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Low-income Canadians' experiences with health-related services: Implications for health care reform☆

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Abstract

This study investigated the use of health-related services by low-income Canadians living in two large cities, Edmonton and Toronto. Interview data collected from low-income people, service providers and managers, advocacy group representatives, and senior-level public servants were analyzed using thematic content analysis. Findings indicate that, in addition to health care policies and programs, a broad range of policies, programs, and services relating to income security, recreation, and housing influence the ability of low-income Canadians to attain, maintain, and enhance their health. Furthermore, the manner in which health-related services are delivered plays a key role in low-income people's service-use decisions. We conclude the paper with a discussion of the health and social policy implications of the findings, which are particularly relevant within the context of recent health care reform discussions in Canada.

Keywords: Poverty; Health-related services; Health care reform; Canada

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1. Introduction

This study explored low-income Canadians' experiences with health-related services[1] by drawing on the perspectives of low-income people, service providers, and managers, advocacy group representatives, and senior-level public servants. Debates about the funding and delivery of health care services have long captured the attention of Canadians [1,2]. In recent years, these debates have centred around, and been shaped by, several federal and provincial health care reform commissions (e.g., the Commission on the Future of Health Care in Canada [3], Standing Senate Committee on Social Affairs, Science and Technology [4], Alberta Premier's Advisory Council on Health [5], Saskatchewan Commission on Medicare [6], Quebec Commission on Health and Social Services [7], National Forum on Health [8]). Even though Canadians have expressed concern in recent years that the health care system is deteriorating [9,10], the majority (55–60%) continue to assign fairly positive ratings to the overall quality [10–12]. Furthermore, few Canadians (13%) report that they did not receive needed health care in the previous year [13]. Nonetheless, the vast majority (87%) of Canadians also believe that there is a need for all levels of government to renew the health care system by acting on the findings from studies [14].

While the outcomes of health care reform are relevant to all Canadians, government decisions affecting the cost, delivery, and access to health care services have particularly significant implications for low-income Canadians. People living with low incomes are less healthy and have more medical conditions and symptoms of illness and disease than their counterparts with higher incomes [15–17]. Consequently, low-income people tend to have greater health care needs than do higher-income people. However, despite their needs, low-income Canadians are more likely than other Canadians to report that they did not receive needed health care in the past year [13,18]. In sum, it seems that low-income Canadians have much to gain – or lose – from changes that are made to health care in Canada.

Researchers have examined the relationships between income and the use of health care services [19–37] and the barriers to health care experienced by low-income Canadians [38–45]. These studies have provided important descriptive information about low-income people's use and non-use of health care services. However, little is known about factors that influence low-income people's decisions regarding health care service-use, which is important information for policy makers to consider as they explore new strategies and arrangements for funding, administering, and delivering health care. In addition, previous studies have focused primarily on treatment-focused and preventive services offered by health care professionals. Researchers have yet to examine a broad range of community-based services, supports, and programs that low-income Canadians use to be healthy (e.g., recreation programs, food banks, support programs). Furthermore, there is a lack of research that explores these questions from the perspectives of low-income Canadians. To begin to address some of the gaps in previous research, we conducted a study on low-income Canadians' experiences with health-related services. The specific objectives of our study were to:

(1) identify the health-related services that low-income people use to attain, maintain, and promote their health;
(2) determine the factors that influence low-income people's use of health-related services;
(3) identify improvements that should be made to policies, programs, and services to meet the health needs of low-income Canadians.

A determinants of health perspective [46–50] provided a theoretical framework for our study. According to this perspective, health is a positive state of physical, emotional, and spiritual well-being that is integral to quality of life. It is not only an end but also a resource that provides people with opportunities to make choices and to lead socially satisfying and economically productive lives [50,51]. Another key premise of a determinants of health perspective is that health care provided by physicians and other health care professionals is

[1] In this paper, we use "health-related services" as a term that encompasses a broad range of services, supports, and programs that people use to attain, maintain, and enhance their health. Health-related services include treatment-focused and preventive services provided by physicians, and other health care professionals (e.g., medical check-ups and treatment, hospital services, physiotherapy, dental care, eye care, naturopathic care) as well as community-based services, supports, and programs that people use to stay healthy (e.g., recreation programs, religious services, food banks, support programs).

only one of many factors that influence health. Health is also influenced by a broad range of community-based services, supports and programs, and by relationships between and among people's personal health practices and coping skills, living and working conditions, and socio-economic, political, and physical environmental contexts [15,17,46–50,52–55]. Accordingly, a determinants of health perspective casts our attention beyond the narrow range of health care services that low-income Canadians use when they are ill to a broad range of services, supports, and programs that they use to maintain and promote their health—what we refer to as health-related services. Prior to describing the methods and findings from our study, we offer both a brief overview of the health-related services that are available to low-income people in Canada and a summary of recent research findings about health-related service-use by low-income Canadians.

