A B S T R A C T

Purpose: To explore poor Edmontonians' access to medical treatment services.

Methods: Data were collected during interviews with 130 poor Edmontonians.

Results: 38% of study participants had failed to obtain physician services when they were sick or bothered by a health problem, and 40% who had been prescribed a medication had not filled the prescription. Participants experienced three main barriers to access: lack of money, lack of comprehensive health care coverage, and lack of affordable transportation. Findings suggest that a variety of health care and social assistance policies limit access to treatment services for people living in poor families.

Conclusion: Despite the principles of the Canada Health Act, access to medical treatment is not based solely on need, but is tied, in part, to income. There is a need for health care, social, and economic policies that aim to reduce the barriers that limit access to physician services and prescription medications by people living in poverty.

A B R É G É

Objet : Explorer l'accès aux services thérapeutiques essentiels dont bénéficient les résidents(es) défavorisé(e)s de la ville d'Edmonton.

Méthodes : Les données ont été colligées lors d'entrevues effectuées auprès de 130 résidents(es) d'Edmonton vivant sous le seuil de la pauvreté.

Résultats : 38 % des participants(es) à l'étude ne se sont pas prévalu(e)s des services d'un médecin lorsque cela s'avéra nécessaire et 40% n'ont pas fait remplir leur ordonnance médicale. Trois principaux obstacles semblent contribuer à limiter l'accès des participants(es) aux soins de santé de base : l'insuffisance de moyens financiers, une assurance médicale partielle, et l'absence de moyens de transport abordables. Les résultats suggèrent qu'une variété de politiques sur les soins de santé et sur l'aide sociale restreignent l'accès aux services thérapeutiques essentiels qu'ont les individus vivant dans des familles défavorisées.

Conclusion : Malgré les principes qui sous-tendent la Loi canadienne sur la santé, l'accès aux soins de santé n'est pas uniquement fondé sur le besoin, il est également partiellement lié au revenu. Il devient donc impératif d'implanter des politiques de soins de santé ainsi que des politiques sociales et économiques visant à réduire les obstacles qui limitent l'accès aux services thérapeutiques de base et aux ordonnances médicales pour les personnes vivant dans la pauvreté.

Poverty and Medical Treatment: When Public Policy Compromises Accessibility

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Access to basic medical care based on need rather than income is a cornerstone, and a highly valued characteristic, of Canada's health care system. Inclusion of accessibility as one of the five principles of the Canada Health Act was intended to ensure that reasonable access to medically necessary physician and hospital services is not jeopardized by financial barriers.¹⁻⁴ Often described as a core component of national identity, equal access to basic medical care for poor and rich alike is a source of immense pride among Canadians. Even in the midst of health care cutbacks that are of unprecedented proportion, Canadians remain passionate about their desire to preserve equal access to necessary medical services that is based on need rather than income.^{2,3} Often it is assumed by Canadians that the Canada Health Act has been successful in ensuring that access to medically necessary services is not jeopardized by financial barriers.²⁻⁴ However, evidence supporting this supposition is lacking. Therefore, this study explored the access that Edmontonians living in poor families have to two medical treatment services: physician services and prescription medications.

METHODS

Sampling

A purposive sample of 130 people living in poor families was recruited from an assortment of human service agencies in Edmonton. Some of the agencies included the Boyle Street Co-op, Edmonton's Food Bank, the CANDORA Society, Norwood Community Service Centre, and the Edmonton Board of Health. In an attempt to increase the degree to which the sample represented people living in poor families, the agencies through which participants were recruited vary with respect to the programs they offer as well as the needs of the people they serve. For example, the Boyle Street Co-op and the Food Bank tend to serve people who are very "needy", in that they have difficulties meeting their basic needs. On the other hand, people who access agencies such as the CANDORA Society and the Norwood Community Service Centre are less "needy" in the sense that they tend to use these agencies to participate in programs such as parenting classes or Collective Kitchens rather than because they are in crisis. In addition, public health nurses at the Edmonton Board of Health who have regular contact with families that are not necessarily experiencing crises, recruited a number of participants who were not clients of the other agencies.

