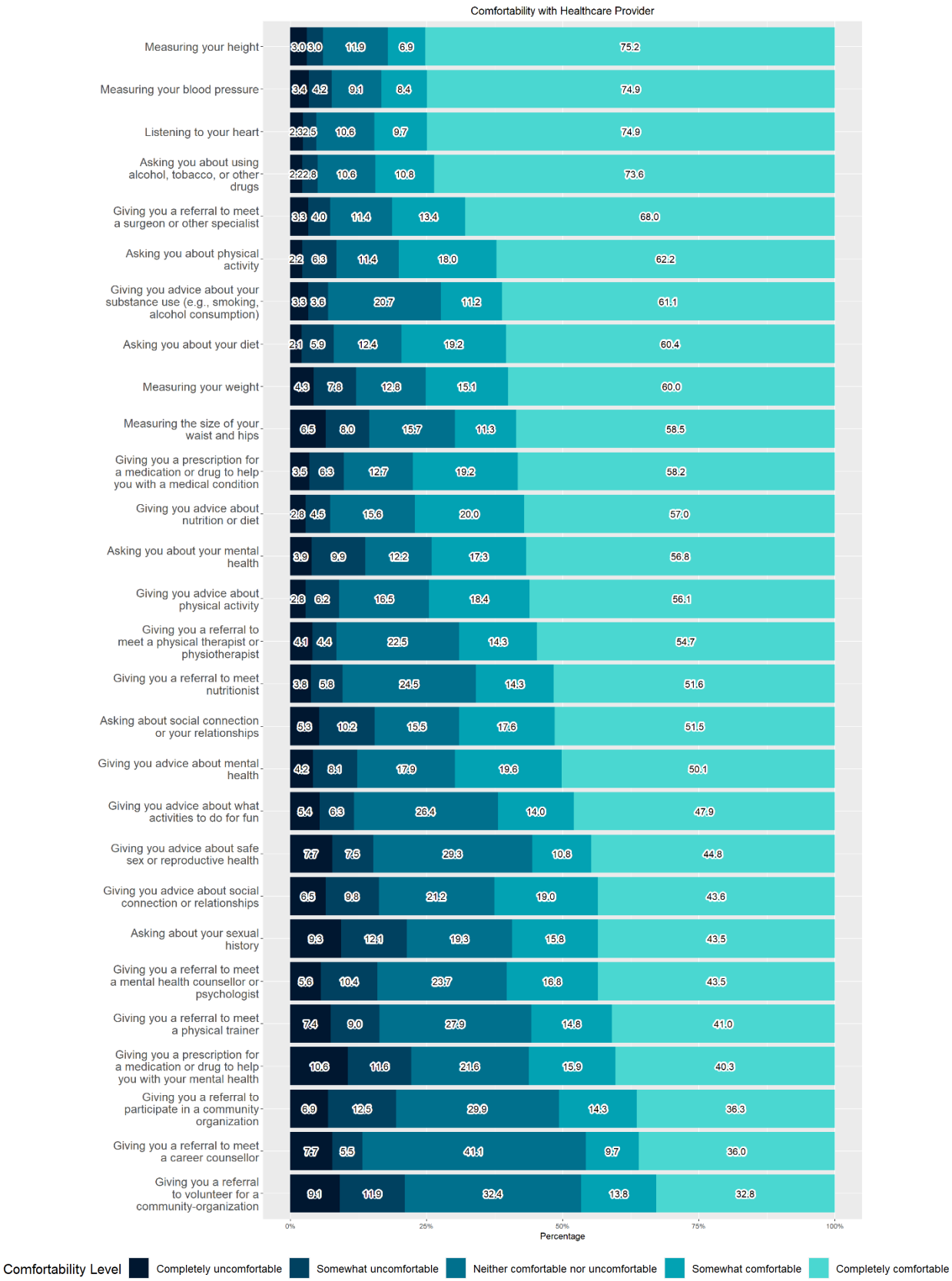
People with disabilities were more likely to experience social anxiety as a barrier than people without disability (18.6% vs 5.5%).

	Overall	Disability	No disability	p
I have social anxiety	151.5 (14.6)	123.1 (18.6)	11.0 (5.5)	0.001
I have a health condition or disability that prevents me	192.0 (18.5)	158.4 (24.0)	12.4 (6.2)	<0.001

Note: Number of weighted participants (percentage chose answer)

Comfort with Screening and Referrals

Participants were asked to rate their level comfort with their healthcare provider or someone working at their local health clinic doing various tasks. Comfortability was rated as completely uncomfortable, somewhat comfortable, neither comfortable nor uncomfortable, somewhat comfortable, and completely comfortable. On average, participants were completely comfortable with their healthcare provider performing most tasks, then comfortable, then neutral (neither comfortable nor uncomfortable), in decreasing percentages. For some tasks, participants were more neutral than comfortable, specifically for tasks that were outside of medical-related issues. For instance, although participants were still majority comfortable, there was a greater proportion of participants who were more neutral towards their healthcare provider giving them advice about social connections, activities to do for fun, referrals for community organizations, and referrals for a career counsellor, to name a few.