1.1. Health-related services for low-income people

Like all residents in Canada, low-income people have access to publicly funded physician and hospital services without direct charges [56].[2] The provision of these services is coordinated by provincial/territorial health care plans, and in most provinces/territories, local health regions are responsible for delivering health care services. In addition to a broad range of physician and hospital services, provincial health care plans tend to include limited coverage for chiropractic care, physiotherapy, and podiatry, whereas prescription medications, routine dental care, and counselling by psychologists are not covered. In addition, there is variation regarding the extent to which each provincial/territorial health care plan covers some services, such as eye care (e.g., optical examinations). For instance, in Alberta, yearly eye examinations are only covered by the provincial health care plan for children and seniors; adults between 19 and 64 years old are charged Canadian$ 55 [58]. In contrast, the health care plan in Ontario covers the cost of eye examinations for children and seniors every year and for adults between 20 and 64 years old every 2 years [57].

Some groups of low-income Canadians are eligible for comprehensive health care benefits that allow them to access some services beyond those provided by provincial health care plans, including prescription medications and dental care. For instance, the federal department of Indian and Northern Affairs provides comprehensive health care coverage to Aboriginals with treaty status, and provincial/territorial social service/human resource ministries provide similar coverage to people receiving social assistance [56]. Furthermore, some provincial/territorial governments provide comprehensive health benefits to children [59,60] and parents [61] living in working low-income families and to parents making the transition from social assistance to the labour market [62,63].

In addition to physician and hospital services provided under provincial/territorial health care plans, community-based social service organizations offer a broad array of services, supports, and programs to low-income people in Canada. These organizations, which are often part of the non-governmental non-profit sector, help low-income Canadians by providing food (e.g., food banks and co-ops), clothing (e.g., clothing exchanges), housing (e.g., subsidized housing, shelters), free and/or subsidized medications and dental care, family support services (e.g., parenting programs, counselling), and employability programs (e.g., job training, educational upgrading) [64]. In addition, some recreational programs offered by municipal government departments waive or subsidize fees for low-income people [65,66].

1.2. Literature review

As noted previously, there is limited research about low-income people's use of community-based services, supports, and programs. As such, current knowledge about health-related service-use by low-income Canadians is largely drawn from studies about treatment-focused and preventive health care services. These studies consistently have shown that, compared to higher-income Canadians, those with low incomes are heavier users of general practitioner, mental health, and hospital services [19–27]. Some researchers have

[2] The federal and provincial/territorial governments share the responsibility for funding medically necessary physician and hospital services, and for the most part, funding is derived from federal and provincial personal and corporate income taxes. In addition, some provinces and territories use sales taxes, payroll levies, and lottery proceeds to supplement the income tax funded portion of health care revenue. And, three provinces (Alberta, British Columbia, Ontario) require that most residents pay health care premiums [56,57].

speculated that low-income people are heavier users of these treatment-focused health care services because they have lower levels of health and more health problems than do people with higher incomes. Findings from the few studies that have explored this hypothesis are, however, inconsistent [19,20,27]. Moreover, there is mounting evidence that low-income Canadians are disadvantaged in terms of their receipt of some specialized treatment services, such as coronary care and joint replacements [23,28,29].

In contrast to findings about the negative relationship between income and use of general practitioner, mental health, and hospital services, low-income Canadians are less likely than their higher-income counterparts to receive services, such as chiropractic and routine dental care [24,35,36], which are not fully covered by provincial health care plans. When low-income Canadians do get dental care, it is less likely to be preventive in nature than the care obtained by higher-income people [36]. Furthermore, the disparity between the percentage of high- and low-income Canadians obtaining dental care has been increasing since the mid-1990s [24]. Similar to the under-use of health care services that are not fully covered by provincial health care plans, low-income Canadians are less likely than higher-income Canadians to use preventive services including cervical cancer screening [30,31,37], eye examinations [32], prenatal care [33], and prenatal classes [34].

In addition to studies that have explored the relationships between income and the use of both treatment-focused and preventive health care services, there is a growing body of research on the barriers that prevent low-income Canadians from obtaining health care. Limited financial resources, lack of comprehensive health care coverage, and lack of affordable transportation are common barriers experienced by low-income Canadians. In fact, low-income Canadians are 10 times more likely than other Canadians to report unmet health care needs due to cost or transportation [38]. Limited financial resources and lack of comprehensive health care benefits particularly limit access to services not covered by provincial health care plans, such as dental care and prescription and over-the-counter medications [39–41]. Other barriers that prevent low-income Canadians from obtaining health care services include discrimination related to ethnicity and poverty, insensitivity of health care workers, negative past experiences with the health care system, lack of childcare, lack of knowledge about available services, inability to get time off work, culture, and language [40,42–45].

