Low-Income Consumers’ Perspectives on Determinants of Health Services Use

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Community Advisory Committee, Edmonton:
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Hersh Sehdev (South Riverdale Community Health Centre), Maureen Thompson (Regent Park Community Health Centre), Sherry Phillips (Lawrence Heights Community Health Centre), Kam Lau (York Community Services), Rick Glazier (St. Michael's Hospital and Department of Public Health Sciences).
Key Implications for Decision Makers

A deeper understanding of factors that influence low-income consumers’ use of health services will help policy decision makers create policies that are inclusive and present no barriers to access. They will also help managers to better identify the service needs of this population, to target and tailor services accordingly. This study identified patterns and determinants of health services use from the perspectives of Canadians living in poverty. It also identified actions that program managers and planners, policy makers, and the public can take to improve health care for low-income consumers. These actions include the following:

Service managers and program planners should:

- Increase accessibility, including:
  - longer hours (including weekends)
  - less waiting
  - more free services
  - easier transportation and better co-ordination between services
  - remove bureaucratic barriers
- Improve quality of service, including:
  - confidentiality
  - sensitivity training (for factors such as gender, poverty, unemployment)
- Increase consumer participation
- Communication better about services and people’s entitlements to those services
- Provide advocacy to navigate the system
- Expand services:
  - dental, eyeglasses, extended health care, mental health, emergency rooms, physicians’ services
  - also recreational, extracurricular, employment, and child care services
- Improve ways for the public to have input into service delivery for low-income people

Policy makers should:

- Focus more on broad determinants of health and meet basic needs by:
  - increasing income levels, in ways such as guaranteed income, changing social assistance rates
  - providing good, affordable housing
  - improving subsidies for basic needs
- Extend health care services and increase their quality
- Expand the range of health, social and community programs, supports, and services
- Focus more on broad determinants of health (such as housing, income, recreation)
- Increase consumer participation in service delivery
- Move past identifying problems and into actual policy change
- Be more responsive to the needs of low-income people

The public should:

- Communicate concerns to service providers, politicians and the media
- Volunteer in community organizations
- Contribute to meetings, elections and advocacy groups
- Present a united voice
Executive Summary

The Context:

A significant number of Canadians live in poverty. This is an issue of increasing importance to policy makers and service providers. Poverty affects health status and life expectancy, and limits activities. Poverty also affects health services use. This research is important to service managers and policy makers because of these factors, as well as factors relating to the organization of health services, the way services are distributed, and the gaps in knowledge about determinants of services use among the poor.

Despite growing evidence from Canadian studies on barriers to health services use, no study has looked into why and how low-income people use these services. This study therefore examined the patterns and determinants of health services use from the perspectives of Canadians living in poverty, with the view to informing programs and policies that address the factors influencing health services use by the poor. Research questions guiding this study were centred on low-income consumers’ perspectives on the health services they access; factors influencing health services use; accessibility, quality, relevance and appropriateness of available health services; and how services, programs and policies could be altered and improved to meet their needs.

Implications for Service Managers and Program Planners:

Low-income people regard community agencies and services as essential for their health and well-being. However, they recommend:

- improving the quality of services and behaviours of service providers
- increasing accessibility and awareness about available services
- enhancing existing services and making available additional (free) programs and services
- establishing mechanisms to ensure consumer input
- reducing barriers

Advocates, service managers and policy influencers spoke of the need to improve the role of agencies in the community, and to enhance the types of available services. Services could be enhanced by:

- better integration and coordination
- allocation of more resources and funding
- improvement of transportation and housing
- making services more community oriented
- expanding consumer participation
- increasing opportunities for advocacy
- staff sensitivity training
These participants’ recommendations reinforced those of low-income people regarding increasing accessibility and quality of services.

**Implications for Policy Makers:**

*Low-income participants* recommended direct courses of action to improve health services by:

- increasing government funding to improve coverage
- establishing more services for particular issues
- improving accessibility.

Indirect courses of action suggested were:

- more funding to reduce workloads in order to avoid burnout
- services for specific groups
- licensing doctors with foreign qualification
- increasing income levels, subsidizing post-secondary education
- making the systems less bureaucratic, and providing quality and affordable housing

*Service managers and policy influencers* focused on:

- providing a guaranteed income
- extending publicly accessible health care
- increasing social assistance and welfare rates.
- provision of quality affordable housing
- increasing mental health and chronic care facilities
- increasing integration and coordination of services
- making services more client-oriented, enhancing accountability
- increasing participation of low income people

**Implications for the Public:**

The low-income participants recommended ways to improve service delivery ranging from individual to group action. Individual efforts include: completing surveys or participating in research studies, attending committee meetings, documenting concerns, using suggestion boxes, speaking with service providers directly, signing petitions, communicating with politicians, avoiding providers that do not show concern for clients, writing letters, running for boards, volunteering, voting in elections, participating in community activities (for example, big parent initiatives), making use of role models, and advocacy by higher-income people. Group actions suggested were: coming together as communities to present a voice, and uniting to elect representatives who relate to concerns of low-income people.

**The Approach:**

This was an exploratory, descriptive and qualitative study of the determinants of health services use by low-income consumers. Three main sources of data were; socio-demographic data forms, individual interviews using interview guides (Phase 1), and focus groups (Phase 2). The study was also
participatory in nature — trained low-income interviewers conducted interviews with low-income users of health services.

**The Results**

Many participants reported using some form of health services and/or community-based services to survive. Services were also viewed as a means to alleviate isolation and cope with stress. The main themes to emerge from the analysis of Phase 1 data include factors influencing utilization of and experiences with health services, and recommendations for improving services and changing policies. Diverse factors influenced use of a variety of agencies and services by having an impact on ability or desire to use services. Competence, confidentiality and the need to be self-reliant emerged as major factors influencing use of services. The ability of providers to listen to, understand, empathize with low-income people, and treat them with respect, influenced use of services. Access to services also depended on proximity, affordability, and convenience of services, knowledge of their existence, and inequity based on low-income status, racism, physical appearance, and the surrounding neighbourhood. Many of the responses revealed people’s experiences with services, as well as needs for services that were met and those that were not. Participants mentioned informal (such as self-diagnosis/treatment) and formal strategies (such as religiosity) that they used to cope with everyday demands. Participants indicated that their low-income status left them with little choice of services to access.

In Phase 2 low-income focus groups reinforced the findings cited above. Participants highlighted the gaps in coverage of existing services. Apart from identifying services that do not meet their needs, participants also pointed out a variety of needed services that are not available. In discussing the action they had taken to address their concerns, participants mentioned corresponding with officials and attending meetings. Participants concurred that there was a need to promote awareness about poverty and create links between the poor and advocacy community organizations to communicate their messages.

The focus groups conducted with advocates, service providers, and policy makers supplemented and reinforced the interviews with low-income consumers. Disjointed policy making, the growing gap between rich and poor, government inaction on issues such as housing, mental and public health were cited as causes of poverty. At a policy level, impediments to quality service provision were identified such as a sluggish and overburdened system, difficulty moving past problem identification toward effective policy creation, and inequitable treatment of low-income people. At a services level, participants spoke of problematic service provider behaviours, high service provider turnover due to burnout, and long waiting lists. The ineffectiveness of agencies and their current practices in dealing with poverty compounded these barriers. There was unanimous agreement that strategies for improving health should be more preventive, focusing on systemic changes that address major determinants of health such as income and housing. Other strategies recommended were: intersectoral action (at higher levels), better integration and co-ordination of services at the community level, staff sensitivity training, redefining poverty, increased accessibility and promotion of (free) programs, and greater consumer input.
The Context

Despite Canada’s relative affluence, 17.4% of Canadians live in poverty (National Council of Welfare, 1997). Poverty is an increasingly important issue for both policy makers and health service managers in Canada. Canadians who live in poverty have poorer health status, whether measured by self-rated health, lower life expectancy, health problems, or activity limitations. Although little is known about how and why health service use decisions are made, low-income consumers are disadvantaged. A combination of factors – growing urban poor populations, increasing emphasis on client-centered health services delivery, relative disadvantage of low-income consumers, poorer health of those with low incomes, knowledge gap about determinants of health services use among the poor – suggests the potential importance of this research for service managers and policy makers.

A deeper understanding of factors that influence poor consumers’ use of health services will help policy decision makers to ensure that policies are inclusive and present no barriers to access, and managers to better identify the service needs of this population, and target and tailor services. There is an increasing body of research that identifies barriers to use of health services in Canada. However, no Canadian studies were found identifying patterns and determinants of use of health services by low-income groups. Research is needed to inform programs and policies that address the underlying determinants of health services utilization by the poor. Accordingly, the purpose of this study was to identify the patterns and determinants of health services use from the perspectives of Canadians living in poverty and the implications for programs/services and policies.

Research Questions: Four research questions guided the study. What are low-income consumers’ perspectives on: (1) which health services they access? (2) determinants of health services use? (3) accessibility, quality, relevance and appropriateness of available health services? (4) how services, programs and policies could be altered and improved to meet their needs?

The Implications

The implications for programs and policies are summarized for each site, each phase of the study, and each group of participants. Common themes are described in the Executive Summary and Main Messages.