The Statistics Canada Low Income Cut-Offs (LICOs) were used to identify poor families. The LICOs are income levels at which families' budget share for expenditures on basic needs (food, shelter and clothing) is 20% higher than the average for all Canadian families. The average proportion of income currently spent on basic needs has been estimated by Statistics Canada to be 35%. Thus, families whose

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expenditures on necessities exceed 55% of their gross income, are living below the LICOs.^{5,6}

Data collection and analysis

Data were collected during face-to-face interviews that were led by a standardized interview guide. The questions that participants were asked about their use of medical treatment services are presented in Table I.

Data about whether participants filled prescription medications and about participants' use of physician services were first analyzed descriptively with means and proportions. Then, independent t-tests and cross-tabulations were used to compare participants living in working poor families to those living in families receiving social assistance with respect to their use of the two medical treatment services which were the focus of this study. Chi-square tests were used to determine whether the relationships shown in the cross-tabulations were statistically significant. An alpha level of no higher than 0.05 was considered acceptable to establish statistical significance of the findings from both the t-tests and the chi-square tests. Last, multiple response cross-tabulations were used to analyze the reasons that participants gave for failing to obtain medical treatment services.

RESULTS

Sample

The sample consisted of 130 people ranging in age from 17 to 59 years. For the 12 months preceding the interviews, 76 (59%) of the participants had been living in families receiving social assistance and 54 (41%) of the participants had been living in working poor families. The social assistance participants lived in families that obtained the majority of their income from government sources. The working poor participants lived in families that received at least one-half of their total income from family members engaged in either full-time or part-time employment. In accordance with the Canada Health Act, individuals living in both groups of poor families were entitled to physician and hospital services that are provided by Alberta Health Care.¹ Participants who

TABLE I
Questions About Use of Medical Treatment Services

1. Sometimes when people need to see a doctor - like when they are sick or bothered by a health problem - they don't go. During the past 12 months, was there ever a time that you needed to see a doctor, but you didn't go?
2. How many times in the past 12 months did you need to see a doctor, but didn't go?
3. For each time that you didn't see a doctor when you needed to, what was the reason?
4. During the past 12 months, was there ever a time when you didn't get a prescription filled?
5. During the past 12 months, how many prescriptions did you not get filled?
6. What was the reason that you didn't get each of those prescriptions filled?

TABLE II
Demographic Characteristics of the Study Participants

	Sample	Social Assistance	Working Poor
Mean age in years (standard deviation)	33.9 (9.1)	32.5 (9.3)	35.9 (8.5)
Mean number of children living at home (standard deviation)	2.1 (1.2)	2.0 (1.3)	2.2 (1.2)
Mean years of education (standard deviation)	11.4 (3.3)	10.5 (2.5)	12.7 (3.8)
Average proportion that gross family income was of the LICOs (%) (standard deviation)	57.6 (15.3)	52.7 (11.1)	64.6 (17.6)
Proportion by gender			
Females	81.5 (n=106)	85.5 (n=65)	75.9 (n=41)
Males	18.5 (n=24)	14.5 (n=11)	24.1 (n=13)
Proportion by marital status			
Single (never married)	26.9 (n=35)	38.2 (n=29)	11.1 (n=6)
Married/Common-law	42.3 (n=55)	23.7 (n=18)	68.5 (n=37)
Separated/Divorced	26.2 (n=34)	31.6 (n=24)	18.5 (n=10)
Widowed	4.6 (n=6)	6.6 (n=5)	1.9 (n=1)
Proportion by level of education			
Less than high school	61.5 (n=80)	77.6 (n=59)	38.9 (n=21)
High school	16.2 (n=21)	10.5 (n=8)	24.1 (n=13)
Post-secondary diploma	12.3 (n=16)	9.2 (n=7)	16.7 (n=9)
Bachelor's degree	8.5 (n=11)	1.3 (n=1)	18.5 (n=10)
Graduate degree	1.5 (n=2)	1.3 (n=1)	1.9 (n=1)