2. Methods

We conducted our examination of low-income people's experiences with health-related services in Edmonton and Toronto from 1999 to 2000. In the latter part of the 1990s, more than one-fifth of residents in both cities had incomes below the Statistics Canada low-income cut-offs [67].[3] Given our interest in low-income people's experiences with health-related services and our interest in exploring factors that influence low-income people's decisions about health-related service-use, we employed an exploratory, descriptive, qualitative research design [69]. This inductive research approach allowed us to investigate low-income people's experiences with health-related services in more depth and detail than is typically possible in studies that employ statistical analyses of survey and/or administrative data. Thus, our study complements previous research by shedding light on a different facet of low-income people's use of health-related services than has been previously examined [70]. Our findings are based on the analysis of data from two phases: (1) individual interviews with low-income people and (2) group interviews with low-income people, service providers and managers, representatives of advocacy organizations, and senior-level public servants.

2.1. Phase I data collection: individual interviews

Between September 1999 and January 2000, face-to-face interviews were conducted with 199 low-income people (99 in Edmonton and 100 in Toronto). Purposive sampling was used to select

[3] The low income cut-offs (LICOs) are income levels at which Canadians, differentiated by family size and the population of the community within which they live, spend 20% more of their pre-tax income on basic needs (food, shelter, clothing) than the average proportion spent by Canadians. The average proportion of income currently spent on basic needs has been estimated by Statistics Canada to be 34.7%. Thus, families whose expenditures on necessities exceed 54.7% of their pre-tax income are living below the LICOs [68].

participants with incomes at or below the Statistics Canada low-income cut-offs. The sample size was determined by our desire that participants represent a variety of socio-demographic characteristics and low-income situations (e.g., working poor, social assistance recipients, unemployed) and by using the concept of saturation (i.e., when no new themes or issues arise in the interviews [71]). Because qualitative studies are interested in exploring people's accounts of their experiences, sample sizes are of necessity usually much smaller than those used in studies aimed at establishing statistical patterns, incidences, and associations among variables [69]. Nevertheless, our desire for a sample that included people with various socio-demographic characteristics and low-income situations led to a larger sample size than is usual in many qualitative studies.

Participants were accessed through community agencies offering health and social services, supports, and programs in Edmonton and Toronto. We systematically chose agencies that provide services to a wide cross-section of low-income population groups throughout both cities. Agency employees talked with clients who fit the selection criteria about the study, and requested permission from these people to provide their names and contact information to the project coordinator. Potential participants were then contacted by the project coordinator, who gave them additional information about the study, confirmed their eligibility, and arranged a mutually convenient time for an interview for those who agreed to participate.

Interviews were conducted in community agencies, located along bus routes, in different parts of Edmonton and Toronto. As a token of appreciation to people who agreed to participate in the study, participants were given $ 20.00 at the time of the interview. Trained interviewers from low-income communities used structured interview guides that included open-ended questions about the services that participants used to attain, maintain, and enhance their health; factors and conditions that influenced participants' use of services; and participants' suggestions for improving health-related services.[4]

The low-income samples in both Edmonton and Toronto comprised people with a range of income sources, such as employment, social assistance, and employment insurance. In addition, as Table 1 shows, the sample was diverse in terms of socio-demographic characteristics.

2.2. Phase II data collection: focus group interviews

Between July and December 2000, 52 low-income people, 17 service providers and managers, 21 members of advocacy organizations, and 15 senior-level public servants participated in 14 focus group interviews. In each city, four focus groups were conducted with low-income people for the purposes of validating findings from Phase I and seeking specific recommendations for improving policies, programs, and services. Two of these groups (in each city) included particularly articulate low-income participants from Phase I, and the other two groups included low-income people who had not participated in Phase I. In addition, service providers and managers from a variety of community-based health and social service agencies, representatives of advocacy organizations, and senior-level public servants from health, recreation, social services, and human resource departments at the local, provincial, and federal levels participated in three separate group interviews in both Edmonton and Toronto. Key topics guiding these focus group interviews included the fit of findings from Phase I interviews with participants' experiences, as well as suggested improvements to health-related policies, programs, and services.

2.3. Data analysis

All individual and focus group interviews were audio-taped and transcribed verbatim. A qualitative data analysis software package, QSR NUD*IST, facilitated data management. Trained research assistants,

[4] Consistent with the determinants of health perspective guiding our study, participants were encouraged by interviewers to think of "health or being healthy" more broadly than simply not being sick. Participants were told that for the study, health meant being able to cope and feeling well physically, socially, emotionally, and spiritually. In addition, interviewers explained that the terms services, supports, resources, and programs would be used interchangeably in the interview to refer to medical or health services covered by provincial health care plans (e.g., physician and hospital services); health services not covered by provincial health care plans (e.g., dental care and naturopathic services); other services that people use to stay healthy (e.g., recreation programs, religious services, food banks, community agencies).