1. IMPLICATIONS FOR SERVICE MANAGERS AND PROGRAM PLANNERS

Edmonton

Phase 1: Low Income Individual Interviews
Low-income people view community agencies and health agencies as essential in providing services they need, not only for their personal health and wellbeing, but also for their families.
Phase 2: Low-Income Focus Groups
Low income participants in Edmonton recommend the following strategies

- **Provide more outreach programs** (e.g., extending home care coverage, home making services for those not able to do their own).
- **Ensure that people are made aware of services** through effective communications and an improved referral system (e.g., community papers, radio, and bulletins in public places).
- **Improve customer services and treatment** (e.g., reducing stigmatization, not to treat customers as numbers).
- **Provide training programs** (e.g., skills development/job training and social skills training for low-income people; health education so that people can take care of themselves).
- **Increase health coverage** (e.g., providing more affordable services, increased access to Fee Reduction programs and Parks and Recreation).
- **Increase accessibility to services** (e.g., by making telephone a basic need in every home and reducing the basic monthly charges to facilitate contacting emergence services and to be able to give telephone number to prospective employers when doing a job search, and making transportation available).
- **Programs and services should adopt a holistic focus**, not separating physical from mental health.
- **Co-opt low-income people into service managerial positions** because they have been there, and they are aware of the needs of the poor.
- **Implement strategies that reduce nosocomial illnesses**.
- **Document consumers’ concerns and complaints and acting upon them**.

Phase 2: Advocacy/Service Managers/Policy Influencers Focus Groups
Participants in Edmonton (mainly in the advocacy focus group), spoke of the need to improve the role and presence of agencies in the community. Specific recommendations for improving services emerged when participants identified the need:

- **to improve funding, transportation, and housing**.
- for intersectoral communication
- **to improve the role of agencies in the community**
- for networking services in communities to avoid fragmentation
- **to make services and programs community oriented**.
- **to increase consumer participation** (e.g., interacting with the poor in order to get their input and make them reach out for services.)
- **to increase accessibility of services** (e.g., making phones available in homes, affordable transportation, comprehensive services such as establishing primary health care one-stop-shops.)
- **to provide opportunities for advocacy** (e.g., empowering CACs to ensure their voices are heard; creation of consumer groups in various sectors; getting non-traditional partners involved, such as finding allies that are key leaders in the community and are influential with politicians.)
- **to improve the quality of services** (e.g., by developing a curriculum that teaches service providers good communication skills and how to treat people as human beings.)
Toronto

**Phase 1: Low Income Individual Interviews**
Four strategies to enhance programs and services were suggested.

- *Increase accessibility* - 25% of participants reported that services could be improved by increasing accessibility through providing longer hours, faster service, transportation, and age appropriate services.

- *Improve the quality of services* - 30% of participants reported a range of possibilities as to how services could be improved or upgraded, including: improvements to the cleanliness of recreational facilities, decreasing eligibility criteria for some services, improving the quality of food available at food banks, improved safety in homeless shelters, greater individual/personal service, and improved comprehensiveness to services.

- *Improve service provider behaviour* - 10% of participants believed that service providers’ behaviour could be improved; for example, by providing more personal service, being kind, sensitive, and respectful, regardless of social class.

- *Increase promotion of services* - 10% of participants reported that information about services available should be promoted and easier to access.

**Phase 2: Low-Income Focus Groups**
Five strategies to improve services were suggested.

- *Enhance existing services to reduce barriers* (e.g., more staff, reduce waiting time in E.R. and for doctor appointments, add evening/weekend hours, provide transportation fare or subsidy, access for disabled persons)

- *Provide additional (free) programs/services* (e.g., parenting, recreational, counselling, adult education/life skills, ESL classes, drop-in programs, interpretation, relaxation classes, transportation to school for children, programs for seniors and disabled persons, day care spaces).

- *Improve service provider behaviour* - provide staff training to improve sensitivity to working with people on low incomes

- *Improve quality of service* (specific changes to many different programs were identified; no distinct pattern across sites, except for food bank service that came up at two sites)

- *Increase promotion of programs and entitlements* (i.e., free services, especially those necessary to survival – free meals, clothing, accommodation and to being a newcomer to Canada)

**Phase 2: Advocate, Service Provider, Policy Focus Groups**
These participants believed that services could be improved as follows:

- Improve integration and coordination of services (*e.g., creation of single access points*)

- Provide staff sensitivity training

- Allocate resources to train staff in advocacy or hire advocates to assist consumers to navigate systems
• Allocate resources to service provider self-care and professional development to prevent burn out, which could be the cause of poor treatment of consumers
• Provide opportunities for greater consumer input in program design
• Increase promotion and access to programs and entitlements
• Provide more recreation and mental health programs/services
• Provide interpretation services

Table 1: Themes in Implications for Service Managers and Program Planners

<table>
<thead>
<tr>
<th>Site</th>
<th>Low-Income People</th>
<th>Advocates, Service Providers, and Policy Influencers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Recommended</td>
<td>Actions</td>
</tr>
<tr>
<td>Edmonton</td>
<td>Creating more outreach programs</td>
<td>Improved funding, transportation, &amp; housing</td>
</tr>
<tr>
<td></td>
<td>Improved treatment of clients</td>
<td>Increased intersectoral collaboration</td>
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<tr>
<td></td>
<td>Increased health coverage</td>
<td>Improved role of agencies in communities</td>
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<tr>
<td></td>
<td>Increased accessibility to services</td>
<td>Increased accessibility of services</td>
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<tr>
<td></td>
<td>Increased consumer participation</td>
<td>Increased consumer participation</td>
</tr>
<tr>
<td></td>
<td>A more holistic focus in programs</td>
<td>Increased networking of community agencies</td>
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<td></td>
<td>Increased communication of services &amp; entitlements</td>
<td>Making programs more community oriented</td>
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<td></td>
<td></td>
<td>Creating opportunities for advocacy</td>
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<td></td>
<td></td>
<td>Improving quality of services</td>
</tr>
<tr>
<td>Toronto</td>
<td>Increased accessibility</td>
<td>Increased accessibility to programs</td>
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<tr>
<td></td>
<td>Improved service provider behaviour</td>
<td>Provision of staff sensitivity training</td>
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<tr>
<td></td>
<td>Improved quality of services</td>
<td>More resources for staff advocacy training</td>
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<tr>
<td></td>
<td>Provision of additional (free) services</td>
<td>Improved integration and coordination of services</td>
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<tr>
<td></td>
<td>Increased promotion of programs</td>
<td>More resources for professional development</td>
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<td></td>
<td>Increased promotion of entitlements</td>
<td>Increased opportunities for consumer participation</td>
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<td></td>
<td>Enhancing existing services to reduce barriers</td>
<td>Increased promotion of entitlements to programs</td>
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<tr>
<td></td>
<td></td>
<td>More recreation and mental health programs</td>
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<td></td>
<td></td>
<td>Provision of interpretation services</td>
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</tbody>
</table>

Summary of Implications for Service Managers and Program Planners

Prevalent themes across sites and respondent groups were expanded accessibility, increased health services coverage, improved quality of services, enhanced service provider training, increased intersectoral collaboration and coordination of services, increased consumer participation, communication of services and entitlements, and expanded range of services (e.g. recreation, housing).

2. IMPLICATIONS FOR POLICY MAKERS

Edmonton

Phase 2: Low-Income Focus Groups

Participants discussed both direct and indirect courses of action for policy-makers to take in order to improve health services. Direct courses of action involved:

• improving coverage and subsidy for basic needs and health services (e.g. bringing essential dental services into the public health care, making sure psychologists are covered through Alberta Health Care.
• establishing more service programs (such as Candora).
• eliminating the two tiered health care system which denies medically necessary and medically related services for people with chronic and permanent medical problems
and in home care service.

- **improving accessibility** by making sure low-income people do not fall into the welfare trap (e.g., failing to access services because they are not poor enough, yet they cannot pay for the services themselves because they do not have enough money).

Indirect action included:

- **providing more funding to service providers** so that service workers are not overworked (Overworked workers were seen to be impersonal and rushed clients. Higher wages for service workers were seen as a good compensation for burnout.), as well as to reduce waiting periods.
- **providing better services to specific groups**, such as people with mental illness, women (especially mothers), children (especially under three years of age) and refugees.
- **increasing the number of doctors** by licensing foreign trained/immigrant doctors.
- **raising the minimum wage.**
- **subsidized post-secondary education so that people get better jobs.**
- There was also discussion around faults within the system and its overly bureaucratic nature, such as the need to improve the appeals process and to decentralize power to make the system more responsive to the consumer.

**Phase 2: Advocacy/Service Managers/Policy Influencers Focus Groups**

At the systemic level, participants identified both direct and indirect changes needed in the system, such as:

- **providing a guaranteed income**
- **extending publicly accessible health care**
- **tying fixed income to a “basket” of price increases**

To address the more deep-rooted problems in the system, the following mechanisms were suggested:

- **communicating the costs of inaction in addressing poverty**
- **re-defining services to be more client-oriented**
- **making people more accountable**
- **working with politicians in a more constructive manner**
- **accessing the powerful political voice of low-income people.**

**Toronto**

**Phase 1 and 2: Low-Income Focus Group**

The focus group participants reinforced the views of interview participants that change has to occur at a systems level.

