

Résumé

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## **Les déterminants en matière d'utilisation des services de santé par les personnes à faible revenu**

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La pauvreté a une influence sur l'état de santé, l'espérance de vie, les comportements en matière de santé et l'utilisation des services de santé. Cette étude avait pour objectif d'examiner les facteurs influant sur l'utilisation des services de santé par les personnes vivant dans la pauvreté. Dans la première phase de l'étude, 199 utilisateurs de services de santé appartenant à la frange pauvre de la population de deux grandes villes canadiennes ont été interviewés par des pairs. Dans la deuxième phase, des entrevues de groupe avec des personnes vivant dans la pauvreté ( $n = 52$ ) ont été effectuées. Les données ont été étudiées à l'aide d'une analyse de contenu thématique. Ainsi, divers services de santé ont été utilisés afin de répondre à des besoins fondamentaux en matière de santé, d'établir des contacts humains et de composer avec les difficultés de la vie. L'utilisation des services dépendait de la proximité de ceux-ci, de la capacité financière des personnes, de la commodité, de l'information fournie ainsi que de l'attitude et des comportements des intervenants. Les obstacles à l'utilisation des services étaient attribuables à des inégalités en matière de revenu. Par conséquent, pour promouvoir la santé des personnes vivant dans la pauvreté, les infirmières, les infirmiers et les autres professionnels de la santé peuvent accroître l'accessibilité et la qualité des services, améliorer leurs interactions avec les personnes à faible revenu, leur fournir de l'information sur les services offerts, procurer des services coordonnés au sein des communautés, collaborer avec d'autres secteurs et préconiser activement la mise en place de services et de politiques plus équitables.

Mots clés : faible revenu, pauvreté, services de santé, déterminants de la santé, professionnels de la santé

# **Determinants of Health-Service Use by Low-Income People**

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Poverty influences health status, life expectancy, health behaviours, and use of health services. This study examined factors influencing the use of health-related services by people living in poverty. In the first phase, 199 impoverished users of health-related services in 2 large Canadian cities were interviewed by their peers. In the second phase, group interviews with people living in poverty ( $n = 52$ ) were conducted. Data were analyzed using thematic content analysis. Diverse health-related services were used to meet basic and health needs, to maintain human contact, and to cope with life's challenges. Use of services depended on proximity, affordability, convenience, information, and providers' attitudes and behaviours. Use was impeded by inequities based on income status. To promote the health of people living in poverty, nurses and other health professionals can enhance the accessibility and quality of services, improve their interactions with people living in poverty, provide information about available programs, offer coordinated community-based services, collaborate with other sectors, and advocate for more equitable services and policies.

**Keywords:** low income, poverty, health services, consumers, health determinants, health professionals

Canadians who live in poverty have poor health status, whether measured by self-rated health, low life expectancy, health problems, or activity limitations (Federal, Provincial, and Territorial Advisory Committee on Population Health [FPT], 1999; Phipps, 2003; Raphael, 2002; Wilkins, Berthelot, & Ng, 2002). Reducing health inequities resulting from inequalities in socio-economic status was identified as a major health challenge almost two decades ago (Epp, 1986). Poverty continues to be described as the greatest determinant of health, as it influences virtually all other determinants, including accessibility to health care (Canadian Institute of Health Information [CIHI], 2004; FPT; World Health Organization [WHO], 1999, 2003; WHO Europe, 2001). Despite Canada's healthy economic growth in the past decade, the rate of poverty has not declined proportionately and, for some groups, has worsened (National Council of Welfare, 2002). In 1999, 16%

of Canadians were living in poverty, as measured by Statistics Canada low-income cut-offs (LICO). The groups most likely to experience poverty are unattached individuals, lone-mother families, people with disabilities, recent immigrants, and Aboriginal peoples (Lee, 2000; National Council of Welfare, 2002).

Accessibility to health services is receiving increasing attention by health policy-makers, as witnessed by numerous health-care commissions and federal funding of innovative delivery methods (e.g., Federal Health Transition Fund, Primary Health Care Transition Fund) (Ogilvie & Reutter, 2002). Moreover, there is concern about the erosion of publicly funded services, which increases the burden on the economically disadvantaged (Raphael, 2002). A body of Canadian research has examined the effect of income on the use of health services. Most of this research, however, has focused on formal health care, and even more narrowly on medical care. Increased understanding of the broad determinants of health requires attention to use, by those living in poverty, of other services and supports that influence health, many of which lie beyond the formal medical-care and broader health-care sectors. Moreover, little is known about the factors that influence use of a broad range of health-related services and supports from the perspectives of people living in poverty. A deeper understanding of these factors will help nurses and other health professionals to identify the unique service and support needs and utilization patterns of this population, to target and tailor services, and to advocate for policies that will enhance accessibility.

Accordingly, the purpose of this study was to identify the types of health services used, the determinants of health-services use, and the implications for practices, programs, services, and policies from the perspectives of Canadians living in poverty. Health services were broadly defined to include both direct health services (e.g., dental and medical care, prescription medications) and health-related services (e.g., food banks, child care, housing) that people living in poverty use to maintain and improve their health and well-being.