Table 1
Socio-demographic characteristics of low-income participants in Phase I

	Edmonton sample ($n = 99$) Number	Toronto sample ($n = 100$) Number	Total sample ($n = 199$) Number (% of sample)
Gender			
Female	70	65	135 (68)
Male	29	35	64 (32)
Highest level of education			
<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)
Race			
Caucasian	51	44	95 (48)
Aboriginal/metis/first nations	30	6	36 (18)
Other racialized minority	15	41	56 (28)
Missing	3	9	12 (6)
Annual family income (previous year)			
$ 0–5000	12	16	28 (14)
$ 5001–10000	34	27	61 (31)
$ 10001–15000	30	22	52 (26)
$ 15001–20000	15	9	24 (12)
$ 20001–30000	4	9	13 (6)
>$ 30000	2	4	6 (3)
Missing	2	13	15 (8)
Children <18 years old			
Yes	57	36	93 (47)
No	40	43	83 (41)
Missing	2	21	23 (12)

in consultation with academic investigators, conducted a content analysis of interview transcripts. The categories guiding the content analysis coincided with the objectives of the study, and were identified by using inductive analytical processes that moved from the particular experiences of participants to general categories that were inclusive, useful, mutually exclusive, clear, and specific. Inter-rater agreement by two independent data coders in both sites was assessed until it reached 80%. Investigators and research assistants from both sites were in regular contact to ensure that the analysis was comprehensive and consistent.

3. Results

The three objectives guiding our study provide an organizing framework for the findings from the individual and focus group interviews. The findings are highlighted by direct quotes from participants.

3.1. Health-related services for attaining, maintaining, and promoting health

Low-income participants, in both the individual and focus group interviews, were asked to discuss what services, supports, and programs they use to stay healthy and what they do when they are ill or injured. All but a handful reported that they use a broad range of both health care and community-based social services.

3.1.1. Health care services

By far, the most often cited health care service used by participants was physicians in private practices, community health clinics, walk-in facilities,

andemergency departments. In fact, only a few participants ($n = 12$; 6%) reported obtaining care from other professional service providers, such as counsellors or physiotherapists. Illness, both acute and chronic, was the most common reason for using physician services ($n = 145$; 73%). Participants' comments indicate that they are judicious about their use of physician services for acute health problems:

If it's not major then like we try to do something for ourselves like using home remedies, but if it's major we go see the doctor.

. . . it depends on how severe it is. Like I don't usually like . . . to go to the doctors . . . I'd rather . . . take care of myself until it's like [serious] . . . I know if I have a broken bone or . . . I feel really sick where I can't eat or I'm throwing up, then I'll see the doctor . . ..

Some participants did, however, obtain physician care on a regular and frequent basis to address serious chronic health problems:

I go see my doctor once a week, sometimes twice a week . . . sometimes three times a week. I go to my doctor quite a bit . . . for depression and chronic pain . . ..

I've just come through 10 years of anemia. I've lost a lot of weight and now I've been seeing a doctor for the last six weeks every Tuesday . . ..

Regardless of the frequency with which participants accessed physician services, several points of discussion during individual ($n = 102$; 54%) and group interviews emphasize the fundamental role that health care services play in the maintenance of low-income people's health. As these two participants explained:

I wouldn't exist [without the health care services] . . . I couldn't exist. I could never pay for the drugs I'm on. I could never pay for the orthopaedic . . . If those things weren't in place I would be probably on the street unhealthy . . . on the street it's as simple as that.

[Without our health plan] most of our income would go directly to health care. [The health plan] is very very important. This is as essential to us as food and water . . ..

3.1.2. Community-based social services

Extending previous research that has focused only on treatment-focused and preventive health care service-use by low-income Canadians, two-thirds ($n = 129$) of low-income participants reported that a broad range of community-based social services are integral to their health. Food and clothing banks, collective kitchens, and shelters were frequently cited. Other types of services and programs commonly used by low-income participants included child and family support services, settlement/cultural services, libraries, religious and spiritual services, and psychosocial programs (e.g., anger management, addictions counselling).

The most common reason offered by almost 90% of participants for using community-based social services was a lack of money or other resources to meet their basic food, shelter, and clothing needs. Many participants indicated that they also seek community-based services when they need to talk with someone about a problem, have difficulty coping, and experience family or personal stress. In addition, it was common for participants to describe how community-based services reduce isolation by providing opportunities to interact with other people. Parents reported using community-based services to address the needs of their children and families, largely through parenting classes, women's groups, and early intervention programs.

In short, health-related community-based services ease the difficulties and challenges of living with a low income. The importance of these services was evident when participants talked about how desperate they would be without them ($n = 102$; 51%). Many were certain that they would be "lost without" them, and that they or their families would not be able 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?

[The services] are very important. Life would be very difficult, very stressful, very lonely, very poor . . ..

3.2. Factors influencing low-income participants' use of health-related services

Income status and quality of service were the two most extensively discussed factors influencing use of health-related services. In addition, some participants explained that transportation, geographical location of services, and waiting times influenced their decisions.