- Increase government funding - 30% of (phase 1) participants wanted services to be improved by increasing government funding to services, employing more staff, reducing costs for consumers, and making services more affordable.

- Provide additional resources to particular service areas - 30% wanted more affordable recreation, extra-curricular, social, and arts programs available.
Provide coverage for extended health services - 15% of participants believed more health services were needed; for example, expanded coverage for prescriptions, dental, chiropractic, massage, and athletic or physiotherapy services.

Expand existing social and community services - 10% of participants also recommended expansion of affordable social or community services; for example, more skill development and ESL classes and greater assistance with concrete/practical concerns (e.g., clothing banks and provision of transportation or bus tickets), services for particular groups (students/youth, disabled, seniors, homeless).

Increase income levels through changes to social assistance or tax breaks to meet basic needs.

Provide quality, affordable housing and rent control policies.

**Phase 2: Advocacy/Service Managers/Policy Influencers Focus Groups**

- Increase social assistance and general welfare rates
- Provide quality, affordable housing
- Increase integration and coordination of services at funding/reporting level
- Increase mental health and chronic care facilities

**Table 2: Themes in Implications for Policy Makers**

<table>
<thead>
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<th>Low-Income People</th>
<th>Advocates, Service Providers, &amp; Policy Influencers</th>
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<tbody>
<tr>
<td></td>
<td><strong>Recommended</strong></td>
<td><strong>Actions</strong></td>
</tr>
<tr>
<td>Edmonton</td>
<td>Improved health services coverage</td>
<td>Provision of a guaranteed income</td>
</tr>
<tr>
<td></td>
<td>Improved subsidy for basic needs</td>
<td>Extending publicly accessible health care</td>
</tr>
<tr>
<td></td>
<td>Creation of more service programs</td>
<td>Matching fixed income to price increases</td>
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<tr>
<td></td>
<td>Improved accessibility</td>
<td>Making services more client-oriented</td>
</tr>
<tr>
<td></td>
<td>More funding to service providers</td>
<td>Increasing accountability of people</td>
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<td></td>
<td>Better services to specific groups</td>
<td>Increasing the participation of low-income people</td>
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<tr>
<td></td>
<td>Licensing foreign-trained doctors</td>
<td>Working constructively with politicians</td>
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<tr>
<td></td>
<td>Raising the minimum wage</td>
<td>Communicating costs of inaction in addressing poverty</td>
</tr>
<tr>
<td></td>
<td>Subsidising post-secondary education</td>
<td><strong>Provision of a guaranteed income</strong></td>
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<tr>
<td></td>
<td>Avoidance of two-tiered health care system</td>
<td>Extending publicly accessible health care</td>
</tr>
<tr>
<td></td>
<td>Decentralization to allow for consumer participation</td>
<td>Matching fixed income to price increases</td>
</tr>
<tr>
<td>Toronto</td>
<td>Increased income levels</td>
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<td>Additional funding for certain services</td>
<td>Increasing accountability of people</td>
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<td>Provision of quality, affordable housing and rent control policies</td>
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<td></td>
<td>Coverage of extended health services</td>
<td>Communicating costs of inaction in addressing poverty</td>
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<tr>
<td></td>
<td>Expanding existing social &amp; community services</td>
<td><strong>Provision of a guaranteed income</strong></td>
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</table>

**Summary of Implications for Policy Makers**

Prevalent themes across sites and respondent groups were: extended (publicly accessible) health services coverage; increased income levels (e.g. guaranteed income, social assistance/welfare rates); provision of quality, affordable housing; improved subsidy for basic needs; mobilize consumer participation; and expanded range of health, social and community programs, supports and services.

### 3. IMPLICATIONS FOR THE PUBLIC

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Edmonton

Phase 1: Low-income People
About a third of the participants (43%) indicated that they had provided input on what or how services and programs are delivered. Some of the situations and strategies that have been used by participants to provide input are:

- *Communicating their concerns directly to service providers* (e.g., suggestions to enhance existing programs/activities and/or expanding their scope.
- *Attending meetings/discussion groups* (e.g., voicing opinions in discussion groups, meetings or workshops.)
- *Communicating with politicians*
- *Signing petitions*
- *Completing surveys/questionnaires* (e.g., the current research project, and feedback cards regarding experiences with the health care system available at the physician’s office.)
- *Media* (i.e., speaking with a newspaper reporter, writing to the newspaper.)

Phase 2: Low-income Focus Groups
In terms of individual action/empowerment, participants spoke of:

- *Exercising choice by avoiding service providers* (e.g., doctors) that show no concern for the patient.
- *Use of the library* (i.e., reading self-help books, playing chess), in order to feel good.
- *Writing letters of complaint to opposition leaders.*
- *Running for the board in order to make input.*

With regard to providing input/taking action, the following suggestions were made:

- *Participating in studies such as the present study.* Engaging low-income participants in studies like this gives them skills to use in bettering their community.
- *Voting in elections.*
- *Participating in programs* such as 'Participation Canada' — in the verbal sense, not physical (where there is an exchange of ideas from everyone), with the idea of improving services.
- *Communities coming together to present one voice,* not as isolated communities.
- *Working together and awakening in low-income people the confidence/empowerment to act.*
- *Working as volunteers with different organizations* for self-fulfillment and to help others.
- *Getting united/together* in order to get representatives that relate to low-income people in positions of power in order for low-income voices to be heard.
- *Making use of role models* to teach youngsters to be physically responsible and forward thinking in their goal setting (e.g., exposing youngsters to the wider community through role models).
- *Non-low-income persons helping the poor/be spokespersons for the poor.*
- *Big Parent initiatives* (to benefit families where both parents are employed and cannot give their children enough attention).

Toronto
Phase 1: Low-income consumers

- Many participants did suggest different ways that low-income consumers could provide input on service delivery including: attending committee meetings, documenting concerns, and by suggestion box. (Unfortunately, not all participants were asked this question.)
- About 40% of participants had taken the opportunity to provide input on how services or programs were delivered by speaking with service providers directly, attending meetings, signing petitions and using a program/agency suggestion box.

Table 3: Themes in Implications for The Public

<table>
<thead>
<tr>
<th>Low-Income People</th>
<th>People</th>
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<tr>
<td>Recommended Actions</td>
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<tr>
<td>Communicate concerns to service providers, media &amp; politicians</td>
<td>Documenting concerns</td>
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<tr>
<td>Attending meetings/discussion groups</td>
<td>Attending committee meetings</td>
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<tr>
<td>Signing petitions</td>
<td>Signing petitions</td>
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<tr>
<td>Taking part in surveys/studies</td>
<td>Using suggestion boxes</td>
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<td>Exercising choice of providers</td>
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<td>Use of the library</td>
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<td>Running for boards to provide input</td>
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<td>Voting in elections</td>
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<tr>
<td>Communities presenting one united voice</td>
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<tr>
<td>Volunteering (e.g., in Big parent initiatives)</td>
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<tr>
<td>Using role models</td>
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Summary of Implications for Public

Low-income participants recommended the following actions for the public: communicate concerns to service providers, politicians and the media; volunteer in community organizations; contribute to meetings, elections, and advocacy groups; and, present a united voice.

4. CHALLENGES TO CHANGE

Edmonton

Phase 1: Low-income People

Forty-five participants indicated that they had not attempted to provide input on what or how services and programs are delivered. Several reasons were given for not providing input, including:
- Perceived ineffectiveness (This was expressed as a feeling of powerlessness.)
- Inadequate opportunities (ranging from: never being asked to provide input, unaware of who to contact, to not having adequate information about opportunities for participation.)

Phase 2: Advocate, Service Provider, Policy Focus Groups

- Stigmatization of poverty.
- Service provider burnout.
- Cutbacks, and reliance on government resources to tackle local problems.
- Lack of consensus on standardized measures (e.g., workable or widely accepted poverty measures; lack of criteria or audit to standardize health care waiting lists.)
- Systemic barriers (e.g., bureaucratic red tape that also makes it hard for people to get involved; traditional professional training procedures favouring scientific approach above people's voices/stories.)
- Lack of information about available resources/programs.
- Providers' policy of not volunteering information on eligibility for services.
- Little value attached to children's services.
- Cultural differences influencing utilization patterns.
- Conflicting/unhelpful political agendas.

**Toronto**

**Phase 1: Low-income People**
- About 26% of the participants indicated that they had not tried to provide any input on service delivery. The reasons for not doing so included apathy, not knowing how to provide input or inadequate information about how to provide input, perceived indifference of service providers, and shyness or personal barriers. (Unfortunately, not all participants were asked this question.)

**Phase 2: Advocacy, Service Provider, Policy Influencers Focus Groups**
- Limited avenues for consumer input on program design and delivery

**Summary of Challenges**
Low-income participants viewed challenges to change as both intrinsic (e.g., apathy, perceived ineffectiveness, shyness) and extrinsic (e.g., inadequate opportunities, inadequate information about how to provide input). On the other hand, participants in the advocacy, service provider and policy influencers’ focus groups voiced concerns over systemic challenges such as: lack of consumer input, lack of information about services and entitlements, service provider burnout, and systemic barriers.