### **Influence of Poverty on Health Status and Personal Health Practices**

The debilitating effects of poverty on health have been well documented in Canada. Regardless of how poverty and health are operationalized, the relationship between poverty and ill health has been consistent. Lower socio-economic status in Canada continues to be associated with lower life expectancy (Wilkins et al., 2002). Adults in impoverished households are more likely to describe their health as poor or fair (FTP, 1999) and to experience sleep difficulty, pain, functional limitations, disability days,

chronic health conditions such as asthma or stroke, and vision, mobility, and cognition challenges than adults in middle- and high-income categories (Canadian Council on Social Development, 2000; Statistics Canada, 1994). Surveys of Canadian children indicate that poor health (e.g., vision, hearing, speech, or mobility problems) and developmental delays are more prevalent among children in impoverished families (Ross, Roberts, & Scott, 2000).

Poverty influences health status through a variety of mechanisms, including material deprivation, excessive stress, uncertainty, and unhealthy behaviours (Raphael, 2002). Compared to people with higher incomes, those living in poverty have higher smoking rates (FTP, 1999; Health Canada, 2003), are less likely to be physically active (CIHI, 2004; FTP), and are less likely to meet nutritional requirements (Che & Chen, 2001; McIntyre, Connor, & Warren, 2000). These behaviours are influenced by limited incomes and may also be coping strategies to manage the stress and uncertainty that accompany poverty (Raphael).

### **Effect of Poverty on Use of Health Services in Canada**

Canadian studies consistently show that income influences health-care utilization. Low-income Canadians are more likely than other Canadians to use general practitioner, hospital, emergency, mental health, and publicly funded home-care services (FTP, 1999; Glazier, Badley, Gilbert, & Rothman, 2000; Kephart, Thomas, & MacLean, 1998; Lin, Goering, Offord, Campbell, & Boyle, 1996; Mustard, Finlayson, Derksen, & Berthelot, 1999; Roos & Mustard, 1997). This is not surprising given the greater health needs identified above. On the other hand, people living in poverty tend to under-use preventive services such as prenatal care, mammography and cervical cancer screening, and dental services (Bell & Edouard, 1992; Katz & Hofer, 1994; Millar & Beaudet, 1996; Millar & Locker, 1999; Mustard & Roos, 1994; O'Connor, 1993; Snider, Beauvais, Levy, Villeneuve, & Pennock, 1997). Canadians living in poverty are less likely to use health-related services that are not publicly funded such as vision-correction services, dental care (Millar & Locker), and alternative health-care practitioners (Millar, 2001). Research also suggests that people living in poverty may be disadvantaged in terms of specialist and in-hospital care (Dunlop, Coyte, & McIsaac, 2000; Kapral, Wang, Mamdani, & Tu, 2002).

In spite of a publicly funded health-care system in Canada, then, barriers to health-care utilization persist for people living in poverty. Financial barriers are particularly evident for impoverished working families without supplementary health-care benefits (Crowe & Hardill, 1993; FTP, 1999; Williamson & Fast, 1998). Indeed, national Canadian

data suggest that unmet health-care needs due to financial constraints are about 10 times greater for members of low-income households than for members of more affluent households (Chen & Hou, 2002).

Other reported barriers to health-services use in Canada reflect availability and acceptability factors (Chen & Hou, 2002). These include discrimination related to ethnicity and poverty, insensitivity of health professionals, negative past experiences with the health-care system, crowded clinics, scheduling difficulties, long waiting times, inconvenient clinic hours, inadequate knowledge of available services, lack of transportation or child care, time constraints, and language barriers (Anderson, Blue, Holbrook, & Ng., 1993; Crowe & Hardill, 1993; Sword, 1999; Waldram, 1990; Williamson & Fast, 1998).

Although the above-cited studies identify gaps in access to health services, they do not delve into the factors that influence the use of services by low-income people and the shortcomings of these services from the viewpoint of those people. Consequently, a study was conducted to investigate factors influencing use of health services and programs from the perspective of people living in poverty. The study was guided by three research questions: What are the perspectives of low-income people on (1) types and importance of health services used, (2) factors determining health-services use, and (3) strategies for enhancing health services.

### **Methods**

This project was conducted in two large Canadian cities — Edmonton, Alberta, and Toronto, Ontario — from 1999 to 2001. At the time of the study, about 21% of the population of these cities lived in poverty (Lee, 2000), as measured by the LICO, the most commonly used measure of low income in Canada. An interdisciplinary team of researchers and staff conducted the study at each site. Communication was facilitated by site coordinators' use of such strategies as e-mail exchange and video- and tele-conferencing. The proposal received clearance from the appropriate university ethics review committees.

Given the paucity of Canadian literature on the lived experiences of impoverished people regarding determinants of the use of a broad range of health services, combined with the sensitive nature of the topic (i.e., poverty), a qualitative descriptive research design was employed (Sandelowski, 2000). Elements of participatory research were incorporated to enhance relevancy, facilitate uptake of the findings, and build individual and research capacity (Green et al., 1995; Green & Mercer, 2001; Mercer, MacDonald, & Green, 2004). For example, community

advisory committees (including representatives from service, advocacy, and policy organizations) at each site guided the design and implementation of the project, interpretation of the results at program and policy levels, and dissemination and uptake of the findings. The research team included both academic investigators and community partners (service manager delivering care to low-income people and a member of a poverty advocacy organization). Indeed, the impetus for the study originated with a consumer advocacy organization. Participation of people living in poverty was fostered by hiring and training 13 impoverished interviewers. The interviewers' similar experiences with poverty increased their empathy and credibility with the participants and hence enhanced the validity of the data. This strategy was also used with a view to empowering the interviewers. A more detailed account of the partnership and participation elements of the project is provided elsewhere (Reutter et al., in press).