TABLE III
Proportion of Participants Who Failed to Use Medical Treatment Services

	Sample N=130	Social Assistance N=76	Working Poor N=54	Chi-Square
	% (n)	% (n)	% (n)	
Did not have at least 1 prescription medication filled in the 12 months preceding the interviews	40.0 (46)	29.2 (21)	58.1 (25)	
-Not applicable (did not have a medication prescribed)	11.5 (15)	5.3 (4)	20.4 (11)	9.42*
Had failed to obtain physician services in 12 months preceding the interviews	37.7 (49)	46.1 (35)	25.9 (14)	5.45**

* $p \leq 0.01$

** $p \leq 0.05$

TABLE IV

Reasons That Prescription Medications Had Not Been Filled in the 12 Months Preceding the Interviews

Reason	Sample (Number of reasons=115)		Social Assistance (Number of reasons=47)		Working Poor (Number of reasons=68)	
	%	(n)	%	(n)	%	(n)
Could not afford medication	74.8	(86)	48.9	(23)	92.6	(63)
Did not think medication was necessary	23.5	(27)	48.9	(23)	5.9	(4)
Other*	1.8	(2)	2.1	(1)	1.5	(1)

* Examples of reasons categorized as 'other' are: allergic to medication, don't like side effects of medication.

TABLE V

Reasons for Not Obtaining Physician Services in the 12 Months Preceding the Interviews

Reason	Sample (Number of reasons=141)		Social Assistance (Number of reasons=91)		Working Poor (Number of reasons=50)	
	%	(n)	%	(n)	%	(n)
Thought (s)he would get well without seeing a physician	23.4	(33)	34.1	(31)	4.0	(2)
Thought doctor would prescribe a medication that would be unaffordable	20.6	(29)	0		58.0	(29)
No transportation/couldn't afford transportation	14.9	(21)	23.1	(21)	0	
Doctors had not been able to help with health problem in the past	12.8	(18)	7.7	(7)	22.0	(11)
Did not have time	8.5	(12)	8.8	(8)	8.0	(4)
Does not like going to doctor	7.8	(11)	12.1	(11)	0	
Too emotionally drained	3.5	(5)	4.4	(4)	2.0	(1)
Could not get an appointment	2.8	(4)	4.4	(4)	0	
Could not afford child care	2.1	(3)	3.3	(3)	0	
Other*	3.5	(5)	2.2	(2)	6.0	(3)

* Examples of reasons categorized as 'other': "I don't have a doctor I like" and "I couldn't get time off work".

were living in families receiving social assistance were also eligible for a variety of additional health care benefits, some of which included coverage for eye glasses, dental benefits, and coverage for a range of medications.⁷ None of the participants living in working poor families had access to these types of comprehensive benefits. Demographic characteristics of the sample are summarized in Table II.

Comparison of the demographic characteristics of the sample with Statistics Canada data⁸⁻¹⁰ shows the sample from the current study to be representative of relevant populations of poor Canadians with respect to marital status, the number of dependent children per family, and educational attainment. The social assistance participants were also representative with respect to gender distribution. On the other hand, women and single earner fami-

lies were over-represented among the working poor participants.

Use of and access to medical treatment services

Findings about the use of and access to medical treatment services by people living in poor families are presented in Tables III to V. Results indicate that 38% of study participants had failed to obtain physician services when they had been sick or bothered by a health problem an average of 2.56 times during the previous 12 months (Table III). Similarly, 40% of the participants who had been prescribed a medication had failed to fill an average of three prescriptions during the previous 12 months. Table III also shows that a significantly greater proportion of the social assistance group than the working poor group failed to see a physician when they had

been sick or bothered by a health problem. Conversely, a greater proportion of working poor than social assistance participants reported that they had failed to fill prescriptions. Findings from independent t-tests indicated that there were no statistically significant differences between the working poor participants and the social assistance participants with respect to the mean number of times that they had failed to seek physician services or the mean number of prescription medications that they had not filled.