**5. IMPLICATIONS FOR DISSEMINATION**

**Edmonton**

**Phase 2: Low-Income Focus Group**
When asked about who should be told about the results of the present study, participants identified several key audiences, including media sources, students in school, the general public, service administrators and advocacy groups, governments at all levels, the upper class, the Prime Minister and the Premiers. They stressed the importance of tailoring messages appropriately, so as to avoid desensitization among the listeners. This would be done by repackaging the way you present it for each different group you present it to, whether it’s the big corporate interests or health care professionals, so that you can pull on the strings that will make them jump.
Phase 2: Advocate, Service Provider, Policy Influencers Focus Groups
There was consensus that research reports ought to be tailored for different audiences based on where it is being sent. Some target groups mentioned were:

- Parkland Institute
- Fraser Institute
- Western Economic Development
- Chambers of Commerce
- Service Clubs

Strategies for dissemination include:
- Low-income people’s workshop for
- Speaking engagements
- Video for educational purposes
- Television public service announcements, press releases
- A speakers bureau for people living in poverty.

Toronto

Low-Income Focus Groups
Target audiences include:
- Members of Provincial and Federal Parliament & City of Toronto Councillors
- Ontario Premier
- City of Toronto Mayor
- School boards
- Agencies that help the homeless (e.g., shelters, hostels, drop-ins)
- Supervisors and the management of social services
- Doctors, dentists, health facilities
- Community health centres, as well as other community organizations

They suggested that the findings be disseminated through:
- community television, newspapers and radio
- community meetings, group discussions

Advocate, Service Provider, Policy Influencers Focus Groups
They recommended that study results be communicated to:
- District Health Council
- Community Health Centres
- Ministry of Health and Long Term Care
- Members of Provincial and Federal Parliament
- Health Canada
- Advocacy groups
- Internet users
**Summary**

Target audiences identified by participants include the general public, advocacy groups, service providers and agencies, research institutes, and various levels of governments. The strategies for dissemination identified by participants include the media (i.e., newspapers, television, and radio), group discussions and/or meetings, and workshops.

**The Approach**

**Phase 1**

Participants were recruited by purposive sampling through various community agencies that work with low-income people on a daily basis. Agencies were selected to provide a cross-section of the low-income population that represents various groups predisposed to poverty in the study cities. In Edmonton, this included agencies that work directly with inner-city, immigrant, aboriginal, and single-parent people and the homeless. In Toronto, this involved working with agencies in certain geographic areas with a high degree of poverty.

A team of peer-interviewers collected data in Phase 1. Low-income people were hired by the research project and participated in a workshop to train them in the fundamentals of interviewing technique. In both sites, the same semi-structured interview guide was employed to ensure consistency in questions (see Appendix 1).

**Phase 2**

Phase 2 of the project involved a series of focus groups conducted with members of the low-income population, advocacy groups, service managers, and policy-makers/influencers. The purpose of the focus groups was to confirm and clarify the findings of Phase 1, while gaining the perspective of those who are in positions to act upon them. For the low-income focus groups, participants were selected from among those who had been interviewed in Phase 1 (two focus groups in each site) and by recruiting new participants (two focus groups in each site). For the advocacy, service manager, and policy influencer focus groups, intense efforts were made to recruit members from varied organizations at the local, provincial, and federal levels. A professional report summarizing the findings of Phase 1 was sent to potential participants to lend credibility and to stimulate interest in the research project. The same interview guide was used in both sites to promote consistency (Appendix 2).

**Interviewer Involvement**

The participatory approach to employing and training low-income interviewers had several spin-off benefits. Foremost, the experience of learning and conducting academic research in collaboration with university staff enabled interviewers to expand their communications and public speaking skills. This benefited the overall quality of the research, as the interviewers spoke eloquently on several occasions at conferences and presentations. This approach also benefited the interviewers from a capacity building perspective. Their involvement in the project increased their employability, as evidenced by the fact that some obtained jobs after the project. In addition, their involvement served to promote research in their communities, thus establishing stronger ties between academia and the people living and working in low-income areas. The interviewers became strong advocates of the research.
The use of low-income interviewers also benefited the project by addressing the issue of power relations between interviewer and interviewee. The fact that the interviewer was from a similar background helped participants feel more comfortable and open during the interviews. From the transcripts, it is evident that the interviewers were able to speak to participants from their own experiences with poverty and were empathetic. Low-income interviewers also contributed to the Phase 2 focus groups by presenting the findings from Phase 1, and helped to ground the discussions by relating their personal perspectives to the other participants. It should be noted that some depth might have been compromised in the Phase 1 data, due to the low-income interviewers’ inexperience with probing.

**Data Analysis**

All individual and group interviews were tape recorded for later transcription for data analysis. Interview transcripts were initially subjected to content analysis using a category system of key concepts and themes before coding. Inductive analysis was used to define the categories for the coding and explicit coding rules were followed to ensure the development and refinement of a coding framework. Inter-rater agreement by the two independent coders in both Edmonton and Toronto was assessed until it reached 80%. With a coding framework developed in QST NUD-IST qualitative data analysis software, the coding process comprised extracting significant statements from transcriptions and placing them into the agreed upon categories or nodes. Teams from both sites met regularly to ensure consistency and comprehensiveness of the analysis.

**Multi-Site Coordination**

This project was conducted in two cities, each with a sub-set of researchers and administrative staff. The compelling advantage of this approach was the ability to compare and contrast the set of findings between sites and differences in their participant profiles. Furthermore, the sample size and representativeness were enlarged. However, one challenge in co-ordinating the two research teams was scheduling cross-site meetings. From an administrative standpoint, the distance made consistent communication difficult, although strategies were put in place to handle this challenge (e.g. email, teleconference meetings, site coordinators).

**Site Community Advisory Committees**

The Community Advisory Committee in each site advised the Research Team on the design and implementation of the project and on dissemination of the project’s findings. Their responsibilities included:

- To review the project design and to provide suggestions to the research team
- To ensure that the project was appropriate to the low-income population of the participating communities and to the providers of health and health-related services
- To promote the value of the project in different settings (i.e., low-income people, health and health-related service providers, government, and current and future funders)
- To help understand and interpret the results of the study
- To help the research team develop strategies for using the project’s findings at program and policy levels

**Sample**

**Phase 1**: 200 low-income people (100 in Edmonton and 100 in Toronto). The demographics of the sample are described in Appendix 3.
Phase 2:

Edmonton
29 low-income people
10 advocates
7 service managers
9 policy makers/influencers

Toronto
23 low-income people
11 advocates
10 service managers
6 policy makers/influencers

The Results

Edmonton
Phase 1: Low-income People Interviews

The findings of Phase 1 were reported to CHSRF in 2000. Briefly, three major themes emerged from the analysis of Phase 1 data: factors that influence low-income people’s use of health services, their experiences with health services, and their recommendations for improving services and changing policies.

Factors Influencing Use of Services. Participants had both positive and negative comments regarding a wide variety of agencies and the services they offered, both of which impacted their perceived ability or desire to use them. Many of their comments involved their experiences and perceived acceptability of health services providers.

*Just the friendly, unjudgmental attitude of the resource workers. They don’t look down their noses at you, or they don’t make any judgments. They don’t judge you.*

Competence and confidentiality was a major concern that influenced participants desire to access services:

*The Food Bank was really embarrassing to go to, and she didn’t tell anybody about it, and they’re confidential, things like that. That’s what I like about it, is that they can keep things quiet.*

In addition, the ability of providers to listen to, understand, and empathize with low-income people were listed among factors influencing use.

Participants’ ability to access services depended on proximity, affordability, convenience, and knowledge of their existence.

Experiences with Services. Participants expressed varied experiences with health services. First, the services identified included those serving basic needs such as food, shelter, and clothing; community services such as recreation; and health care services. Across all three types of services, participants identified needs that were met and needs not met.
A broad theme of “coping” emerged from Phase 1, where participants discussed the informal and formal strategies they employed to cope with everyday circumstances relating to poverty, and the role services played in helping them to cope. One respondent revealed her personal experience of inadequate and inappropriate help in a time of need:

*What happens when you slide or when you’re at the bottom? There should be people there to help you. In some circumstances there’s so many people that suffer internally, and I was one of those people who internalized things and blamed myself, and I had shame and guilt, and I think it made me sicker in a mental way because I was worthless.*

Another respondent speculated on what her life would be like if the services she accessed were no longer available:

*They’re pretty important right now, because if I didn’t have some services I’d 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.*

Religion played a profound role in many low-income people’s lives. Respondents mentioned the church community and formal services as a means to cope with life and find support. Finally, a theme of “self-reliance” emerged from participants’ dissatisfaction or avoidance of health services. Participants discussed self-diagnosis/treatment, their use of social support, their emphasis on healthy lifestyles, and self-education as viable and often preferable means of dealing with their own health independent of formal services.

**Recommendations to Improve Services.** A variety of recommendations came out of the Phase 1 interviews, both for improving or expanding existing services and for implementing strategies to change the system as a whole. Many of these low-income people wanted improved accessibility to services. Temporal accessibility was emphasized. For instance, longer hours of service, shorter waits for doctors and specialists, and services on weekends were needed as expressed by the following participant:

*Just pay more attention to everybody, because it is lacking. People come in there, are left sitting for hours, you know, waiting.*

With regard to financial accessibility, some respondents wanted more free services. Some respondents felt Alberta health care premiums should be eliminated.