Comfortability with Healthcare Provider
Measuring your height
3.0 3.0 11.9 6.9 75.2
Measuring your blood pressure
3.4 4.2 9.1 8.4 74.9
Listening to your heart
2.3 2.5 10.6 9.7 74.9
Asking you about using alcohol, tobacco, or other drugs
2.2 2.8 10.6 10.8 73.6
Giving you a referral to meet a surgeon or other specialist
3.3 4.0 11.4 13.4 68.0
Asking you about physical activity
2.2 6.3 11.4 18.0 62.2
Giving you advice about your substance use (e.g., smoking, alcohol consumption)
3.3 3.6 20.7 11.2 61.1
Asking you about your diet
2.1 5.9 12.4 19.2 60.4
Measuring your weight
4.9 7.8 12.8 15.1 60.0
Measuring the size of your waist and hips
6.5 8.0 15.7 11.3 58.5
Giving you a prescription for a medication or drug to help you with a medical condition
3.5 6.3 12.7 19.2 58.2
Giving you advice about nutrition or diet
2.8 4.5 15.6 20.0 57.0
Asking you about your mental health
3.9 9.9 12.2 17.3 56.8
Giving you advice about physical activity
2.8 6.2 16.5 18.4 56.1
Giving you a referral to meet a physical therapist or physiotherapist
4.1 4.4 22.5 14.3 54.7
Giving you a referral to meet nutritionist
3.8 5.8 24.5 14.3 51.6
Asking about social connection or your relationships
5.3 10.2 15.5 17.6 51.5
Giving you advice about mental health
4.2 8.1 17.9 19.6 50.1
Giving you advice about what activities to do for fun
5.4 6.3 26.4 14.0 47.9
Giving you advice about safe sex or reproductive health
7.7 7.5 29.3 10.8 44.8
Giving you advice about social connection or relationships
6.5 9.8 21.2 19.0 43.6
Asking about your sexual history
9.3 12.1 19.3 15.8 43.5
Giving you a referral to meet a mental health counsellor or psychologist
5.6 10.4 23.7 16.8 43.5
Giving you a referral to meet a physical trainer
7.4 9.0 27.9 14.8 41.0
Giving you a prescription for a medication or drug to help you with your mental health
10.6 11.6 21.6 15.9 40.3
Giving you a referral to participate in a community organization
6.9 12.5 29.9 14.3 36.3
Giving you a referral to meet a career counsellor
7.7 5.5 41.1 9.7 36.0
Giving you a referral to volunteer for a community-organization
9.1 11.9 32.4 13.8 32.8
0%
25%
50%
75%
100%
Percentage
Comfortability Level
Completely uncomfortable
Somewhat uncomfortable
Neither comfortable nor uncomfortable
Somewhat comfortable
Completely comfortable

Differences by Age

The older age cohorts of participants are a bit more comfortable on average with various screenings and referrals.

	Overall	55-64	65-74	75-84	85-99	p
Measuring your weight	3.19 (1.18)	3.14 (1.16)	3.12 (1.27)	3.44 (1.00)	3.24 (1.14)	0.005
Asking you about your diet	3.30 (1.03)	3.23 (1.01)	3.26 (1.09)	3.49 (0.94)	3.53 (0.93)	0.002
Asking you about your mental health	3.13 (1.19)	2.99 (1.25)	3.14 (1.19)	3.43 (0.93)	3.35 (1.12)	<0.001
Asking about social connection or your relationships	3.00 (1.25)	2.86 (1.31)	2.96 (1.24)	3.39 (0.99)	3.28 (1.15)	<0.001
Giving you advice about nutrition or diet	3.24 (1.05)	3.16 (1.09)	3.19 (1.05)	3.51 (0.92)	3.38 (0.97)	<0.001
Giving you advice about mental health	3.03 (1.18)	2.91 (1.25)	3.01 (1.15)	3.33 (1.01)	3.33 (0.99)	0.001
Giving you advice about social connection or relationships	2.83 (1.26)	2.75 (1.29)	2.79 (1.28)	3.08 (1.17)	3.12 (1.01)	0.027
Giving you advice about what activities to do for fun	2.93 (1.21)	2.77 (1.27)	2.97 (1.18)	3.21 (1.08)	3.17 (1.13)	0.003
Giving you a prescription for a medication or drug to help you with a medical condition	3.22 (1.11)	3.02 (1.21)	3.35 (1.00)	3.37 (1.04)	3.49 (0.90)	0.001

Note: Average comfort with screenings and referrals on a scale from 0 to 5. Where 0 is completely uncomfortable and 5 is completely comfortable.

Differences by Gender

Men in general are more comfortable with various screenings and referrals than women and non-binary participants.