The reasons that participants gave for not getting prescription medications filled and for not obtaining physician services are presented in Tables IV and V respectively. In response to open-ended questions, participants provided a reason for each prescription that they did not get filled. Chi-square statistics are not reported in Tables IV and V because this test cannot be done with multiple response cross-tabulation analysis. Table IV shows that while almost 100% of the reasons given by participants living in working poor families were that they could not afford the prescribed medications, fewer than half (49%) of the reasons given by the participants living in families receiving social assistance were lack of affordability of prescribed medications.

The reasons that participants gave for not obtaining physician services even though they had been sick or had been bothered by a health problem are presented in Table V. Findings indicate that a broader range of reasons were given by the social assistance group than by the working poor group. The greatest proportion of reasons given by the social assistance group was that they believed they would get well without seeing a physician, whereas the greatest proportion of reasons given by the working poor group was that they thought the doctor would prescribe a medication that they would be unable to afford.

DISCUSSION

While Canadians often believe that our health care system ensures equal access to basic medical treatment services for the poor and rich alike,²⁻⁴ findings from this study make it clear that barriers associated

with poverty exist. Some of the reasons given by the study participants who had failed to obtain physician services when they had been sick or bothered by a health problem, call into question the assumption that the Canada Health Act has been successful in ensuring access to medical treatment services that is based on need rather than income. In addition, and consistent with other Canadian studies,¹¹⁻¹³ more than one third of the participants who had been prescribed (a) medication(s) failed to fill at least one prescription during the previous 12 months.

Furthermore, results suggest that it is a variety of health care and social policies that limit access to medical treatment services for people living in poor families. Keeping in mind that one of the chief differences between the social assistance group and the working poor group was the differential availability of prescription medication coverage, findings from the cross-tabulations illustrate the manner in which social policies limited access to prescription medications for poor Edmontonians. Of those participants who had received prescriptions from their physician, a much greater proportion of the working poor than those receiving social assistance (58% compared to 29%) had failed to fill at least one prescription medication during the previous 12 months. Almost all of the reasons (93%) given by working poor participants for not filling their prescriptions were that they could not afford prescribed medications. It is true that Alberta Blue Cross comprehensive health care insurance coverage is available to working poor families at a reduced rate. Nevertheless, the working poor participants in this study probably would have been unable to afford even the subsidized rate of \$86.00 for three months.¹⁴ Results from a related study of working poor Edmonton families indicated that 80% of the families spent at least 90% of their income on food, clothing and rent.¹³ In other words, there was little or no money available for medical care expenses or additional health care insurance. Since the average gross family incomes of the working poor participants in the current study were 66% of the LICOs, it is likely that, even at the reduced rate, the costs associated with

Alberta Blue Cross coverage would have been prohibitive. Moreover, Alberta Blue Cross claimants must pay 30% of the cost of prescription medications,¹⁴ which further diminishes the affordability of these benefits for working poor families. In sum, it is apparent that insufficient labour market earnings and unaffordable comprehensive health care insurance were both barriers to obtaining needed prescription medications for participants living in working poor families.

Almost half (49%) of the reasons given by the participants living in families receiving social assistance indicated that they too had not filled prescriptions because they could not afford them. At first glance it may seem odd that some social assistance participants, whose families were receiving comprehensive health care benefits, cited lack of affordability as a reason for not filling prescriptions. However, prescription medication benefits available to social assistance recipients have recently been reduced.⁷ As a consequence, and underscoring the role that social assistance policies play in determining access to prescription medications, social assistance participants stated that the medications they could not afford were medications no longer covered by Alberta Family and Social Services.