3.2.1. Income status

Respondents frequently reported ($n = 132$; 66%) that they only use services and programs "that are available for a low cost or for free" such as food banks, community-based non-profit agencies, community health clinics, and early childhood intervention programs:

"If it wasn't for my income, I wouldn't have to use the food bank."

But if – if it weren't for the fact that we're low income, he would not be in Early Ed. because it's [a] low-income [program]. Like, I can't get him in playschool because I can't afford the playschool.

Almost 40% of participants ($n = 74$) also explained that their low income directly limits their choices by hindering access to a broad array of services and programs that they cannot afford. Professional treatment services (e.g., physical therapy, dental care, chiropractic care, counselling, eye care, medications) not covered by provincial health care plans, social services, or Indian and Northern Affairs were most frequently cited by respondents ($n = 52/74$; 70%) as services that they choose *not* to use because of their low-income status. Examples of common responses include:

The psychologist was not covered through [provincial health care plan], so I had to stop seeing her.

. . . a lot of times [my children have] gone to a doctor and maybe there is a medication they need, but I can't afford it . . ..

Social assistance only covers so much, so you know, I can't afford to fix my teeth, so they're being pulled out one by one . . . I can't afford to get them fixed, so that government only affords to pay for them to get yanked . . . if you have bad teeth . . . it's going to affect your health and you're going to get sick . . . It's a shame . . . You go for a job . . . who's going to hire you with no teeth in your mouth?

. . . there's . . . more that . . . I'm not able to do because I don't have the money. I cannot go to my eye doctor . . . because it's 55 dollars to walk in.

The inability of low-income people to afford many professional services that are not covered by provincial health care plans was echoed by service providers and managers in group interviews. As this participant explained:

We're getting more and more [people where] . . . they need more than just standard health care. They might need a chiropractor or some other specialist and they can't afford it, so although they're doing the best they can with what they have, they need more service than they may get.

Of the participants who talked about the restrictions that their low income places on the services and programs that they can use, almost one-fifth ($n = 13/74$) reported that they and their children are not able to use recreation programs and activities. Although these participants recognized the importance of recreation for health and well-being, they found that many programs are unaffordable:

Sure. Like, I'd like my kids to get into some extra-curricular things, but I can't afford to pay to put them . . . It's not a choice, really . . . Anything, like skating or dancing . . . anything to keep them busy, to make them feel like . . . I always tell the kids we can't afford it, and that's not fair.

My physical health is horrible. My doctor wants me to go to a gym. Sports equipment, and get the therapy going and doing treadmills and the whole thing, and I can't afford it.

Although some recreational programs in both Edmonton and Toronto waive or subsidize fees for low-income people [54,55], the programs remained unaffordable to

some participants, particularly those wanting to register more than one child. Additionally, public servant group interview participants in Toronto explained that there are insufficient spaces in fee-waiver programs, and consequently, program quality is jeopardized by overcrowding.

3.2.2. Quality of services

Our findings indicate that another common factor influencing low-income participants' use of services is the quality of services, both in terms of front-line service provider behaviours and the service environment. Approximately half ($n = 107$) of participants explained that they are more likely to use services where providers are friendly, welcoming, empathic, compassionate, and respectful. As these participants explained, low-income people want service providers to care, to show that their concerns and complaints matter, and to treat them with respect:

. . . people who are kind, friendly. They sit down and talk with me. I feel comfortable. People that are real . . ..

And it's the smallest things [that count]. Just . . . asking 'how are you today?', 'how are you feeling?' Letting me talk, letting me say what was on my mind or how I slept or what I've eaten.

On the other hand, and not surprisingly, participants tended to avoid services where front-line staff had been abrupt, rude, indifferent, and judgemental in the past. Several participants ($n = 79$; 40%) indicated that they stopped using certain health-related services because providers did not listen to them. Negative experiences with service providers are exemplified in the following quotes:

I remember at one point I had gone into a drug store. I had to get a prescription filled, and the pharmacist . . . said that there was a two-dollar charge and I said 'that's fine'. He said 'welfare case', and I heard it, and my daughter was standing right beside me.

You feel like you're begging to those people . . . I always feel like I've got to beg for everything and you got to talk through windows with ten people standing there listening to everything you're talking about . . ..

3.2.3. Transportation and geographical location of health-related services

Transportation issues and the geographic location of services also played a role in many low-income participants' use and non-use of health-related services ($n = 93$; 47%). Many participants said that their use of health-related services is limited to those that they can access by public transportation or those that are located close to home. In addition, participants' access to services is sometimes limited because they are unable to afford transportation:

But I guess there was a situation where, I think it was on a weekend, and my son had fallen and 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.

And that's why my family were going—we were all going for family counselling . . . but we had to back out because I just couldn't afford the fee plus the transportation for everybody.