*Actually there is two things that would make the health care system easier, and that would be getting rid of the Alberta 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 that they would actually be doing justice to the poor.*

Some participants reasoned that removal of bureaucratic barriers could also enhance access to services. Transfer of records across provincial boundaries posed bureaucratic problems. Some pointed to the need for unlimited coverage without imposed limits, while others stressed the importance of physical or geographic accessibility. They wanted transportation to services, multiple services in one site, home visits and outreach services. Some suggested that access could be improved if services were expanded in number and scope. It was also believed that expansion of existing services could help to improve access.

Improved quality of services also featured as a major concern among participants. In their view, confidentiality, gender sensitivity, and accountability were important attributes of services. Some
thought the quality of services could be improved by increasing the number of staff. The following words from one participant articulate this concern:

Well, I would like to see... an adequate amount of doctors and clinics and things, because I feel that there is not enough physicians that are willing to work in clinics.

Another common concern was increased government funding for services and programs. There needs to be more money put into the health services, child care, schools, stuff like that.

Other participants wanted to see more comprehensive services, including extracurricular and recreational programs, employment services, and child care. Services for youth and children were considered particularly important, as indicated by the following participant:

(We need) more help for kids and stuff like that. More things for the younger generation, I guess, so they don’t fall in the same trap that other people have.

Information about available services also emerged as a common theme:

(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.

Social marketing could help promote services. Services for people on low-incomes are available, but many do not hear about them or know how to access them. Participants therefore suggested that information about available services should be more effectively disseminated.

Phase 2

Low-Income Focus Groups. Overall, low-income focus group participants reinforced the views expressed in the individual interviews. One participant noted how the Phase 1 findings reflected her previous experiences with the health care system:

Oh yeah. I’ve been to other meetings where I heard different topics, including the health care about other things, and that’s pretty much the same, the scenario you know. And everything that’s here is true you know, about the health system. It’s the pits. The real pits. For the land of milk and honey, you know.

Participants in these focus groups discussed several areas where existing services and supports have not met their needs and suggested ways of improving them. For example, one participant commented on how existing services, as they are currently structured, often do not meet the needs of low-income people:

In a lot of cases you’re not treated as an individual, you’re treated as a number. You’re a number. It’s very impersonal, and there are very many reasons why it’s that way, but it’s not effective and it’s not very good...that contributes to people’s feeling stigmatized.

Participants were also quick to point out a variety of services that are not currently available to low-income people. Their comments centered on programs for children, employment, housing, and education. In particular, there was concern that lack of opportunities for children made parenting difficult, especially when faced with limited income and conflicts with work:

Where do I find (recreational) activities for the younger groups? There ain’t many out there that will deal with the one-year-olds and the two-year-olds. It’s all three and up. Well, what am I supposed to do? They’re still, they’re little people. They want to get in there. They want to interact, but there ain’t much out there.
Participants discussed their personal experiences in taking action regarding their concerns and frustrations with the system. One participant described writing to a government leader to communicate the inability of government assistance to help her find meaningful work:

I said I want to learn, I want you guys to stop...putting us on work fair, making us do work for nothing, and giving me a job that I don’t want to do...and I said this is enough of it, I’m fed up with this.

There was a considerable amount of discussion around suggestions for providing input. Participants mentioned several interesting and innovative ways to promote better service delivery to low-income people through communication, education, and participatory action. They stressed the need to promote awareness about poverty and emphasized the importance of partnerships between low-income advocacy groups and organizations with the capacity to communicate their message (e.g., communications students, community advocacy groups). Most often, participants recommended that their message should be heard by governments at all levels. One participant stressed the need for collective action in addressing the systemic barriers faced by the low-income community:

They’re put there to be brought down, to get rid of—barriers, you know? Everybody’s got to work at it. Maybe one, two, three people can’t do it alone—it takes a team to tear down barriers. And without a team it’ll never happen—these kind of barriers that we face today on these low incomes.

Advocates/Service Managers and Policy Influencers Focus Groups. The series of separate focus groups conducted with members of advocacy organisations, service providers, and policymakers reinforced the findings of the individual interviews and the perspectives of the low-income focus groups. Participants spoke from their personal experiences in working with the low-income population, and were quite frank in their discussions of the problems they faced in service delivery and policy-making. In all three focus groups, participants discussed what they perceived to be the root causes of poverty, citing examples of disjointed social policy and pointing to the growing gap between the province’s wealthy and poor. For example, one participant suggested that current government policies make it increasingly difficult for low-income people to meet their basic needs:

Government policies right now are doing things that are driving up the cost of essential services to everybody. It’s having a huge impact. You look at the Statistics Canada information—poor people are losing even more of their income than they did five years ago to the basics of food and shelter.

Other participants noted that government inaction resulted in specific problems related to housing, mental health, and public health.

Another theme that emerged was the effectiveness of agencies and their current practices in dealing with poverty. One participant in the advocacy focus group noted:

Sometimes I feel that we’re part of the problem rather than part of the solution, because everything we do to fill in the gaps take the onus off government doing it properly in the first place.

Participants felt that the solution to this problem was through intersectoral action and that real progress can only be made by coming together to alleviate the problems faced by low-income people:

So how can low-income people be involved in making changes? Everybody’s got to be involved in making changes, so somehow, we’ve got to shift the paradigms so that within communities it’s everybody’s business. So it’s not about “we’re going to help
Challenges to change were a prominent theme during all three focus groups. Participants identified several problems within the system at individual, provider, policy, and societal levels. At the individual level, some participants discussed how informal community care is utilized by low-income people, and that these informal supports are not recognized by the system. Another problem with health services utilization is that these services are often seen as a last priority by people whose limited income must first be spent on basic needs. At the provider level, participants emphasized that the system is already overburdened, making positive change difficult due to limitations on resources, time, and money. One participant depicted this problem in terms of a race:

*All I can do at the moment is stop it from getting worse, and that’s what we’re basically doing. We’re running as hard as we can to stop it from getting any worse than it is.*

Another participant maintained:

*We have no time to think about how to make it better, and I think perhaps what we have to do is admit the fact that we can’t stop it from getting worse until we take the time to work on making it better.*

Finally, a third participant pointed to a member of the research team who was acting as the group facilitator:

*We don’t have time and money to do it, so you gotta do it.*

At the policy level, participants describe the current degradation of the system, referring to previous policy makers as more responsive to low-income people’s needs. One participant commented:

*I spoke to people in Social Services, and they said “It’s not our policy to tell people what they can get. It’s up to the person to let us know what they need.”*

Participants noted their frustration with the difficulty in moving past problem identification toward creating effective policies:

*I find, having sat on multiple things like this that we are possibly getting stuck at the problem identification part of all this. So we sit here and we can talk about our specific piece of that problem and our specific experience of that problem. But how do we get to the next stage, which is actually influencing policies and services? We could sit here and hash it out for another hundred years, and it would still be as valid as it is today. So how do we get to the next stage?*

Finally, at the societal level, there was consensus in all groups that society creates the problems being faced by low-income people. However, there was a notable difference between groups on the assignment of blame. The advocacy group framed their societal problems around corporate responsibility. Service providers spoke of fixing the system through better employee training and alleviating burnout. Policymakers/influencers pointed to problems with defining poverty and the difficulties in “accessing” the system. These participants suggested re-framing poverty as participation in society, and that money and income-levels are not the bottom line. They also believed that the social norms of the system prevent people whose appearance or credentials are not within those norms from being heard. Related to this, one participant admitted that her formal training in the “scientific method” was a barrier to hearing the perspectives of “outsiders,” suggesting that epistemological differences can translate into power inequities.
In all three focus groups, participants contributed recommendations for improving both local and systemic issues related to poverty and health services use. Their ideas stemmed from both personal experiences of success as well as frustrations toward the current state of service delivery and policy. They identified a lack of intersectoral communication, neglect of untapped power in communities, and the need to adopt a philosophy of “working ourselves out of a job” when approaching problems of poverty. One participant commented on her organisation’s strategy:

*Our consumer group, whenever they decide the government isn’t going in the way that they want them to, go to the press or phone the minister, and get everybody on their list to phone the minister...but I think consumers or low-income groups far more frighten the government...they have so much power.*

**Toronto - Interviews with Low Income People**

**Use of Services**

Almost 90% of participants reported using some form of primary health care, a doctor, community health centre, walk-in clinic, or health bus. Almost 70% reported also using a range of social and community-based services (food banks, addiction counseling, drop-ins, job placement services, newcomer services). Many individuals who were homeless or living in shelters/hostels in two inner city communities relied upon a continuum of street-based services on a daily basis.

*On Sundays I help out and get a lunch... the community centre on Church Street. I go there quite a bit. There’s some of the people that have become very close personal friends of mine. I go on Tuesdays and Thursdays to Metropolitan United and have lunch. Counsel Fire is a great place. I sleep there some times.... I also go on Mondays to St. Simons ... [and] I sleep there sometimes.... [And] I’ve been staying lately at the Seaton House [but] you can never get in the shower.... So when it comes around Sunday I say well ‘gees I haven’t had a shower since Wednesday and I want to go to church’ so I’ll go to St. Simons to have a shower there.... And Sanctuary where I worship has a shower, but you can only have a shower after 2:00 o’clock and only on Wednesday so I sometimes take a shower there.”*

**Factors that influence use of services**

**Survival: meeting basic needs.** Individuals from two inner-city communities indicated that they needed services to survive -- without the services they did not feel like they could make it, or at the very least, their lives would be made much more difficult. As many stated quite bluntly, having access to health care and community-based services was a matter of life and death.