### ***Phase I Data Collection***

In phase I, data were collected from 100 participants in Toronto and 99 in Edmonton; this sample size allowed for an adequate number of participants in various low-income situations with diverse demographic characteristics. Purposive sampling was employed to select people whose incomes were at or below the Statistics Canada LICO and who represented a variety of low-income situations (e.g., working poor, social-assistance recipients, unemployed, homeless) and demographic characteristics (i.e., gender, family size and composition, age, ethnicity, education, occupation) (see Table 1). A sociodemographic data sheet was completed before each interview. Potential participants were accessed through community organizations offering health and human/social services in low-income neighbourhoods throughout each city. Interviewing through agencies was considered most appropriate, to enhance accessibility and safety for low-income interviewers and to provide backup support related to technical use of recording equipment, referral of participants in crisis, and financial reimbursement of participants.

Individual face-to-face interviews were conducted by people living in poverty who had received 14 hours of training in interviewing techniques (e.g., making initial contact, confirming confidentiality, obtaining consent, maintaining interview schedules). The interviewers were recruited from agencies serving low-income people, through word of mouth from community partners, and through the community advisory committee. They were given an honorarium for participating in the training sessions and received payment per interview conducted (plus child care and transportation if required).

<b>Table 1 Sociodemographic Characteristics of Participants in Phase I</b>			
	<b>Edmonton Sample (N= 99)</b>	<b>Toronto Sample (N= 100)</b>	<b>Total Sample (N= 199) (% of sample)</b>
<b>Gender</b>			
Female	70	65	135 (68)
Male	29	35	64 (32)
<b>Highest level of education</b>			
< Grade 9	7	3	10 (5)
Grade 9-13	57	49	106 (53)
College/trade/technical certificate/diploma	18	26	44 (22)
University undergraduate degree	8	17	25 (13)
University graduate degree	7	3	10 (5)
Missing	2	2	4 (2)
<b>Race</b>			
Caucasian	51	44	95 (48)
Aboriginal/Métis/First Nations	30	6	36 (18)
Other racialized minority	15	41	56 (28)
Missing	3	9	12 (6)
<b>Annual family income (previous year)</b>			
\$0-5,000	12	16	28 (14)
\$5,001-10,000	34	27	61 (31)
\$10,001-15,000	30	22	52 (26)
\$15,001-20,000	15	9	24 (12)
\$20,001-30,000	4	9	13 (6)
> \$30,000	2	4	6 (3)
Missing	2	13	15 (8)
<b>Children &lt; 18 years old</b>			
Yes	57	36	93 (47)
No	40	43	83 (41)
Missing	2	21	23 (12)

The phase I semi-structured interview guide for both sites consisted of fifteen items covering five areas: services that people living in poverty use to stay healthy and to cope when not feeling well, factors influencing use of services/supports, reasons for using services/supports, importance of services in meeting their needs, and suggestions for enhancing services and programs. The interview guide was developed in consultation with the community advisory committee and pilot-tested with low-income people at each site. The individual interviews lasted from 40 to 90 minutes (60 minutes on average).

### ***Phase II Data Collection***

In phase II, group interviews were conducted with 52 low-income people at the two sites to validate data from phase I and to focus on specific implications regarding programs, policies, and practices. The most articulate participants in phase I were selected for four group interviews and new participants were recruited for four other group interviews. The same selection criteria were used as in phase I for new participants. The group interviews were facilitated by two investigators. Peer interviewers also contributed to group interviews by relating their experiences in phase I and reporting on the findings. The interview guide for people living in poverty included seven items covering six themes: (1) the fit of findings from phase I interviews with participants' experiences; (2) strategies for improving services and programs; (3) new services needed; (4) required policy changes; (5) potential influence of people living in poverty on services, programs, and policies; and (6) target audiences and approaches for dissemination of results. The same semi-structured interview guide was employed at each site to ensure consistency. The group interviews lasted from 70 to 120 minutes (90 minutes on average).

Participants in the individual and group interviews received payment for their participation in the study, as well as for child care and transportation if needed.

### ***Data Analysis***

All individual and group interviews were audiotaped and transcribed prior to analysis. The transcripts were subjected to thematic content analysis using a framework of key concepts and themes derived from the data and were coded by trained research assistants (Cresswell, 1994; Hammersley & Atkinson, 1983). The categories guiding coding were identified via inductive analysis (moving from particular experiences of participants to general themes or categories) and had to meet specific criteria (i.e., inclusive, useful, mutually exclusive) (Cresswell; Morse & Field, 1995). The coding framework was transferred to QSR NUD\*IST

qualitative data-analysis software to enable data management and coding. The coding process entailed extraction of significant statements from transcripts and classification into appropriate categories. Interrater agreement by the two independent coders across sites was assessed until it reached 80%. Following the comprehensive coding process, a thematic analysis was conducted to classify common themes within the framework into larger clusters (Cresswell; Morse & Field). Investigators and research staff across the sites met regularly to ensure consistency and comprehensiveness of the data analysis.

## Findings

In this section we will report the perspectives of the participants on (a) types of health services used by people living in poverty, (b) factors influencing use of services, and (c) strategies for improving services and programs.

### *Types and Importance of Health Services Used by People Living in Poverty*

The participants accessed services for basic health-related needs such as food, shelter, and clothing; community-based services relevant to health promotion such as recreation; and a broad range of health services. Across all three types of services, participants described needs that were met and unmet. Almost all participants reported that they used some form of primary health care such as physicians, community health centres, and walk-in clinics. Sixty-five percent of these people accessed a range of other health-related services, including food banks, addiction counselling, drop-in and job-placement services, and newcomer and recreation services. Many individuals who were homeless or lived in shelters relied upon a continuum of street-based services on a daily basis. Participants identified several reasons for their use of services, the main ones being to meet health needs, to meet basic needs, to make human contact, and to cope with life's challenges.