3.2.4. Long waiting times

Lastly, long wait times were cited by one-quarter ($n = 50$) of low-income participants as a factor that limited their use of some health-related services. While most of these concerns were associated with treatment-focused health care services such as those offered by physicians and hospital emergency departments, participants living in inner-city communities also spoke of difficulties accessing community-based services because of long line-ups and limited hours of operation.

3.3. Participants' recommendations to improve health-related policies, programs, and services

All participants, in both phases of our study, were asked to make recommendations for improving health-related policies, programs, and services for low-income Canadians. The recommendations that participants made fall into two broad categories: (1) improvements to current health-related services and (2) actions to improve the life circumstances of low-income Canadians.

3.3.1. Improvements to current health-related services

Low-income participants tended to focus most of their attention on changes to current services. In this regard, they made several recommendations, which for the most part, corresponded with their descriptions of the impact of low-income status and quality of service on their use and non-use of health-related services. Most frequently, participants expressed the desire to have the same service choices as higher-income Canadians, and they suggested two key strategies for achieving this goal. First, they contended that their choices could be enhanced if a number of professionally provided treatment services, such as physiotherapy, chiropractic care, dental care, eye care, and counselling, as well as prescription and non-prescription medications, were covered by provincial health care plans, social services, and Indian and Northern Affairs. The following quotes represent recommendations made by low-income participants.

I would like to have a truly universal health care system . . . [that] also extends to people with chronic illness and permanent disabilities.

Basic health professions – eye specialists, dentists, counsellors – all those things [need] to be covered.

Some also recommended that recreational services and programs should be more affordable to people with low incomes. Other less common recommendations for enhancing access to health-related services included longer and flexible hours of operation.

Service providers/managers, advocates, and public servants recommended that, in addition to expanding health care coverage, low-income people's access to health-related services would be enhanced if a broad range of services were provided under one roof in community-based centres located in low-income residential areas. These participants based their recommendation on concerns that services are not well-integrated or coordinated within and across sectors. As this public servant pointed out:

When I talk to people, it's pretty obvious that . . . social service providers don't actually know a lot about the health care system, so too the health providers don't know about the social services . . ..

Another common recommendation made by low-income participants as well as senior-level public servants and service providers/managers was that all people, regardless of income level, deserve compassionate, sensitive, and respectful service provision. Most often, participants suggested sensitivity training to increase the awareness and understanding of front-line service staff about the unique challenges, experiences, and needs of low-income people.

Limited awareness of low-cost or free health-related services was another point of discussion by low-income participants, in response to questions regarding recommendations for improvement to services. As these two participants explained:

I [do] not know how many services and supports are available right now. I came from Mainland China [and] I am not used to asking for services and supports . . . [The] local community centre . . . promote their service more than right now. If you have [a] service and want people to use them you should let people know . . ..

I'd like to have an idea what other services are available to those on low incomes . . ..

Not surprisingly, then, another key recommendation from several low-income participants, as well as senior-level public servants, was that front-line service providers should make a more concerted effort to disseminate relevant service information to low-income people. One suggested strategy for ensuring dissemination of information about health-related services was to employ advocates at different agencies who could help low-income people navigate the system.

3.3.2. Improvements to the life circumstances of low-income people

Despite low-income participants' extensive discussion about the difficulties posed by their low incomes, only a few made recommendations about the need for additional financial and/or in-kind supports. Nonetheless, service providers/managers, advocates, and senior-level public servants in group interviews all recommended the need for actions to improve the life circumstances of low-income Canadians. Specifically, these participants argued for strategies that address the root cause of low-income people's difficulties meeting basic needs and accessing needed health-related

services, namely inadequate income. Participants' key points are illustrated in the following quotes:

We have this whole food bank system set up, well if we just gave enough income . . . and access to affordable, nutritious food we wouldn't need food banks in the beginning. So, it's like stopping and being holistic about the whole cost benefit of the whole health system . . . The whole health care [system] needs to realize that there would be significant benefits if we put more into prevention.

. . . even recreation user fees wouldn't be an issue if people had enough money to pay them. Bitchy food bank workers and poor quality food in food banks wouldn't be an issue if people had enough money to go to [the grocery store]. I mean all of these things are by their very nature due to low income and low incomes that are going down and not improving, and you know the one magic bullet to improve things would be to improve people's income and you know you would start with welfare, because the lowest of low-income people are on welfare . . ..

Service providers/managers, advocates, and public servants participating in group interviews in Toronto highlighted the high cost of housing, and the subsequent need for affordable housing through rent caps, subsidies, more shelters, and co-operative housing. The focus group of advocates spoke passionately about the issue, recommending that housing should be a right to which all Canadians are entitled. Participants in Edmonton did not raise the need for affordable housing, which may be due to the fact that, until the past few years, there has been a greater availability of affordable housing in Edmonton than in Toronto [72,73].