*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 the orthopaedic not as it is now. If those things weren’t in place I would be probably on the street unhealthy ... on the street it’s as simple as that.*

*[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.*

Several newcomers to Canada also expressed the importance of having free health-care services available to them, through the community health centres because they did not yet have OHIP cards.

*Those services are very important to me. For example, if there is no [community health centre], I would have problems to see a doctor especially the first three months when I was in Canada because I did not have coverage of OHIP. Those services are very important to newcomers without those services their lives will be very awful.*
Breaking isolation: the need for human contact. In all the Toronto communities, low-income spoke of the importance of having social interaction with others, breaking their isolation, and just being with other people. Parents spoke of the loneliness of child rearing on their own and the need to connect with other adults. Drop-ins and other services for the homeless served to quell the loneliness of living on the street.

[The drop-in centres are places] where I can relax and I can ... 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 anymore.

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 [community health centre] I go to.

Coping with stress. People talked about the importance of services in helping them cope, providing support, and basically dealing with personal and family stress:

When [I’m] depressed ... I can call and go anytime [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.

Experiences with Services

Lack of Choice. “I just take what I can. You can only go by what you can afford.” People from all four communities echoed this person’s sentiment that on a low income there is very little choice. Services that people would have liked to access, but could not because of their low incomes included dental services, extended health care services (e.g., chiropractic, naturopathic, massage, etc.), vitamins and healthier foods, eyeglasses, counselling or mental health services, and recreational programs.

My other daughter she had a real dental problem [and] I never had the money ... to take her to the dentist and for that reason she never use to smile much because ...every time she smiled she said she [thought] that some of the people would laugh at her.

Inequity of Service. In all communities, there were individuals who felt that income status was an inhibiting factor in receiving better quality service. They believed that they were mistreated because of being poor, the way they looked, their race, or the neighbourhood they lived in.

[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 they way you look.

Desire to be Self-Reliant. Individuals from two communities, in particular, reported that even though their incomes were low and they had to use several services, they wanted to be as self-reliant as possible. Some explained that their pride stopped them from accessing a particular service or using services on a regular basis.
I use the services, that's the feeling that I have, when I'm no longer able to do it on my own .... Because for me that's almost like a failure .... With all my pride ... going to ... professional help ... it means that I wasn't able to get rid of the problems on my own .... It makes me feel shame ... not so much what people think because I don't care ... it's just because I don’t like to feel weak.

**Service Provider Behaviour or Characteristics.** Service providers had a very powerful influence on consumers’ reactions to a service, and in some cases, whether or not they used the service at all. In particular, low-income people wanted to be treated with respect, with compassion and caring, and wanted service providers to take time with them, and not rush them out the door. They wanted to feel like “you can keep your dignity and get services.” Anecdotes of negative experiences centred around the treatment received at food banks and social assistance offices in particular.

Sometimes the service you receive from the workers is not appropriate. They don’t have any patience. At the welfare offices... sometimes you receive bad treatment from the workers, as if money was coming out of their own pockets. It is a very drastic attitude. It is a very bad situation especially for people who are unemployed. For this reason some people don’t use the services, like in my case I wouldn’t go to welfare if I didn’t need it .... Most people use it because they need it. They have no choice but to resort to welfare, otherwise they become homeless.

**Accessibility.** People remarked on the problem of waiting – getting an appointment with a doctor, waiting for the doctor, and waiting for service at Emergency Rooms. Individuals from two inner city communities also spoke of the long line-ups and limited hours of operation for some street-based services.

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

Lack of transportation, or inadequate money to cover transportation costs, was reported as an inhibiting factor in accessing services in two communities. As one person put forth, “‘If it involves taking a bus forget it... because half the time you don’t have money to go to the appointments.

**Recommendations to Improve Services**

In Toronto, recommendations for services for low-income consumers could be grouped into two categories: systemic change versus “band-aid” improvements. Several people, particularly in the focus groups, remarked that the health of the low-income population could be addressed if income levels were raised, more affordable housing was available, and there was greater coordination or integration of services. In addition to these systemic changes, many low-income consumers (in Phases 1 and 2) recommended enhancements or improvements to existing services.

**Raise Income Levels.** In each community, people spoke of their struggles with living on social assistance or on low incomes. People discussed the importance of making changes to existing assistance programs, and raising the income levels of consumers.

Another thing I don’t think is fair is the Child Tax in Social Services ... Social Services they take from that. When that cheque that you get from Social Services is more like
your rent and your groceries ... [and] you need that ... then like maybe when you get your child tax [you use it] for your bills, you know what I mean.... It is unfair because ... you’ve got to budget different, like all over again.

**Improve Housing.** People from all four communities talked of the dire need for affordable housing and greater rent control policies.

*The rents are so high and you only get a certain amount, like with Social Services. Like I’ll give you an example of myself. My rent is $750 and I’m in like the 900’s and I have two kids, but with a two bedroom I was lucky, they told me I was lucky because it’s only $750 ....There’s no ... rent control.*

**Increase Funding and Expansion of Services.** The five main areas recommended for greater funding and expansion included dental services, extended health care services (e.g., prescriptions, chiropractic, massage, physiotherapy, etc.), mental health or counselling services, emergency room, physicians’ services, and recreational programs and facilities.

*Well, prescriptions would be good, because I pray every day that my kids don’t get sick. That’s part of my prayer when I get up every morning.... maybe not all of it [covered] but at least something.*

*[The] government needs to open ... for people who have low incomes ... swimming pools, aerobics.... For children it is very necessary [to have healthy children] in the future in Canada.*

**Staff Sensitivity Training.** One common suggestion for enhancing the quality of service that focused on service provider attitudes and behaviour toward low-income consumers. People had experienced or had witnessed staff conveying superiority, ignorance, disdain and disregard for people living in poverty. A course of action that was recommended was to provide training to improve service providers’ sensitivity to working with those living in disadvantaged circumstances.

*Perhaps a training or a retraining to 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 anymore. It’s as logistical as you can get. So I don’t know if it’s as simple as a retraining, a reality check, I don’t know what, but certainly the issue needs to be addressed.*

**Increase Access to Information and Entitlements.** A very clear theme that emerged from the study, particularly in the two inner city communities, was that many people were not aware of all the services that were available to them, nor were they aware of certain entitlements that should be available. Several participants commented on a general lack of knowledge about what services were available, and believed that there should be a more concerted effort to disseminate information to potential consumers.

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

*It’s a matter of being knowledgeable, and knowing where to go and not to go .... Just before I became homeless, or when I became homeless, and I came down, I was*
spending money, that I couldn’t afford on certain things that I found out later were available to me free of charge. Such as meals, accommodation. Now, I learned from somebody that I befriended on the street. But there was no one area where I could go for official information to tell me these things. To have something like that set up would be great. Maybe there is and I’m just not aware of it.

**Advocacy to navigate the system.** Several low-income people suggested that one way to ensure proper dissemination of information is to have advocates who can help low income consumers “navigate” the system.

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 .... Information has been so bad coming out of the family benefits for me .... I don’t understand why they can’t give you a sheet saying this is what you can have or what you qualify for, this is how you go about it and how many times you can have it. You always have to go out and dig and look and find out and nobody tells you anything and I find that a real setback.

**Focus groups with advocates, service providers, and policy makers.** The focus groups conducted with policy makers, service providers and advocates supported the findings of the interviews with low-income consumers. Based on their experience of working with the low-income population or organizations that serve this population, they identified barriers to service and expressed their opinions on the organizational and systemic problems that give rise to these obstacles.

They highlighted the need for more health care and recreation services.

We’re getting more and more [people where] ... we’re finding ... they need more than just the 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. (Service Provider)

Policy makers, service providers and advocates also reported on the inequity of treatment of people living on low incomes.

I do think that what happens to low-income people is that they are consistently confronted with this different attitude. And of course if I walk into an emergency room and somebody else walks in who was obviously poor, badly dressed or whatever, that there’s just a different dynamic between what happens for me, and it’s not with everybody, but it just happens. So here you are, you might see that different dynamic, in fact you might have a high sensitivity to it, because ... you’re being jerked around by the food bank, you’re being jerked around by every place you go .... I’m not saying everywhere, but I do think that experience is there. (Policy Maker)

The low-income people’s views about the importance of service providers’ behaviours in accessing services, were reinforced by policy-makers, service providers, and advocates.

[The results from this study] re-affirmed some information that we had gathered at the [Toronto] District Health Council on a project we were doing around homeless health.... We had consultants [conduct]... four focus groups [with] homeless people, and overwhelmingly that’s what they said.... The main determining factor of where they would go for service was the way they were treated by the people. (Policy Maker)
Service providers from food banks talked about the rude and punitive behaviour of some of the front-line staff.