	Overall	Man	Non-binary	Woman	p
Measuring your weight	3.19 (1.18)	3.42 (1.04)	2.18 (1.44)	2.96 (1.26)	<0.001
Measuring the size of your waist and hips	3.07 (1.28)	3.39 (1.06)	2.00 (1.52)	2.75 (1.39)	<0.001
Measuring your blood pressure	3.47 (1.05)	3.56 (0.98)	3.27 (0.98)	3.38 (1.11)	0.026
Asking you about your diet	3.29 (1.04)	3.42 (0.95)	2.18 (1.15)	3.15 (1.11)	<0.001
Asking you about physical activity	3.30 (1.05)	3.43 (0.94)	2.56 (1.51)	3.17 (1.13)	0.004
Asking you about your mental health	3.12 (1.20)	3.22 (1.17)	2.81 (1.39)	3.02 (1.22)	0.035
Giving you advice about social connection or relationships	2.82 (1.27)	2.84 (1.29)	1.22 (1.08)	2.83 (1.23)	<0.001
Giving you a prescription for a medication or drug to help you with your mental health	2.65 (1.37)	2.74 (1.37)	1.16 (1.02)	2.57 (1.36)	<0.001
Giving you a prescription for a medication or drug to help you with a medical condition	3.23 (1.11)	3.35 (1.02)	2.40 (1.00)	3.11 (1.18)	<0.001
Giving you a referral to participate in a community organization	2.59 (1.28)	2.59 (1.30)	1.11 (1.03)	2.62 (1.25)	<0.001
Giving you a referral to volunteer for a community-organization	2.48 (1.30)	2.46 (1.34)	1.58 (0.79)	2.52 (1.27)	0.005

Note: Average comfort with screenings and referrals on a scale from 0 to 5. Where 0 is completely uncomfortable and 5 is completely comfortable.

Differences by Income

For the majority of categories, the participants in the lowest income category are the least comfortable with screenings and referrals than other income groups.

	Overall	<$30,000	$30,000 - $59,999	$60,000 - $99,999	$100,000+	p
Measuring your height	3.51 (0.97)	3.39 (1.04)	3.51 (0.97)	3.56 (0.98)	3.77 (0.66)	0.003
Asking you about using alcohol, tobacco, or other drugs	3.52 (0.91)	3.43 (0.96)	3.50 (0.93)	3.58 (0.94)	3.77 (0.58)	0.007
Asking you about physical activity	3.32 (1.04)	3.21 (1.14)	3.29 (1.01)	3.39 (0.97)	3.63 (0.81)	0.003
Asking you about your mental health	3.13 (1.19)	2.99 (1.24)	3.10 (1.21)	3.23 (1.17)	3.47 (0.92)	0.01
Giving you advice about your substance use (e.g., smoking, alcohol consumption)	3.24 (1.08)	3.10 (1.20)	3.26 (1.05)	3.25 (1.04)	3.61 (0.76)	<0.001
Giving you advice about nutrition or diet	3.25 (1.03)	3.12 (1.10)	3.21 (1.05)	3.37 (0.98)	3.50 (0.71)	0.05
Giving you advice about mental health	3.04 (1.16)	2.92 (1.19)	2.99 (1.21)	3.14 (1.12)	3.35 (0.92)	0.051
Giving you advice about physical activity	3.19 (1.07)	3.15 (1.07)	3.09 (1.14)	3.22 (1.05)	3.55 (0.82)	0.005
Giving you advice about safe sex or reproductive health	2.78 (1.28)	2.63 (1.31)	2.86 (1.21)	2.75 (1.31)	3.10 (1.29)	0.031
Giving you a referral to meet a surgeon or other specialist	3.43 (1.00)	3.27 (1.09)	3.41 (1.02)	3.59 (0.88)	3.66 (0.79)	0.002

Giving you a referral to meet nutritionist	3.05 (1.14)	2.86 (1.20)	3.07 (1.15)	3.21 (1.08)	3.27 (1.00)	0.018
Giving you a referral to meet a physical trainer	2.76 (1.26)	2.55 (1.33)	2.77 (1.24)	2.88 (1.19)	3.08 (1.13)	0.016
Giving you a referral to meet a physical therapist or physiotherapist	3.15 (1.12)	2.90 (1.17)	3.14 (1.11)	3.34 (1.03)	3.53 (0.96)	<0.001

Note: Average comfort with screenings and referrals on a scale from 0 to 5. Where 0 is completely uncomfortable and 5 is completely comfortable.

Differences by Urban/Rural

The lowest level of comfort with screenings and referrals is in medium cities/towns for measuring the size of waist and hips and asking about one's diet.

	Overall	Large urban centre	Medium city/town	Small city/town	Rural area	p
Measuring the size of your waist and hips	3.07 (1.28)	3.07 (1.21)	2.80 (1.45)	3.19 (1.27)	3.20 (1.24)	0.034
Asking you about your diet	3.29 (1.04)	3.23 (1.00)	3.15 (1.16)	3.35 (1.05)	3.45 (0.97)	0.008

Note: Average comfort with screenings and referrals on a scale from 0 to 5. Where 0 is completely uncomfortable and 5 is completely comfortable.

Differences by Sexual Orientation

The difference between Straight and 2SLGBTQ+ participants seems to show that 2SLGBTQ+ participants are more comfortable with physical screenings, but they are less comfortable with mental health screenings and social connection referrals.