4. Discussion

Our study enhances current understanding of low-income Canadians' experiences with health-related services by providing insights into the types of services that are used by low-income people in two large Canadian cities to attain, maintain, and promote their health. The study also extends previous research by uncovering factors that influence urban-dwelling low-income people's use and non-use of health-related services. The consistency of findings across both data collection sites, as well as the diverse nature of the sample in terms of socio-demographic characteristics, increases our confidence about the extent to which the findings reflect the experiences of low-income Canadians living in moderate and large-sized urban Canadian cities other than Edmonton and Toronto. However, it is also likely that the experiences of our study participants differ to some extent from those of low-income Canadians living in small urban centres and rural areas. Consequently, generalization of the findings to low-income populations living outside of moderate and large-sized Canadian cities should be made with caution.

Low-income participants' perspectives on health-related services, in combination with recommendations by service providers/managers, advocates, and public servants, have several policy implications, which are particularly relevant within the context of recent discussions about health care reform in Canada. First, our study reveals that both physician services and a broad range of community-based health and social services are integral to the health and well-being of low-income Canadians. Despite the importance of these health-related services, the results also underscore the constraints that low incomes place on people's choices about the health-related services they use. Few low-income participants reported that they used recreation programs and health care services not covered by provincial health care plans. In addition, participants' low incomes made it difficult for some of them to afford transportation to health-related services. These findings support an ever-growing body of evidence that low-income Canadians are often unable to afford recreational activities, as well as many treatment-focused and preventive services for which they do not have health care coverage [39–41,74].

Nevertheless, it is important to recognize that some low-income people, who cite prohibitive costs and lack of insurance benefits as reasons for not using some health-related services, may not use the services even if there are no costs involved. Despite this reality, Livingstone et al. [61] found that low-income families living in Saskatchewan got more prescription medications filled and increased their use of both chiropractic and optometric services after the province introduced a supplementary health benefit plan, which provides coverage to low-income families for a number of treatment-focused health care services that are not

covered by the provincial health care plan. In addition, there is some evidence indicating that Canadians with dental insurance are more likely to have seen a dentist in the previous year than Canadians without such coverage [32]. Thus, it seems that while (low/no) cost, on its own, is probably not sufficient to determine people's use and non-use of health-related services, it is a necessary factor.

4.1. Increase access to health-related services

Clearly, our study, together with previous research, emphasizes the need for policies that increase low-income Canadians' access to a broader range of health-related services than those currently covered by provincial health care plans. Some recommendations by recent Canadian commissions could serve as a starting point for reforms that increase the scope of health-related services available to low-income Canadians. One such starting point is the endorsement of innovative health care delivery systems, such as primary health care, by recent national-level reviews [3,4,8]. Since 1997, when the National Forum on Health [8] proposed the need for integrated approaches to health care delivery, the federal government has provided financial support through the Health Transition Fund and the Primary Health Care Transition Fund for the implementation and evaluation of innovative approaches to health care delivery [75]. Some of the demonstration projects that have received federal funding are community-based health centres in which multidisciplinary teams of providers offer a variety of treatment-oriented and preventive health and social services [76,77]. These types of community-based health centres are consistent with the recommendation made by service providers/managers, advocates, and public servants in our study as a strategy for increasing low-income Canadians' access to a broad range of health-related services. However, our findings also suggest that a key reason that low-income people do not use health-related services that are not covered by provincial health care plans is that they cannot afford the services. Therefore, it is likely that community-based health centres will do little to increase the scope of services available to low-income Canadians unless services, such as dental care, physiotherapy, eye care, and prescription medications, are available at no cost.

In this respect, the provision of comprehensive health benefits by some provincial governments to children [59,60] and parents [61] living in working low-income families and to parents making the transition from social assistance to the labour market [62,63] are steps in the right direction—but do not go far enough. Our findings reinforce the need identified in a previous study [78] for the federal and provincial/territorial governments to ensure the provision of comprehensive health benefits to all those with low incomes, including people employed in low paying jobs, people receiving employment insurance, and people receiving student loans. In this regard, assertions by some recent national health care reform commissions and some health policy experts about the importance of expanding the comprehensiveness of publicly funded health care services in Canada are encouraging. Specifically, publicly funded provision of some prescription medications, recommended by the National Forum on Health [8], the Commission on the Future of Health Care in Canada [3], and Rachlis [79], would reduce the impediments that working low-income Canadians, who do not have health benefits through social services or Indian and Northern Affairs, commonly experience. Furthermore, low-income Canadians' access to a broader range of health-related services than what they currently use would be further enhanced if policy makers act on the call by the Commission on the Future of Health Care in Canada [3] for the ongoing augmentation of publicly funded services.