**Meeting health needs.** When asked, "What do you do when you are not feeling well — for example, when you are ill or injured?," most participants said they went to a physician, medical centre, hospital emergency room, community service, or church, or talked with friends:

*When I'm not well I have a physician, yes, I have somebody I see regularly. And if I need to go for the tests, she recommends me for such tests. But I have a physician I see when I'm ill.*

Illness was the most common reason for using health services. Many participants cited illness in themselves or their children as the main

reason for using supports and services. Some identified emotional or mental health issues, while others identified physical health problems such as injuries:

*[I use services] just when the boys get sick or when I get sick myself. Usually I tend to take care of the boys more with the medical services.*

*Just if I'm sick or damaged myself in one way or the other, or the kids...if there is an accident and they have...a broken bone or something.*

In order to stay healthy, participants used a wide range of health services. While many of them visited private physicians, some went to a medical centre or a church and others used support groups or community services/programs, including recreation groups, parenting groups, life-skills programs, programs for psychosocial problems, and child- and family-related programs. Other health-maintenance strategies included counselling and culturally appropriate social groups (e.g., *sweats*):

*I wouldn't exist [without health services]...I could never pay for the drugs I'm on, I could never pay the orthopedic, not as it is now. If those things weren't in place I would probably be on the street unhealthy...on the street, it's as simple as that.*

*Those services are very important to me. For example, if there was no [name of health centre] I would have problems to see a doctor, especially the first 3 months when I was in Canada because I did not have [government health-care] coverage... Those services are very important to newcomers. Without those services their lives will be very awful.*

Some participants found that the programs and services helped them to cope and to maintain their health and their positive health behaviours:

*I wish to get to the point where my body can be flexible and I can have — I likely won't have — but as productive a lifestyle that I can have. That's what my goal is.*

*They [services] help me talk over..., the Sober Meetings have to do with everything. Everything — financial, substance abuse, alcohol abuse — everything. I find they help me lots.*

**Meeting basic needs.** Accessing services/supports to meet basic needs was the second most commonly cited reason for using services. Many people living in poverty contended that they needed services for survival. Some used supports and services to meet their family's need for food, clothing, and shelter. Supports and services were also means to improve

their life and to access financial aid. Services were also used for day-to-day coping. Without services, they believed, their lives would be much more difficult. Many participants stated eloquently that access to food banks, child care, and housing was a matter of life and death:

*I use the food bank because usually we have used the money to pay bills and stuff, so we are running low on food, so we have to use the food bank.*

*[The services] stop me from going hungry... They put clothes on my back... I'd be dead [without them]... It's a matter of life and death.*

**Making human contact.** People living in poverty spoke of the importance of social interaction in reducing their isolation. To illustrate, parents described the loneliness of childrearing on their own and the need to connect with other parents. Drop-ins and other health-related services for the homeless relieved the loneliness of living on the street:

*[At the drop-in centres] I can relax and...collect my thoughts...and socialize with certain people who may have the same problems that I may have...when I get lonely or I [feel]...isolated... [like] I'm not part of the world any more.*

*Because I need support, it really helps me get through the week. I need human contact. I don't have any [family] here... It's my only way of getting contact with people... It gets me through the week. Sometimes that's the only place I go to.*

**Coping with life's challenges.** Many participants described the impact of health-related services and resources on their ability to cope with personal and family stress:

*When [I'm] depressed...I can call and go any time [to the community centre] and someone is there to see me...and help me through my problem.*

*[The] parenting program...really empowers me... All the services I got all over, they changed my life. I'm really grateful... I was an abusive parent and then I got help and I saw that I was an abusive parent and that it was because I was an abused child and an abused wife... I got really good support. For all that I got I'm really grateful.*

*Right now if I didn't have some services I would be stuck at home just taking care of [my child], and I wouldn't be able to do anything in terms of making plans to go back to work or school or do anything with my life.*

Overall, the supports and services available to people living in poverty made their daily lives much easier.

### **Importance of Services for Survival**

When asked directly to imagine what life would be like for them without health supports and services, many participants indicated that they or their families would be unable to cope:

*I would have some very sick kids and I would be probably digging a hole under my house and hiding in it! It would be terrible. How do you cope if you don't have the things that you need?*

Some participants said their survival would be threatened if they did not have access to resources and services. Others maintained that their families and/or children would experience greater stresses due to their inability to afford children's services such as babysitting and pediatric care, parenting difficulties, family violence, apprehension of children, and poor child outcomes.

Many participants believed that if supports and services were withdrawn they would have to resort to demoralizing and dangerous behaviour such as theft, prostitution, panhandling, or sleeping on the street. Participants also believed that mental health problems would result, as well as suicide and increased crime. The following comments illustrate the importance of services:

*I don't think I would be alive if I didn't have the help at certain times in my life... I don't know what would have happened. I don't want to think about it.*

*My children wouldn't survive.... If these services are not provided...these children are going to be on the street. They are not going to know how to deal with it. They are going to have mental problems. They are going to have anxiety attacks. They are going to have depression states.*

### **Factors Influencing Use of Services**

Factors influencing use of services included service-provider behaviours and attitudes, accessibility of services, and self-reliance and readiness.