	Overall	Straight	2SLGBTQ+	p
Measuring your weight	3.19 (1.18)	3.17 (1.18)	3.54 (0.96)	<0.001
Measuring your height	3.50 (1.00)	3.51 (0.98)	3.66 (0.84)	0.035
Measuring the size of your waist and hips	3.08 (1.27)	3.11 (1.24)	3.21 (1.28)	0.02
Measuring your blood pressure	3.49 (1.03)	3.49 (1.02)	3.66 (0.83)	0.043
Asking about your sexual history	2.72 (1.37)	2.79 (1.34)	2.52 (1.47)	0.039
Giving you advice about your substance use (e.g., smoking, alcohol consumption)	3.24 (1.09)	3.31 (1.04)	3.08 (1.10)	0.018
Giving you advice about mental health	3.04 (1.18)	3.11 (1.12)	2.82 (1.37)	0.011
Giving you advice about social connection or relationships	2.84 (1.26)	2.92 (1.20)	2.54 (1.42)	0.015
Giving you advice about safe sex or reproductive health	2.78 (1.30)	2.83 (1.27)	2.66 (1.41)	0.049
Giving you a prescription for a medication or drug to help you with a medical condition	3.24 (1.09)	3.27 (1.07)	3.26 (1.16)	0.051

Note: Average comfort with screenings and referrals on a scale from 0 to 5. Where 0 is completely uncomfortable and 5 is completely comfortable.

Differences by Disability

For almost all of the categories, participants without disabilities are on average more comfortable with screenings and referrals.

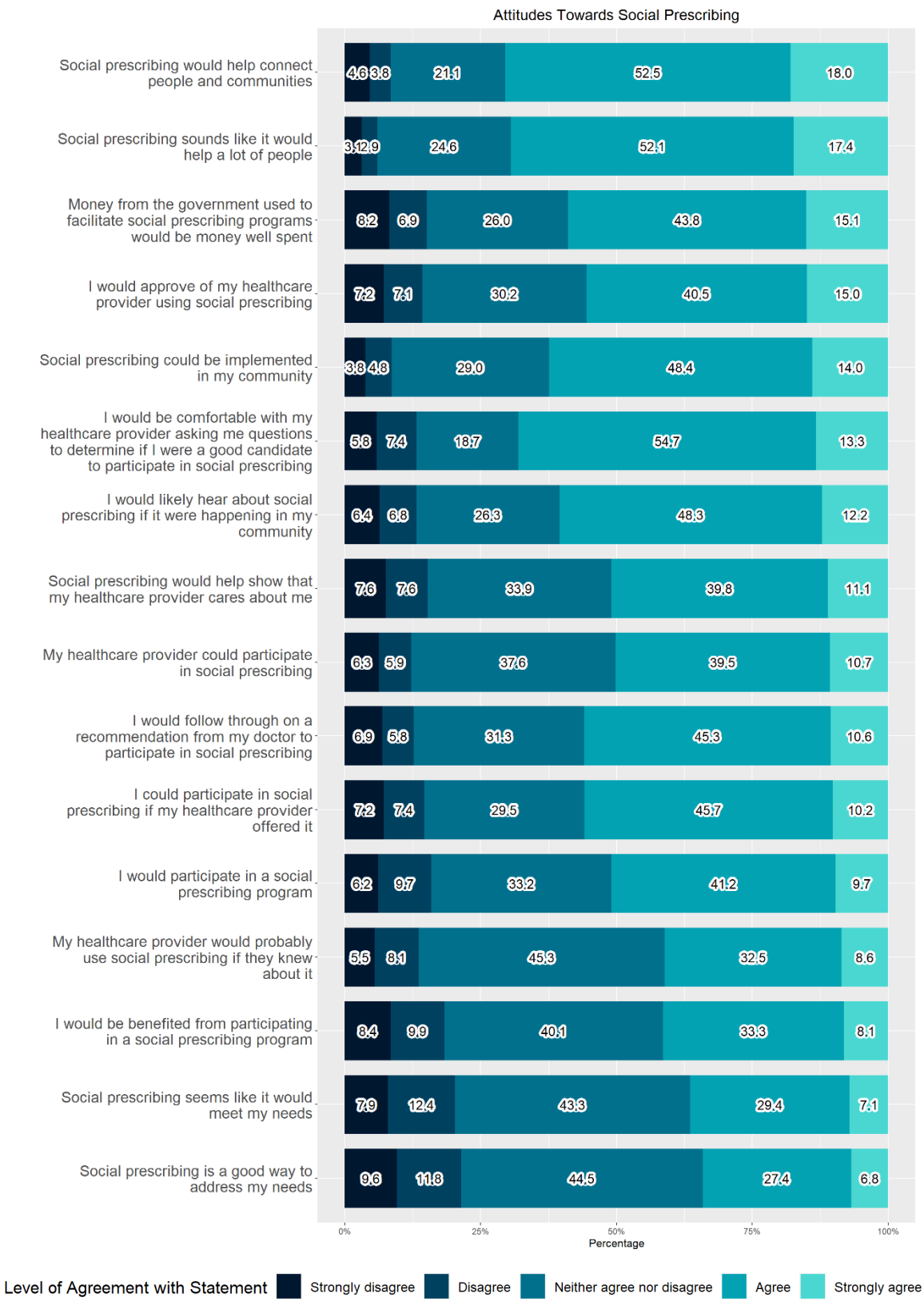
	Overall	Disability	No disability	p
Measuring your weight	3.19 (1.18)	3.14 (1.21)	3.36 (1.08)	0.011
Measuring the size of your waist and hips	3.08 (1.28)	3.02 (1.30)	3.29 (1.17)	0.011
Listening to your heart	3.53 (0.94)	3.50 (0.96)	3.64 (0.85)	0.027
Asking you about using alcohol, tobacco, or other drugs	3.51 (0.94)	3.46 (0.99)	3.69 (0.72)	0.005
Asking you about your diet	3.29 (1.03)	3.22 (1.07)	3.59 (0.82)	<0.001
Asking you about physical activity	3.31 (1.04)	3.23 (1.09)	3.64 (0.76)	<0.001
Asking you about your mental health	3.12 (1.20)	3.03 (1.25)	3.48 (0.89)	<0.001
Asking about social connection or your relationships	3.00 (1.25)	2.91 (1.28)	3.33 (1.02)	<0.001
Asking about your sexual history	2.71 (1.37)	2.65 (1.39)	2.95 (1.26)	0.015
Giving you advice about nutrition or diet	3.23 (1.05)	3.18 (1.09)	3.44 (0.87)	0.007
Giving you advice about mental health	3.03 (1.18)	2.96 (1.21)	3.27 (1.04)	0.004
Giving you advice about physical activity	3.19 (1.09)	3.11 (1.13)	3.47 (0.85)	<0.001
Giving you advice about social connection or relationships	2.83 (1.26)	2.77 (1.30)	3.06 (1.09)	0.025
Giving you advice about what activities to do for fun	2.92 (1.21)	2.87 (1.24)	3.13 (1.08)	0.02