4.2. Compassionate respectful health-related services

The finding from our study that low-income Canadians' service-use is influenced by the quality of their interactions with front-line service providers also has policy and program implications. Low-income participants' service-use was restricted by interactions that lacked empathy, compassion, and respect on the part of service providers. This finding is not really surprising. Presumably, most people, regardless of income, avoid services where they have experienced dissatisfying interactions with providers in the past. There is, however, some evidence from previous research that low-income people are more likely to be treated poorly by service providers than are higher-income people [80]. Middle-class people in general, as

well as middle-class professionals more specifically, tend to have more negative attitudes and beliefs about low-income people than about higher-income people. Furthermore, there is some evidence that people who negatively stereotype low-income people tend to think that low-income people are responsible for their problems because they lack initiative and intelligence and that they squander opportunities [80,81]. Negative stereotypes about low-income people, held by some middle-class professionals and other front-line service providers, could readily result in service provision that is less compassionate, empathic, and respectful than the care provided to higher-income people.

This problem requires action on the part of service providers/managers and post-secondary educators. Our findings, together with literature about common middle-class attitudes and beliefs about low-income people, point to the need for education programs that ensure post-secondary health and social service students and providers have opportunities to address and critically examine the validity of common stereotypes about low-income people. In addition, it is important that education programs include opportunities for front-line service providers and students to develop the skills necessary for the provision of empathic, sensitive, and respectful care to all people—regardless of income, race, culture, and gender [82].

Despite the important role that education programs can play in increasing awareness, knowledge, and skills, they will not, on their own, improve the quality of interactions that service providers have with low-income Canadians. Poor treatment of low-income clients by service providers may be associated with increasing workloads and deteriorating, stressful working conditions, resulting from workforce reductions necessitated by federal and provincial/territorial government spending cutbacks to health and social services throughout much of the 1990s [3,83,84]. Tired and over-worked front-line workers are unlikely to have adequate time or energy to provide empathic, compassionate, and respectful care to all people all of the time. Again, recognition by recent health care reform commissions of the need to invest in health care providers is promising. Both the Commission on the Future of Health Care in Canada [3] and the Standing Senate Committee on Social Affairs, Science and Technology [4] outlined a number of strategies to better understand and to effectively address concerns about the supply, distribution, education, and skills of Canada's health workforce.

4.3. Beyond health care reform

Lastly, our findings about the constraints that low income placed on both the ability of participants to meet their basic needs and their choices of health-related services point to the importance of policy reforms that extend beyond health care to include a broad range of social and economic policies. As was recommended by service providers/managers, advocates, and public servants in our study, there is a need to reform social assistance, minimum wage, and housing policies to improve the socio-economic conditions that currently make it difficult for low-income Canadians to meet basic needs and access some health-related services. This recommendation corresponds with growing evidence of the influence that psychosocial factors and socio-economic conditions exert on health status [15,17,46–48,52–55] and evidence that health care services contribute no more than half of the variability in health outcomes [83,85]. In spite of this evidence, provincial/territorial health ministries, regional health authorities [86,87], and recent health care reform commissions [3,4] have all focussed the vast majority of their attention on health care services. Unfortunately, for low-income Canadians, the narrow focus on health care services casts significant doubt on the possibility that federal and provincial/territorial policy makers in the health sector will either act on their own or work with their counterparts in social service and human resource and employment sectors to develop policies and programs that improve the socio-economic conditions that influence the health of low-income Canadians.

5. Summary and conclusions

Examination of findings from this study in relation to recommendations by recent health care reform commissions leaves little doubt that low-income Canadians have much to gain from some of the proposed changes to health care delivery. In particular, low-income people's ability to access a broad range of health-related services would be enhanced with the implementation of three specific recommendations: (1) the expansion of the comprehensiveness of publicly

funded health care services; (2) community-based health centres offering a variety of treatment-oriented and preventive health and social services; (3) investments in Canada's health workforce [3,4]. However, the value of these recommendations to low-income Canadians depends on the extent to which policy makers and service providers/managers advance them beyond their current status as words on paper.

Furthermore, low-income Canadians' ability to attain, maintain, and promote their health will, ultimately, be improved by a network of social assistance, economic, and employment policies and programs, which lead to significant reductions in the rate and depth of low income among Canadians. In this regard, recent health care reform commissions have been disappointing. It is likely that the silence by the Commission on the Future of Health Care in Canada [3] and the Standing Senate Committee on Social Affairs, Science and Technology [4] regarding strategies for altering the socio-economic and political conditions within which low incomes are rooted is associated with the fact that such strategies lie outside the mandate of the health sector. Nonetheless, evidence about the negative influences of low-income status on health is well established [15–17]. As such, policy makers in the health sector have a key role to play in the initiation of partnerships with their counterparts from other sectors to develop a comprehensive network of policies that improve the socio-economic determinants of health in Canada. In addition to facilitating low-income Canadians' ability to meet their basic needs and access a broad range of health-related services, the development and implementation of such a network of policies will, over time, improve the health of low-income Canadians. Better health among Canadians with low incomes will subsequently decrease their need for publicly funded treatment-focused health care services.

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