**Service-provider behaviours and attitudes.** Service providers had a powerful influence on the reactions to and use of services by people living in poverty. The participants wished to be treated with respect, compassion, and care, and they wanted service providers to spend time with them. Some cited professional competence and trustworthiness as important service-provider qualities. Providers' ability to listen to, understand, and empathize with people living in poverty influenced use of services. Welcoming, receptive staff are very important to the decisions of low-income people regarding the use of services:

*Just the friendly, non-judgemental attitude of the resource workers. They don't look down their noses at you, or they don't make any judgements.*

*It's the smallest things [that count]. Just calling me and asking, "How are you today, how are you feeling?" Letting me talk, letting me say what is on my mind or how I slept or what I have eaten.*

Negative provider behaviours deterred some participants from using services and programs. Concerns about the competence of providers and the confidentiality of their interactions with them made the participants reluctant to use services. Negative experiences included poor treatment at health-care facilities and community agencies such as food banks and social-assistance offices. Some participants described provider behaviour as rude, critical, condescending, or controlling — “telling people what they should and shouldn't do with their lives”:

*[In] some places these people can treat you however they want. You can't do anything about it, because you'll either get barred from the place or they'll call the cops on you, and you're not going to be believed, just because you're a street person and the way you look.*

*I had gone into a drugstore. I had to get a prescription filled, and the pharmacist...said that there was a \$2 charge...and I said, "That's fine." He said, "welfare case," and I heard it, and my daughter was standing right beside me... When you come across people like that, that have closed minds and attitudes — they prejudge you — that is so cruel and unfair.*

*[There is a] longer wait, definitely. Once they see your income or whatever, it's like they kind of push you to the back and the paying customers come first.*

Several participants indicated that they stopped using particular health services because the health professionals did not listen to them or made them feel uncomfortable. One participant's lack of input into his treatment was an important factor in his decision not to use the service:

*I was told I needed physiotherapy. I accepted that idea but I wasn't given the choice of where to go. And then on top of that, they just kept moving me around to others and it made me unhappy. And then the type of physiotherapy: the doctor who referred me instructed the physiotherapists what type of therapy I needed and didn't let them decide after assessing my needs. They had to go with what the doctor said and they didn't have flexibility to adjust the therapy.*

Participants also explained that negative service-provider behaviours and the attendant poor service resulted from more general inequities.

They believed they were receiving inferior treatment because of discrimination and stigmatization on the basis of their gender, ethnicity, appearance, income status, or neighbourhood of residence. Most participants felt that income status was a factor in the quality of care they received, that they were mistreated because they were poor. Discrimination based on ethnicity is illustrated in the following comment:

*If you are a Native or a member of an ethnic group [you] are sort of given the lowest of things. I see that. It's hidden. It's very hidden. But I see it.*

According to some participants, gender barriers resulted in inequitable treatment:

*I found I got more out of [female] nurses after they got to know me than I got out of the [male] doctor.... You are a girl, you are a woman, you know? You are an idiot. They have an attitude.*

*I think there's always the stigma of people who are single parents, especially single moms.... If you're a single mom you're...classified as this or that, and it's usually not very good. There are lots of really good single moms out there who are working their butts off to get what they got to survive.*

**Accessibility.** Participants' ability to use services depended on affordability, proximity, convenience, and knowledge of their existence. Financial inaccessibility was a key barrier to health-services use. Almost half of the participants could not use particular services because of lack of public insurance coverage. Not surprisingly, dental care was the most frequently mentioned inaccessible service, given that dental care is not covered by basic health-care plans in Alberta and Ontario:

*I need to go to a dentist because I have a tooth cavity which has been bothering me for the last 6 months, but I can't afford to go to the dentist so I just put up with it.*

*I know I need...to get some dental work done, because I have wisdom teeth that need to be taken out and other stuff like that. But I can't do it, can't afford it, so I'm not getting it done. And it won't get done. I mean, I'll have to live through pain. And if it ends up — if those wisdom teeth start coming out...*

The next most frequently discussed professional services that were inaccessible because they were not covered by health plans were chiropractic services, eye and ear examinations, and orthopedic services. Several other services, such as counselling, physiotherapy, and alternative

medical therapy (e.g., acupuncture, homeopathy, herbal therapy) were covered only partially if at all:

*I have a specific physiotherapist downtown. He worked on my back when I was pregnant, and he is the finest in town. I can't afford to go see him to get my back fixed.*

*Well, I could really use the services of a chiropractor right now but there's just no way that it's covered. So, no way.*

Another important factor in the use of services was temporal inaccessibility. Participants expressed concerns about long waiting periods in emergency rooms and physicians' offices. Inner-city residents also spoke of long line-ups and limited hours of operation of some street-based services:

*It can take forever to get an appointment. You can die waiting to get an appointment.... [At the community health centre] you have to wait 2 weeks to see my doctor.*

*Sometimes I have to wait 4 to 5 hours to see a doctor.*

Many participants identified geographic accessibility as a critical determinant of service use. Lack of transportation or insufficient money for transportation was a key inhibiting factor. Participants explained that transportation deficits prevented them from gaining access to certain services or forced them to accept a lower-quality service in their own community:

*If it involves taking a bus, forget it...because half the time you don't have money to go to the appointments.*

*There was a situation where — I think it was on a weekend — and my son had fallen and I needed to get to the medical clinic. And there was just no way to get there at all, so I had to wait a couple of days until I had the money to get on the bus and go there.*