Giving you advice about safe sex or reproductive health	2.77 (1.30)	2.71 (1.33)	2.98 (1.14)	0.031
Giving you a referral to meet nutritionist	3.04 (1.16)	2.99 (1.19)	3.22 (1.01)	0.044
Giving you a referral to meet a physical trainer	2.72 (1.28)	2.64 (1.32)	3.02 (1.06)	0.001
Giving you a referral to participate in a community organization	2.60 (1.28)	2.54 (1.30)	2.82 (1.16)	0.022

Note: Average comfort with screenings and referrals on a scale from 0 to 5. Where 0 is completely uncomfortable and 5 is completely comfortable.

Attitudes Towards Social Prescribing

Participants were given different statements regarding possible attitudes towards social prescribing interventions, and asked to indicate to what extent they agree or disagree with each statement. Level of agreement ratings ranged from strongly disagree, disagree, neither agree or disagree, agree, or strongly agree. Generally, most statements were either agreed to, or neutral towards (neither agree nor disagree), with agreed statements being slightly greater in percentage. Interestingly, the most neutral responses (neither agree nor disagree in turquoise) were for statements that suggested social prescribing would benefit the participant themselves; examples include, “Social prescribing seems like it would meet my needs”, “social prescribing is a good way to address my needs”, and “I would be benefited from participating in a social prescribing program”. Another statement that had more neutral rather than agreed responses, was “My healthcare provider would probably use social prescribing if they knew about it”. In contrast, participants were more likely to strongly agree or agree with statements that suggested social prescribing would help other people; examples include “Social prescribing would help connect people and communities”, and “Social prescribing sounds like it would help a lot of people”.


Attitudes Towards Social Prescribing
Social prescribing would help connect people and communities
4.6
3.8
21.1
52.5
18.0
Social prescribing sounds like it would help a lot of people
3.1
2.9
24.6
52.1
17.4
Money from the government used to facilitate social prescribing programs would be money well spent
8.2
6.9
26.0
43.8
15.1
I would approve of my healthcare provider using social prescribing
7.2
7.1
30.2
40.5
15.0
Social prescribing could be implemented in my community
3.8
4.8
29.0
48.4
14.0
I would be comfortable with my healthcare provider asking me questions to determine if I were a good candidate to participate in social prescribing
5.8
7.4
18.7
54.7
13.3
I would likely hear about social prescribing if it were happening in my community
6.4
6.8
26.3
48.3
12.2
Social prescribing would help show that my healthcare provider cares about me
7.6
7.6
33.9
39.8
11.1
My healthcare provider could participate in social prescribing
6.3
5.9
37.6
39.5
10.7
I would follow through on a recommendation from my doctor to participate in social prescribing
6.9
5.8
31.3
45.3
10.6
I could participate in social prescribing if my healthcare provider offered it
7.2
7.4
29.5
45.7
10.2
I would participate in a social prescribing program
6.2
9.7
33.2
41.2
9.7
My healthcare provider would probably use social prescribing if they knew about it
5.5
8.1
45.3
32.5
8.6
I would be benefited from participating in a social prescribing program
8.4
9.9
40.1
33.3
8.1
Social prescribing seems like it would meet my needs
7.9
12.4
43.3
29.4
7.1
Social prescribing is a good way to address my needs
9.6
11.8
44.5
27.4
6.8
0%
25%
50%
75%
100%
Percentage
Level of Agreement with Statement
Strongly disagree
Disagree
Neither agree nor disagree
Agree
Strongly agree

Differences by Gender

Non-binary participants have on average more positive attitude towards social prescribing than men and women, and women have more positive attitudes than men.