*I am so fed up with giving training to my staff and to my volunteers and seeing the same behaviour over and over and over again.* (Service Provider)

Service providers identified staff burnout and poor incentives as contributing to the high service provider turnover in communities with a greater population at risk for health problems.

*There’s no services or incentives to keep ... that happy ... person sitting behind the glass, because they get burned out and move on ... Same with the doctors ... You just finally get one that you like and ... she’s good, she’s got another job, she’s gone, right. So we have to look at the way that we’re like revolving door people out of those communities.... There’s no incentives. There’s no saying we value servicing these communities well.* (Service Provider)

Policy makers, service providers, and advocates also recognized the impact of current resource limitations of the health care system. They confirmed that long waiting lists at community health centres, emergency rooms, and street-based services are discouraging, especially for those who might not have anywhere else to go.

*Certainly with the emergency room, waiting a long time is a big decision to go in there sometimes, even when critical care is necessary .... We try and help a person, or encourage a person, to go to the emergency room because they are so ill [but] they will still not want to go because of the amount of time that they have to wait or because of the incredible amount of inconvenience, or sometimes they also prioritize other things as being more important.* (Advocate)

*Health and social services are an issue after 4:30 [or] 5:00 [p.m.] ... as well as on weekends.... So if you are in any kind of crisis, it is hard to find a place in Toronto that can help you.* (Policy Maker)

**Recommendations to Improve Services and Policies.** Policy makers, service providers, and advocates concurred with low-income consumers that more attention has to be paid to preventing health problems through systemic change, in particular, by addressing two critical determinants of health – income and housing. In addition, they believed that integration and coordination of services at the community level would eradicate barriers to access, but for this to happen, integration would also have to occur at the government level.

*My basic and essential difficulty with all of this discussion is that 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 Loblaws. 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.* (Policy Maker)

*Affordable well maintained housing .... And of course it has to be geared to the size of the family.”* (Service Provider)

Policy makers, service providers and advocates also identified the need for improvements and enhancements to local services, including staff sensitivity training and increased accessibility and
promotion of (free) programs. Service providers and advocates felt that the quality of service could be improved if there was greater consumer input.

*Even the social service providers are no longer able to take them through the process to get the income. All a welfare worker can do is hand a package to the person who may or may not be literate, who may or may not speak English, and so on and so forth .... I’d love to have I don’t know a dozen floating people who just run out into the food bank and sit down with everybody to see just if they’re getting all of the things they’re entitled [to]. (Policy Maker)*

*To systematically move the consumers up the participation chain. So sort of move people from increasing access to the services to increasing participation in how those services are actually delivered, to in fact designing the system and the services at the beginning. (Policy Maker)*

**SUMMARY OF RESULTS**

**Use of Services** (Research Question 1)
The following emerged as the most frequently used services:
- primary health care services
- acute care services
- basic needs services
- social and community based services

**Factors Influencing Use of Services** (Research Question 2)
The most common positive and negative factors influencing use of services were:
- survival needs
- support needs
- coping strategies (e.g., self-reliance)
- choice of services
- equity of services
- service provider interactions, behaviours and competence
- confidentiality of services
- accessibility of services (proximity, affordability, etc.)

**Accessibility, Quality, Relevance and Appropriateness of Services**
Low-income people, policy makers, service managers and advocates concurred on issues compromising accessibility, quality, relevance and appropriateness of services for low-income people, and how services could be improved. The most common solutions to improve these services were:
- longer hours, shorter waits, and service on weekends (i.e. temporal accessibility)
- improved transportation and better coordinated services (i.e. geographical accessibility)
- removing bureaucratic barriers
- improved government funding, free services, and increased income levels (i.e. financial accessibility)
- gender sensitivity, increased confidentiality, and accountability (i.e. for improved quality)
- increase recreation programs, employment and child care services (i.e. to improve appropriateness and accessibility)

**Improvement of Services, Programs, and Policies** (Research Question 4)
Policy makers, service providers, and advocates concurred with low-income people that the improvement of services, programs and policies could be brought about by a number of actions, including:

- increase accessibility of services and programs
- improve quality of services
- expand comprehensiveness and range or services
- increase information about services
- improve training of service providers (i.e., attitudes, behaviours, interactions)
- increase intersectoral action and communication
- mobilize consumer and community participation
- promote services that meet basic needs (e.g., increase income levels, improve housing)
- increase government funding of health-related services and programs for low-income people
- increase access to information and entitlements.

The most common courses of action to improving services that came from low-income people and service managers, advocates and policy influencers were: communicating concerns to the people in power (e.g. managers of service organizations, politicians); participatory action, and creation of partnerships between low-income and advocacy groups.

**Presentations/ Dissemination**

**Edmonton**

- **Qualitative Health Research Conference**: *Training Interviewers to Assess Low-Income People's Perspectives on Health Services*. Banff, AB, April 7-9, 2000 (Kim Rain-Travers, PhD, RD, Linda Reutter, PhD, RN, Deanna Williamson, PhD, Miriam Stewart, PhD – members of research team).
- **Symposium accepted at CARHE Conference (Congress 2000)**: Edmonton, AB, May 28, 2000
  - *Low-Income People's Perspectives on Health-Related Services and Supports: An Overview of the Study* (Miriam Stewart, PhD, Principal Investigator).
  - *Participatory Research: Reflections from the Community Partners* (Deanna Shorten –)
  - Poverty-In-Action Society, and Sharon Thurston – Boyle McCauley Health Centre, members of Research Team).
  - *Participatory Research: Low-Income Interviewers' Experiences*, (Carl Boon, Claudete Cardinal, Shawne Cook, Linda Gellert, Carole Lambert, Belinda Outzen )
  - *Participatory Research: Successes and Challenges Experienced by the Academic Researchers*. (Linda Reutter, RN, PhD, Deanna Williamson, PhD, Kim Raine-Travers, PhD, RD – members of Research Team).
- **Canadian Public Health Association Conference**: Abstracts accepted, Ottawa, October, 2000
  - *Policy and Program Implications of Low-Income People's Perspectives on Health-Related Services and Supports* (Deanna Williamson, PhD, Kim Raine-Travers, PhD, RD, Janet Fast, PhD, Irving Rootman, PhD, Miriam Stewart, PhD – members of Research Team).
  - *Low-Income People's Perspectives on Determinants of Health Services Use*, (Miriam Stewart, PhD, Linda Reutter, PhD, RN, Janet Fast, PhD, Kim Raine-Travers, PhD, RD, Deana Shorten, Sharon Thurston, Doug Wilson, PhD, Irving Rootman, Rhonda Love, Dennis Raphael – members of Research Team).
- **CAPC/CPNP Alberta Conference, Children & Families**: Celebrating Strengths, Edmonton,

**Toronto**
- **University of Toronto, Community Health Research Day, February 25, 2000**
  - Overview of Project and highlights of Challenging Issues in Conducting this Research and the Impact on the Interviewers, (Rhonda Love, PhD., member of Research Team).
- **Urban Health Research and Policy Forum, April 4 and 5, 2001**
  - *Low Income Consumers’ Perspectives on Determinants of Health Services Use*, (Irv Rootman; Karen Hayward, members of Research Team).

**Additional Resources**
- CHSRF report on Phase 1
- Public report on Phase 1 (Edmonton)
- Summary Report (Toronto)

**Further Research (to be elaborated)**
Participants from a variety of sectors (public, programs/services, policy) concurred that the recommended actions should be tested in future participatory research. Intervention research is timely. Future research could be launched in other Canadian cities with a high incidence of poverty (e.g. Montreal).
APPENDIX 1: INTERVIEW GUIDE

Before you begin the interview, make sure…

- the Participant has read the Information Sheet
- the Participant has signed the Consent Form
- the tape recorder is on and works
- you have filled in the box above

A. Opening Script

We are interested in hearing about your experiences and opinions. There are not right or wrong answers.

Before we begin, I want to explain some of the words we’ll be using throughout the interview so that everyone has the same understanding.

1) The first is “health or being healthy”. Being healthy means different things for different people. For this study, being healthy means more than not being sick. Being healthy is being able to cope and manage your life. It means feeling good physically, socially, emotionally, and spiritually. Throughout this interview, we would like you to think about health in this way.

2) We will also be using words supports, services, resources and programs. For the purpose of this interview, health-related supports, services, resources and programs includes all of the following things:

   a) medical or health care services covered by Alberta Health Care, like family physician, hospital use, a specialist

   b) health services not covered by Alberta Health Care, such as a chiropractor, naturopath, massage therapy, traditional healers, and other such services

   c) other supports and services that people use to stay healthy, such as food banks, self-help groups, social support groups, recreational programs, herbal remedy stores, religious services, or other things like that.

Any questions?

I will be taking some notes during the interview to help me stay on track and remember what you have said.
B. Interview Questions

→ People can do lots of different things to stay healthy and different things to cope when they are not feeling well. We want to start with asking you to think about your own health.

1) a) What do you do to stay healthy?
   b) What do you do when you’re not feeling well; for example, when you are ill or injured?

If necessary probe with:
   - What medical services do you use?
   - What other health resources or programs do you use?
   - What social programs or services do you use?
   - What other community resources and programs do you use?

If participant says that s/he doesn’t use any of these kinds of services or supports, go to Question 3.

2) Which of these services or resources do you (and your family) use most often?