Knowledge of available services and familiarity with agency staff and services were considered important determinants of accessibility. Some participants had initially been unaware of services and programs to which they were entitled:

*Information is very, very important. This Fee Reduction thing...has been lying here but it's like I have not really, really paid attention to it. And I don't know if it's even applicable to me anyway.*

*I didn't know they had stuff like that out there, like food banks and women's shelters for abused women... To me those are big things and nobody ever referred me to any of that stuff.*

Financial, geographic, and temporal accessibility and knowledge of services were perceived as affecting choice and even quality of services. It was not uncommon for participants to report that they used only services and programs that were “available for a low cost or for free.” People living in poverty identified an array of services, supports, and programs that they could not afford and therefore did not use. These included extended health care (e.g., naturopathy, physiotherapy, dental care, chiropractic care, counselling, eye care, and home care); vitamins and healthier foods; and treatments and diagnostic services (e.g., orthopedic devices, prescription and non-prescription medications, eyeglasses, magnetic resonance imaging) not covered by government (e.g., public health insurance, Social Services, Indian Affairs):

*I just take what I can. You can only go by what you can afford.*

*My income status dictates that I have no choice.*

*[You use] the services around here because you have to. ...you take it because you can't travel to other parts of town where you can, I feel, get better service medically wise.*

Some participants reported inadequate support in times of need. They received poorer-quality services because they had “no choice” due to their inability to pay for uninsured benefits. The following woman’s lack of income influenced her use of a variety of services that she needed:

*There's still more that I have to do that I'm not able to do because I don't have the money. I cannot go to my eye doctor... I have...a little bubble on my eye that was there about a month ago... I can't go to a doctor because it's \$55 to walk in. I...can't afford for them to tell me, “You need a new prescription and you have to wear glasses every day”...so why bother? I know there's no point in me going to get an appointment with the chiropractor, because I can't afford to go back... So it's really hit and miss, and if my health deteriorates because of money, so be it. I have no options right now. I can't go to the dentist... In fact I had one tooth pulled because I knew to get it refilled and refilled would mean I would go back and spend much money. And this way I just said, “Pull it,” because I cannot afford subsequent visits. I can't go to the doctor because even if they told me something was wrong I couldn't afford to fix it.*

In the phase II group interviews, the participants shared concerns regarding needed services that were unavailable or unaffordable. The participants pointed to a variety of services that were not available to people living in poverty, thus limiting their choices. These included

programs focused on children, employment, housing, and education. Concern was expressed that lack of opportunities for children made parenting difficult, especially in the face of limited income and conflicts regarding work.

**Self-reliance and readiness.** Participants' avoidance of formal health services was sometimes linked to a need for self-reliance. Many reported that even though their incomes were low and use of services was often necessary, they wanted to be self-reliant. Personal readiness to use particular services was also mentioned by several participants as a factor in their use of services:

*They'll watch [special-needs children] for the weekend for you. I've never had that kind of care where people will take them somewhere... I wasn't ready, I think, to send him for a weekend without me. But he's going on 13 and I think that he's ready. And I'm ready. So hopefully in the New Year I can get him into something.*

Participants described self-diagnosis and treatment, use of informal social supports, adoption of healthy lifestyles, and self-education as viable and often preferable means of managing their health. Despite low income and a need for services, they wanted to be as independent as possible.

Many participants reported that they tried to be self-reliant, particularly when attempting to cope with their day-to-day problems, and used services only as a last resort:

*I don't like people knowing my personal business... I feel I can handle it.*

*I work [problems] out on my own. I try to just deal with the problem the best I can. ...I don't use any kind of services for anything. Like, that's the last resort.*

*In general, if I have problems that cannot be resolved on my own I will seek supports and services.... Usually I try to resolve problems by myself first.*

Some participants seemed proud of their ability to deal with issues on their own. For some, pride prevented them from accessing particular services. Others reported feeling ashamed or uncomfortable using specific services:

*Your pride gets in the way. It makes me feel uncomfortable.... I wish I didn't have to use [the services] all the time.*

*I feel bad about it, because I wasn't able to deal with it on my own...like, you feel you lose your self-respect and pride.*

### **Strategies to Improve Health Services and Programs**

The individual and group interviews with people living in poverty elicited many recommendations for improving or extending services/programs and for changing health policies. These recommendations centred on improving accessibility, enhancing sensitivity of service providers, and increasing advocacy with and for low-income people.

**Improving accessibility.** Suggestions varied from eliminating bureaucratic barriers to access (e.g., easier transfer of records), to providing unlimited coverage without imposed limits, to promoting geographic accessibility. Many participants wished to see geographic accessibility through transportation to services, multiple services at one site, home visits, and outreach programs. They also expressed a need for temporal accessibility through longer hours of service, shorter waits, and weekend services. They were unanimous in their desire for strategies to increase financial accessibility. In the province of Alberta, the full-subsidy threshold for payment of health-care premiums is an annual income of \$12,450. An individual with annual earnings of over \$15,970 is required to pay the full premium of \$528/year. In Ontario at the time of the study, health-care coverage was free for Canadian citizens, landed immigrants, and residents and was not determined by employment or income-tax contributions (this policy has recently changed). Consequently, some participants wished to see more free services, the elimination of health-care premiums, and the public funding of a broader array of health services such as dentistry, mental health counselling, emergency room, specialists, extended health care (e.g., prescriptions, chiropractic, massage, physiotherapy), employment, child care, and recreation. Increased funding would result in an increase in the number of health and other services as well as in the hours of availability. With regard to emergency room and specialist services, increased funding would also help to decrease waiting times. Some participants thought the quality of services could be improved by increasing the number of staff:

*Actually, there [are] two things that would make the health-care system easier, and that would be getting rid of the...health-care premium. Getting rid of it. I mean, if they are talking about all these tax cuts that they want to make, that would be one area [where] they would actually be doing justice to the poor.*

*Well, I would like to see...an adequate amount of doctors and clinics and things.*

Some participants wanted to have more comprehensive health-related services, including extracurricular and recreation programs, employment

services, and child care, to increase choice. Others suggested that access could be improved if services were increased in number and scope.