	Overall	Man	Non-binary	Woman	p
I would approve of my healthcare provider using social prescribing.	2.50 (1.06)	2.41 (1.07)	3.18 (0.85)	2.57 (1.04)	0.012
I would participate in a social prescribing program.	2.41 (0.99)	2.29 (1.00)	3.25 (0.80)	2.49 (0.96)	0.001
Social prescribing seems like it would meet my needs.	2.17 (0.99)	2.04 (1.01)	2.85 (1.09)	2.26 (0.96)	0.016
Social prescribing sounds like it would help a lot of people.	2.79 (0.87)	2.66 (0.91)	3.16 (0.96)	2.89 (0.81)	0.01
Social prescribing could be implemented in my community.	2.65 (0.91)	2.49 (0.96)	3.13 (1.01)	2.77 (0.83)	0.003
My healthcare provider could participate in social prescribing.	2.45 (0.96)	2.32 (1.02)	2.95 (0.62)	2.54 (0.90)	0.008
I could participate in social prescribing if my healthcare provider offered it.	2.46 (1.01)	2.32 (1.10)	3.31 (0.75)	2.56 (0.92)	0.003
I would be comfortable with my healthcare provider asking me questions to determine if I were a good candidate to participate in social prescribing.	2.64 (0.99)	2.56 (1.03)	3.22 (0.66)	2.70 (0.95)	0.019
I would follow through on a recommendation	2.49 (0.98)	2.39 (1.04)	3.32 (0.73)	2.56 (0.93)	0.003

from my doctor to participate in social prescribing.					
Money from the government used to facilitate social prescribing programs would be money well spent.	2.53 (1.08)	2.34 (1.14)	2.96 (1.25)	2.68 (0.99)	0.002
Social prescribing would help connect people and communities.	2.77 (0.95)	2.53 (1.07)	3.23 (0.97)	2.95 (0.78)	<0.001
I would likely hear about social prescribing if it were happening in my community.	2.54 (1.00)	2.40 (1.06)	2.74 (0.79)	2.65 (0.94)	0.011

Note: Average attitudes towards social prescribing on a scale from 0 to 5. Where 0 is strongly disagree and 5 is strongly agree.

Differences by Income

Participants from the lowest income group have on average the most positive attitude towards various social prescribing statements.

	Overall	<$30,000	$30,000 - $59,999	$60,000 - $99,999	$100,000+	p
Social prescribing seems like it would meet my needs.	2.20 (1.00)	2.38 (1.00)	2.13 (0.93)	2.19 (0.94)	1.78 (1.11)	<0.001
My healthcare provider could participate in social prescribing.	2.44 (0.98)	2.57 (0.95)	2.42 (0.82)	2.40 (1.02)	2.14 (1.11)	0.051
I could participate in social prescribing if my healthcare provider offered it.	2.48 (1.02)	2.62 (0.99)	2.41 (0.92)	2.47 (0.99)	2.13 (1.19)	0.032
I would follow through on a recommendation from my doctor to participate in social prescribing.	2.49 (1.01)	2.69 (0.93)	2.40 (0.93)	2.44 (1.03)	2.17 (1.18)	0.01
Social prescribing is a good way to address my needs.	2.13 (1.02)	2.33 (1.07)	2.02 (0.89)	2.10 (0.99)	1.84 (1.07)	0.006
I would be benefited from participating in a social prescribing program.	2.25 (1.04)	2.45 (1.05)	2.19 (0.91)	2.21 (1.03)	1.83 (1.09)	0.001
My healthcare provider would probably use social prescribing if they knew about it.	2.34 (0.94)	2.50 (0.90)	2.27 (0.84)	2.31 (1.00)	2.04 (0.94)	0.005
Money from the government used to facilitate social prescribing programs would be money well spent.	2.55 (1.08)	2.72 (0.98)	2.47 (1.06)	2.51 (1.10)	2.24 (1.28)	0.053

Note: Average attitudes towards social prescribing on a scale from 0 to 5. Where 0 is strongly disagree and 5 is strongly agree.

Differences by Urban/Rural

In general, in bigger cities and towns have more positive attitude towards social prescribing on average than participants from smaller areas.