It is noteworthy that approximately one quarter of the working poor participants (26%) and almost one half of the social assistance participants (46%) had failed to obtain medical care by a physician when they were sick or bothered by a health problem—even though they all had Alberta Health Care benefits. Findings suggest that the lack of prescription medication benefits not only hindered access to prescription drugs, but also acted as a barrier to accessing physician services. Fifty-eight percent (58%) of the reasons given by working poor participants for failing to see a doctor when they were sick or bothered by a health problem were that they thought the physician would prescribe medications that they would not be able to afford.

Further illustrating the impact that policies external to the health care sector can have on access to medical treatment services, this study identified transportation

costs as crucial. Almost one quarter (23%) of the reasons given by social assistance participants for not seeing a physician when they were sick or bothered by a health problem were that they lacked affordable transportation. Significant spending cutbacks to social assistance programs in Alberta since 1993 have resulted in decreases of 10% to 23% in shelter benefits and reductions of 7% to 16% in overall social assistance cash benefits.¹⁵ As a result of cutbacks to shelter allowances, social assistance recipients have been using the portion of their cheque intended for requirements such as food, clothing, and transportation to pay their rents. Consequently, increasing numbers of recipients do not have enough money to meet their basic food, clothing, and transportation needs.^{16,17} Thus, it is not surprising that inability to afford transportation acted as a barrier to physician services for study participants who were living in families receiving social assistance.

Even though the findings from this study provide evidence that a variety of health care and social policies limit access to medical treatment by people living in poor families, some of the results introduce more questions than they answer. For example, the findings from this study do not explain why a significantly greater proportion of the reasons for not obtaining physician services given by the social assistance group (34% compared to 4%) were that they thought they would get well without seeing a physician. Similarly, it is difficult to explain why almost one quarter of the reasons given by working poor participants who had not obtained physician services were that doctors had not been able to help with their health problems in the past, while this reason represented fewer than 10% of the reasons given by the social assistance participants.

CONCLUSION

Canadians uphold our health care system as distinctively superior to the US health care system.² Yet, the barriers to medical treatment services that were experienced by participants in this study were similar to three of the four barriers identified in a recent US study that explored

access to health care among impoverished individuals: lack of money, lack of health care insurance, and lack of affordable transportation.¹⁸ If Canadians sincerely value and desire access to medical treatment services that is based on need rather than income, we must reduce the barriers associated with poverty. However, reductions of such barriers will only be realized if Canadians first recognize our false assumptions about access to medical treatment services. Findings from this study make it clear that, contrary to both the intentions of the Canada Health Act and Canadians' values and beliefs, access is not based solely on need. Real access continues to be tied, in part, to income.

Acknowledgement alone, that access to medical treatment continues to be partially dependent on income, will not be sufficient to reduce the barriers that are faced by people living in poverty. Findings from this study show that some health care and social assistance policies impede access to both physician services and prescription medications by people living in poor families. These findings point to a need for a complex of health care, social, and economic policies that aim to overcome barriers to medical treatment services that are associated with poverty.

The universal provision of medically necessary prescription drugs, as was recently recommended by the Liberal Party of Canada,¹⁹ Lexchin,¹² and the National Forum on Health,² would reduce many barriers related to the lack of comprehensive health care insurance. Barriers associat-

ed with lack of money and lack of affordable transportation experienced by social assistance recipients could be reduced by increasing social assistance cash benefits to levels that reflect the market cost of basic needs such as food, clothing, shelter, and transportation. Moreover, the development of economic policies that effectively increase the number of Canadians employed in jobs that allow them to escape from poverty would, undoubtedly, reduce the barriers to medical treatment services that are faced by people living in poor families. Until Canadians recognize the barriers to medical treatment services that are experienced by people living in poverty, and hence invest in a broad range of health care, social, and economic policies that will reduce and/or eliminate financial barriers to these treatment services, access to medical treatment that is based on need rather than income will remain an important but unrealized goal.

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Nutrition, Health, and Child Development: Research Advances and Policy Recommendations

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