As noted, lack of information about available services and entitlements emerged as a major challenge to accessibility. Although services were available, many people living in poverty do not hear about them or know how to access them. Several participants believed that there should be a more concerted effort to disseminate information about available services to potential consumers. Social marketing was suggested as a strategy to promote services:

*[We need] more information — if there was more information on everything, not having to go into a little book to find it. It should be out in the open, easy to find.*

**Enhancing sensitivity of service providers.** One common suggestion for enhancing the quality of services focused on service-provider attitudes and behaviours towards people living in poverty. The participants had experienced or witnessed providers conveying a sense of superiority over or disdain for low-income people and also displaying ignorance towards them. In the view of participants, confidentiality, sensitivity, and accountability are important attributes of services. Training and incentives were recommended as strategies for increasing providers' sensitivity to the circumstances and needs of people living in poverty and improving their behaviours towards these clients:

*Perhaps a training or a retraining of staff...to see what it's like on the other side of the fence, might be an idea.... They need a reality check. These people need to realize that if us as clients stop lining up, you as a person don't have a job any more.*

**Increasing advocacy with and for people living in poverty.** Participants emphasized the importance of promoting awareness about poverty and creating partnerships between people living in poverty and organizations with the means to communicate their message (e.g., community advocacy groups). They recommended that messages about poverty be targeted at all levels of government. If those living in poverty had adequate information about the system, they would be better equipped to access the range of services available to them. Several participants expressed a need for advocates to disseminate information about available services and help low-income consumers to navigate the system. But while some participants recommended collective action, others favoured advocacy as a means of assisting individuals:

*I'd love to find a support — somebody, an advocate, who can help me get through all this bureaucracy and red tape to find a place to live that I could afford.*

### **Limitations**

This study had several limitations. Although our findings were similar for two large cities and we used a diverse sample of people living in poverty, the experiences of the participants may not be generalizable to low-income Canadians in other urban or rural areas.

Other limitations relate to the recruitment of participants through agencies, which excluded people living in poverty not currently using services, and the quality of the data collected. The purpose of using peer interviewers was twofold: to put the participants at ease, and to provide training opportunities for impoverished individuals living in the community. Although training was provided, qualitative interviewing is a particular skill developed over time. There was some disparity in the quality of transcripts among the interviewers, with some displaying a greater aptitude than others for probing into important issues around the interview guide. All peer interviewers believed, however, that their participation in the interview process helped to elicit open and honest responses and opinions, thus enhancing the validity of the data.

### **Discussion**

The study bridges a knowledge gap with regard to the determinants of health-services use from the perspective of a vulnerable group. Such knowledge is needed to ensure that policies are inclusive and allow for complete accessibility, to identify the service needs of this vulnerable population, and to target and tailor services. Moreover, the study focused on a variety of supports and services, rather than solely on health care.

In the two large Canadian cities, people living in poverty reported that medical and health-related services were crucial to their survival and greatly enhanced their health and well-being. Services were viewed as a means of coping with stress and alleviating isolation. Stress and isolation have been reported as factors influencing health (Canadian Council on Social Development, 2000; Donner, Busch, & Fontaine, 2002). Participants discussed the importance of both formal and informal health services as well as other human services and supports in managing everyday circumstances related to poverty. The significance of these services and supports in the lives of people living in poverty cannot be overstated; a recent World Bank global study of 60,000 such people found that "health care services are vital to their survival and livelihood" (Dodd & Munck, 2002).

The main barriers to services use identified in this study were (1) inaccessibility — financial, temporal, and geographic; and (2) negative service-provider behaviours and attitudes. The interviews revealed

important factors influencing use of health services related to poverty status.

In each community, people spoke of their struggles living on social assistance or on low incomes, of the need for changes to existing assistance programs, and of the need for increases in the income levels of consumers. Barriers to accessibility relating to socio-economic status, despite the existence of universal health-care coverage, have been reported elsewhere (Morton & Loos, 1995; Williamson & Fast, 1998). Disincentives to seeking services that were found by both the World Bank study and the present study include direct costs of medications, cost of transportation to health services, and time lost waiting for treatment. Temporal and geographic accessibility and perceived quality have also been cited elsewhere as factors determining service utilization and health inequalities (Wagstaff, 2002).

The finding that low-income status reduces accessibility and use of health services confirms the dynamic interaction of health and poverty reported elsewhere (Dodd & Munck, 2002; European Commission on Development, 2000; Wagstaff, 2002; WHO Europe, 2001; Wolfe, 1999). Participants highlighted gaps in coverage of existing services. In addition to identifying services that failed to meet their needs, they described a variety of essential services that were either unavailable or unaffordable. Given the federal and provincial cuts in social and income-security spending in the last decade and a half, this is not surprising (Torjman, 2001). The comments of the participants confirm the finding of previous studies (Dodd & Munck; Wagstaff; WHO Europe; Wolfe) that there is an urgent need to promote awareness of poverty as a grave problem in order to influence health-services utilization and address health inequalities.