Skip Question 3 unless person has said they do not use any other supports or services listed in Question 1.

3. You have not mentioned using any kind of program or service to help you stay healthy or when you are ill. What are your reasons for not using any kind of service or program?

Probe if necessary with: What prevents you from using health-related services or programs?
The next few questions are about when and how often people use health-related supports and resources.

For participants who do not use services, ask 4A instead of 4.

4A) In the past 6 months, did you (or your family) use any services or programs?
   ____YES   ____NO

   If says, YES, ask (a) and list the type of service and how often below.
   If says, NO, go to Q. 6A.

   a) What services or programs did you use?
   b) How often did you use them?

4) In the past 6 months, did you (or your family) use the services and supports that you have told me about? Let’s begin with the first thing you mentioned.

   a) Did you use __________?
      - Go through all the services and programs given as responses to questions 1a and b
      - Do not ask about lifestyle & nutrition choices like exercise, eat well, sleep etc.

   b) How often did you use this support/service?

   Skip Q.5 with Participants who do not use services and supports.

The next few questions are about why people use various health-related services and supports. People use different kinds of services and supports for different reasons.

5. In general, what are your reasons for using the supports and services you have told me about?
Before going through the list below, make sure you check all the reasons mentioned up to this point in the interview. Then ask about all the reasons that were not mentioned and ask Participant to elaborate on each “yes” response.

There are some other reasons people have for using particular supports and services for their health. I would like to go through some of these with you to see if any have ever applied to you. Do you use programs and services…

Repeat “Do you use supports and services…” every 2 – 3 times.

a) ____ when you are ill?
b) ____ when you don’t have the money or resources to meet your needs?
c) ____ when you have family or personal stress?
d) ____ when you feel lonely or isolated?
e) ____ when you need to talk to someone about a problem
f) ____ when you don’t know what else to do to cope?
g) ____ because you have been told to do so by a professional or agency?

Does using a service or program depend on … (Repeat this phrase as needed)

a) ____ how familiar is it to you?
b) ____ on whether your friends or family members use the same service?
c) ____ how easy it is to get to?
d) ____ how affordable it is?
e) ____ the quality of the service you receive?

→ The next few questions are about how well health-related services and supports meet people’s needs.

With participants who do not use services and supports, skip 6 and 7 and ask Q. 6A and 7A on the next page.

6) Overall, how well do the programs and services that you have used meet your needs (and your family’s needs)?
Ask the following questions unless they have clearly answered them:

a) What kinds of things make you feel comfortable using services and programs?

b) What kinds of things make you feel uncomfortable using services and programs?

c) What makes it easy for you and your family to use programs or services?

d) What makes it difficult for you and your family to use services and supports?

7) What would life be like for you if you could not use the health-related resources and services you’ve told me about?

Probe: How important are these health-related programs and services to you (and your family)?

6A) Overall, how well are you able to meet your (and your family’s) health needs?

Ask the following questions, unless they have clearly answered them:

a) What kinds of things would make you feel comfortable using health-related services and programs?
b) What kinds of things make you feel uncomfortable using services and programs?

c) What would make it easy for you and your to use programs and services?

d) What makes it difficult for you and your family to use services and supports?

7A) What would life be like for you (and your family) if you could not use health-related resources and services?
Probe: How important is it for you to be able to use health-related programs and services?

8) Did you ever feel that you were not getting as good services as other people?
_____ Yes _____ No
If says YES, ask (a):
   a) What made you think so?  What happened?

9)  In particular, do you think your income status affects the quality of service you receive?  ____ Yes  _____ No

   If says YES, ask (a):
   What made you think so?  What happened?

10) Have you or your family ever needed or wanted to use a particular service or support, but have not?  ____ Yes  _____ No

   If Participant says YES, then ask (a) and (b):
   a)  What services or supports did you want to use?

   b)  What were your reasons for not using that service or support?
11) In particular, does your income status affect the services or programs you choose to use or not use? ____ Yes  ____ No

   If Participant says YES, then ask (a) & (b):
   a) What services or supports do you choose not to use?
   (if necessary, explain that “other than because of the cost of the service”)

   b) What made you feel that way? What happened?

12) How could the services and supports that you (and your family) use or would like to use be made better?

13) What services and supports would you like to see that are not available?

14) How do you learn about the services and programs that are available to you (and your family)?
The next question is about the influence people feel they have over health-related services and supports. In the past few years, there has been a lot of talk about making sure the general public has more input on decisions about how health services and supports are organized and delivered.

15) Have you ever tried to provide input on what or how services and programs are delivered? _____Yes  ____No

If YES, probe with (a):

a) Please tell more about that situation? What service was it? What did you do? What happened?

If participant is not able to answer, say the following:

Some people provide input by telling service providers what they think about the services or make suggestions about services that not available, others to meetings or work on committees dealing with health services and supports. What kinds of things have you done to provide input on services or programs?

If NO, ask (b):

b) What are your reasons for not providing input on what or how services and programs are delivered?

c) Would you like to have a say on what or how services and programs are delivered?

d) In what ways would you want to provide input on what or how services and programs are delivered?
So that we can give a general description of people who took part in the study, I’m going to ask you some general questions about your age, education, number of kids, cultural background and income.

1) Gender and Participant: Male: □ Female: □

2) What is your age? _____

3) What is your level of education? (Read the entire list and check off all that apply)
   - Less than grade 3
   - Grade 9 - 13
   - Trade or technical certificate/diploma
   - University undergraduate degree
   - University graduate degree

4) How would you describe your cultural identity or background? For example, French, English, Portuguese, Chinese, Irish, Ojibway)
   ___________________________________________

5) What is your occupation?
   ___________________________________________
6) Now I will read off a list of sources of income. Please tell me which ones apply to you. Are you receiving income from: (check off all that apply).
- Full time employment
- Part time employment
- Irregular, casual, or seasonal employment
- (Un)Employment Insurance
- Family Benefits
- Welfare/Social Assistance/SFI
- Disability Pension
- Other ______________________________

If participant is living with spouse/partner, ask Question 7

7) Now, how about your partner? Is s/he receiving income from: (check off all that apply).
- Full time employment
- Part time employment
- Irregular, casual, or seasonal employment
- (Un)Employment Insurance
- Family Benefits
- Welfare/Social Assistance/SFI
- Disability Pension
- Other ______________________________
8) What was your main source of income during the past 12 months?
________________________________________

9) What is your annual family income? ________________

For Participants who refuse to give an exact income, say the following:
*Would you mind showing me which range your annual family income fits into?*

If Participant agrees, show the Participant the following ranges of income and check the appropriate one.

- _______ 0 - 5,000
- _______ 5,000 - 10,000
- _______ 10,000 - 15,000
- _______ 15,000 - 20,000
- _______ 20,000 - 30,000
- _______ Over 30,000
If participant has children living with him/her, ask Question 10.

10) **How old are your children?** (If they have more than five children, add to bottom of list).

   _______ Child 1
   _______ Child 2
   _______ Child 3
   _______ Child 4
   _______ Child 5

→ I want to let you know that someone from our Research Team may call you at some point in time to ask you about how this interview went.

→ We would also like to know if you would like to receive a summary of the results of the Study. _____ Yes _____ No

→ Also, whom do you think we should inform about the results of this study?

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*We have reached the end of the interview. Thank you very much for taking the time to answer the questions. Your answers are very important to the success of this project.*
APPENDIX 2: Interview Protocol for Phase II Group Interviews

Low income People:

Distribute a handout summarizing the project and key responses for selected questions before interview (attached). An interviewer from Phase 1 will give a short presentation of the findings to date. Present the range of responses for key questions and 1 – 2 exemplar quotations per question (attached)

Interview Questions:

1. How does this information fit with your own experiences?
   - What are similarities? What are differences?

2. How can services and programs for low-income people be made better?

3. What new services and programs would you like to see for low-income people that are not now available?

4. What policy changes are needed?

5. How could low-income people be involved in influencing services, programs, and policies?

6. Who should be told about the results of this study?

7. What are the best ways to communicate this information?
### Appendix 3. Demographics of the Edmonton and Toronto Phase 1 Samples

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<th>Toronto %</th>
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<td>(Toronto N = 100) Male</td>
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<td></td>
</tr>
<tr>
<td>Other visible minority</td>
<td>16</td>
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</tr>
<tr>
<td><strong>Annual Family Income</strong></td>
<td></td>
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</tr>
<tr>
<td>$0 - $5000</td>
<td>12</td>
<td>16</td>
</tr>
<tr>
<td>(Edmonton N = 97) $5000 - $10,000</td>
<td>35</td>
<td>27</td>
</tr>
<tr>
<td>(Toronto N = 87) $10,000 - $15,000</td>
<td>31</td>
<td>22</td>
</tr>
<tr>
<td>$15,000 - $20,000</td>
<td>16</td>
<td>9</td>
</tr>
<tr>
<td>$20,000 - $30,000</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Over $30,000</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td><strong>Children</strong></td>
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</tr>
<tr>
<td>No</td>
<td>41</td>
<td>34</td>
</tr>
<tr>
<td>(Edmonton N = 97) Yes</td>
<td>59</td>
<td>58</td>
</tr>
<tr>
<td>(Toronto N = 92)</td>
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