	Overall	Large urban centre	Medium city/town	Small city/town	Rural area	p
I would approve of my healthcare provider using social prescribing.	2.50 (1.06)	2.50 (1.12)	2.70 (0.94)	2.48 (0.94)	2.32 (1.07)	0.038
I would participate in a social prescribing program.	2.40 (1.00)	2.43 (1.00)	2.62 (0.88)	2.28 (1.00)	2.20 (1.05)	0.006
Social prescribing seems like it would meet my needs.	2.16 (1.00)	2.24 (1.02)	2.25 (0.97)	2.00 (0.87)	2.03 (1.03)	0.036
Social prescribing sounds like it would help a lot of people.	2.78 (0.87)	2.84 (0.87)	2.93 (0.80)	2.61 (0.86)	2.64 (0.92)	0.006
Social prescribing could be implemented in my community.	2.64 (0.91)	2.71 (0.90)	2.80 (0.85)	2.41 (0.99)	2.52 (0.90)	0.01
My healthcare provider could participate in social prescribing.	2.43 (0.97)	2.50 (0.96)	2.56 (0.98)	2.13 (0.97)	2.37 (0.93)	0.005
I could participate in social prescribing if my healthcare provider offered it.	2.45 (1.01)	2.53 (1.00)	2.61 (0.95)	2.25 (1.03)	2.29 (1.06)	0.012
I would follow through on a recommendation from my doctor to participate in social prescribing.	2.48 (0.99)	2.52 (0.97)	2.67 (0.89)	2.31 (0.94)	2.31 (1.11)	0.023
Social prescribing is a good way to address my needs.	2.10 (1.02)	2.18 (1.00)	2.26 (1.04)	1.90 (0.94)	1.94 (1.03)	0.007

I would be benefited from participating in a social prescribing program.	2.24 (1.02)	2.29 (1.03)	2.45 (1.00)	1.98 (0.91)	2.11 (1.03)	<0.001
Social prescribing would help show that my healthcare provider cares about me.	2.40 (1.03)	2.47 (1.04)	2.55 (0.98)	2.15 (0.95)	2.26 (1.07)	0.005
Money from the government used to facilitate social prescribing programs would be money well spent.	2.52 (1.08)	2.59 (1.06)	2.79 (0.92)	2.25 (1.07)	2.29 (1.19)	<0.001
Social prescribing would help connect people and communities.	2.76 (0.95)	2.83 (0.98)	2.89 (0.84)	2.61 (0.95)	2.59 (0.97)	0.011

Note: Large urban centre (100,000+ people), Medium city/town (30,000-99,999 people), Rural area (Less than 1000 people), and Small city/town (1,000-29,999 people). Average attitudes towards social prescribing on a scale from 0 to 5. Where 0 is strongly disagree and 5 is strongly agree.

Differences by Ethnicity

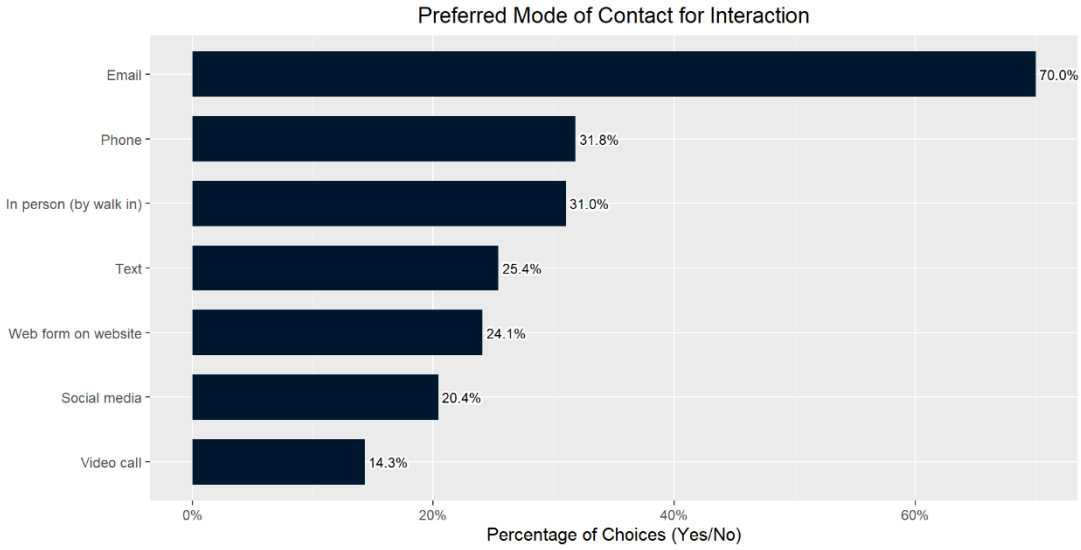
Indigenous participants have the lowest average attitude towards social prescribing than visible minorities or white participants.

	Overall	Indigenous	Visible Minority	White	p
Social prescribing seems like it would meet my needs.	2.16 (1.00)	1.77 (1.04)	2.36 (0.99)	2.10 (0.99)	0.006
I could participate in social prescribing if my healthcare provider offered it.	2.45 (1.01)	2.03 (1.01)	2.49 (1.05)	2.46 (0.99)	0.029

Note: Average attitudes towards social prescribing on a scale from 0 to 5. Where 0 is strongly disagree and 5 is strongly agree.