The behaviours of service providers emerged as a critical factor in service utilization. The ability of providers to listen to, understand, empathize with, and respect low-income people influenced their use of services. Indeed a World Bank study corroborates this finding, revealing widespread disappointment among poor people in their treatment by health-agency personnel (Dodd & Munck, 2002). Moreover, disadvantage and discrimination experienced by people living in poverty can exacerbate health problems (Shaw, Dorling, & Smith, 1999).

Recommendations for services, programs, and policies across sites reflected the main barriers to service use identified. The recommendations included increased accessibility and range of services, increased health-insurance coverage, staff sensitivity training, and communication of services and entitlements. The six areas requiring greatest attention were dental services, extended health-care services (e.g., prescriptions, chiropractic, massage, physiotherapy), mental health services such as

counselling, emergency-room services, physician services, and recreation programs and facilities.

Many of the suggestions articulated by participants concerned policy. These included extended publicly funded health coverage, raised income levels, affordable housing, increased subsidy for basic needs, and consumer participation. Such strategies reflecting broad determinants of health, decreased inequities and barriers to access, and public participation are consistent with the findings of previous research (Donner et al., 2002; Torjman, 2001; Wagstaff, 2002; WHO, 1999). In a Canadian study, Eyles et al. (2002) advise against piecemeal efforts and recommend resource shifting and funding for programs in sectors relevant to health.

The present findings are particularly germane given the climate of concern over the sustainability of Canada's health-care system and the need for increased access for those living in poverty: "This is precisely the reason why Canada's medicare system was introduced — to avoid a situation where wealthy people get access to all the health care services they needed and poor people could not" (Romanow, 2002). This position was reiterated in a recent Speech from the Throne (2004): "The Government's commitment to health care rests on one fundamental tenet: that every Canadian have timely access to quality care, regardless of income or geography — access when they need it."

### **Implications for Nursing**

Despite barriers to access, Canadians living in poverty are, by virtue of their greater health needs, more likely than other Canadians to come into contact with health professionals, to be hospitalized, and to use various health-related services (Reutter, 2000; Sword, Reutter, Meagher-Stewart, & Rideout, 2004). Nurses therefore have a role in ensuring that services and supports for people living in poverty are accessible and sensitive to their unique needs. Accessibility to health supports and services is a principle of primary health care, which Canadian nurses have been advocating for some time (Ogilvie & Reutter, 2002; Stewart, 2000).

The insensitivity to the context and experiences of people living in poverty revealed in this study suggests a need for more education about poverty and its effects both in professional curricula and in-service. Nurses need to critically evaluate their own attitudes towards low-income people, particularly the attribution of poverty and its effects on health. A recent Canadian study found that baccalaureate nursing students would benefit from further content and clinical practice with populations living in poverty (Reutter, Sword, Meagher-Stewart, & Rideout, 2004; Sword et al., 2004). A nursing curriculum that explores the structural causes of poverty, the influence of poverty on health, the negative effects

of poverty on society, and strategies to minimize the effects of poverty would enable nurses to re-evaluate their own attitudes towards the poor and would equip them to work more effectively with impoverished people (Reutter, 2000; Sword et al., 2004). A critical social perspective on poverty that explores the psychosocial and socio-economic contexts of individual concerns and problems will lead to more sensitive care (Stewart, 2000). Empowering approaches at the individual level (Labonte, 1993) include listening to the experiences of those living in poverty, acknowledging their constraints as well as their strengths, exploring realistic approaches, and advocating for and with clients regarding access to resources.

Beyond ensuring that clients receive sensitive care on an individual level, nurses have a role to play in working collaboratively with professionals in health and other sectors to advocate for services, supports, and policies that will enhance accessibility to health services. Nurses can advocate for broader coverage of publicly ensured health services, particularly dental care. Given that financial constraints are a major barrier to service accessibility and that people living in poverty use services to meet their basic needs and their health needs, nurses can also advocate for incomes that ensure access to food, shelter, and other essentials. For example, social-assistance rates have never reached the poverty line, for any family type, anywhere in Canada (National Council of Welfare, 2002). The earnings of Ontario and Alberta families working at minimum wage do not reach the poverty line (National Council of Welfare, 2004).

The recent focus in Canada on care 24 hours a day, 7 days a week, and innovative service delivery using a primary health-care framework may enhance geographic and temporal accessibility, particularly if services are provided “under one roof.” This may ease some of the transportation barriers faced by people living in poverty. However, there is a need for advocacy regarding affordable transportation services. Advocacy work could also include raising awareness among other professionals and sectors of the effects of poverty on health, which could lead to more positive attitudes towards poor people and reduce bureaucratic barriers to their use of services.

Accessibility of services and empowerment of people living in poverty can be enhanced by egalitarian relationships centred on clients’ needs and wishes. This requires nurses and other health professionals to actively acknowledge service users as full members of the collaborative team (Shields & Lindsey, 1998; Stewart, 2000; Whitehead, 2001). As equal partners, people living in poverty would be included in the design of services, thereby ensuring that services are relevant and sensitive.

Nurses can take a leadership role in the development of innovative service-delivery models that facilitate access; reflect the broad determinants of health; incorporate individual, community, and societal interventions; and ultimately promote the physical and psychosocial health of people living in poverty. Nurses are in a key position to advocate for policies that increase accessibility to a broad range of services that meet health-care needs as well as other prerequisites for health.

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