Preferences for Mode of Social Prescribing Contact

Participants were asked “How would you like to interact with someone working to help connect you to community services as part of a social prescribing intervention?” They were allowed to select multiple choices. E-mail was the most preferred mode of contact (70.0%), with all other forms, such as in-person, by phone, and video call, ranging from 14.3% to 31.8%.



Differences by Age

Participants in the youngest age bracket (i.e. 55-64) were more likely to be interested in digital forms of contact, such as with texting, video call, social media, and web form on websites.

	Overall	55-64	65-74	75-84	85-99	p
Text	397.9 (25.4)	214.2 (31.0)	114.1 (23.0)	53.3 (19.7)	16.3 (15.2)	0.028
Video call	223.7 (14.3)	135.2 (19.6)	68.0 (13.7)	16.5 (6.1)	4.0 (3.7)	<0.001
Social media	319.1 (20.4)	166.4 (24.1)	91.5 (18.4)	53.0 (19.6)	8.2 (7.7)	0.044
Web form on website	377.0 (24.1)	191.9 (27.8)	119.8 (24.1)	55.4 (20.5)	9.9 (9.2)	0.041

Note: Number of weighted participants (percentage chose answer)

Differences by Gender

Non-binary persons (83.8%) and women (31.9%) were more likely to indicate that they prefer in person social prescribing than men.

	Overall	Man	Non-binary	Woman	p
In person (by walk in)	485.5 (31.0)	207.7 (30.8)	13.7 (83.8)	251.5 (31.9)	0.006

Note: Number of weighted participants (percentage chose answer)

Differences by Urban/Rural

Participants in rural areas generally less preferred email, video call, and web form on website compared to the overall population. In particular, video call was not as preferred amongst rural and small city/town participants.

	Overall	Large urban centre	Medium city/town	Small city/town	Rural area	p
Email	1095.2 (70.0)	466.5 (75.2)	245.9 (77.9)	220.8 (63.8)	136.2 (63.9)	0.006
Video call	223.7 (14.3)	114.9 (18.5)	56.7 (18.0)	31.1 (9.0)	17.8 (8.3)	0.012
Web form on website	377.0 (24.1)	180.5 (29.1)	92.8 (29.4)	65.0 (18.8)	33.2 (15.6)	0.011

Note: Number of weighted participants (percentage chose answer). Large urban centre (100,000+ people), Medium city/town (30,000-99,999 people), Rural area (Less than 1000 people), and Small city/town (1,000-29,999 people).

Differences by Living Arrangement

Participants living alone prefer phone and text slightly more than participants not living alone.

	Overall	Alone	Not alone	p
Phone	497.0 (31.8)	91.8 (39.0)	388.8 (31.0)	0.05
Text	397.9 (25.4)	81.4 (34.6)	305.4 (24.4)	0.012

Note: Number of weighted participants (percentage chose answer)

Conclusion

Our recent report strongly argues for the necessity of social prescribing in Canada, particularly for older adults. It becomes more compelling when we consider the evidence from the study that shows nearly a third of older adults have fair or poor mental health and almost half have fair or poor physical health. Furthermore, one in ten participants can't leave their home without assistance and three-quarters live with disability or chronic health conditions, creating a profound impact on their lives and overall well-being.

Significantly, experiences of loneliness and isolation among seniors are varied yet prevalent, and thus an approach like social prescribing that directly targets these issues can be highly beneficial. The data reveals a high prevalence of healthcare utilization among seniors, with most accessing care in the past year. At the same time, the demand for a wide array of health services is considerable, including primary care, dental care, financial supports, and mental health supports.

Despite the frequency of healthcare use, our report found that the healthcare system does not adequately meet all seniors' needs. While approximately 40% of seniors report no challenges accessing care, the majority report at least one barrier. These range from difficulty accessing appointments and long wait times, to negative experiences with doctors. Geographical barriers and cost, along with inconvenient hours of operation, were identified as significant hindrances. This finding underscores the importance of integrating health and community services, taking into account the unique needs of each patient, and employing a team-based approach.

We found a high interest in community participation among seniors, particularly in seniors' organizations and hobby groups. Many are already involved in such groups, indicating a readiness for social prescribing initiatives. However, barriers to participation such as fear of participating alone, cost barriers, disability, and social anxieties were identified. This emphasizes the importance of tailoring social prescribing interventions to the individual's needs to support shared decision making, empowerment, and autonomy.

Individuals with disabilities or social marginalization were found to experience more health needs and greater barriers to care, reinforcing the need for an equity-oriented approach to social prescribing. Interestingly, while patients generally reported a high level of support for social prescribing programs, they seemed to trust it more in meeting other people's needs. This suggests that there is work to be done in helping patients understand the value of social prescribing and how it can be part of their routine care.

In conclusion, our report makes a strong case for the necessity and potential benefits of social prescribing for older adults in Canada. However, it emphasizes the importance of designing these programs to be attentive to the individual needs of clients, taking an equity-oriented, holistic approach that empowers seniors and allows them to participate in their care actively.

Suggested Citation

Yu et al. (2023) “Social Prescribing Needs of Older Adults in Canada.” Canadian Alliance for Social Connection and Health.