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Barriers to Primary Healthcare for the Homeless: The General Practitioner's Perspective

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Barriers to primary healthcare for the homeless

The general practitioner's perspective

Helen Lester, Colin P Bradley

Objective: The objective of this qualitative study was to examine in depth the barriers to primary healthcare for homeless people from the point of view of the general practitioner.
Method: Semi-structured interviews were undertaken with twenty-five general practitioners in Birmingham, UK. The major themes in the topic guide were training, views of the homeless, practice policy and initiatives for providing primary care for the homeless.
Results: Although factors relating to the practice (such as the role of the receptionist and practice workload) and to aspects of 'the system' (such as local and national policy) were mentioned, the major barriers related to aspects of the doctors themselves, particularly their attitudes towards homeless people and their consultation style. There also appeared to be a dichotomy in GPs' attitudes and behaviours towards homeless patients.
Conclusion: This study suggests that a major barrier to care for the homeless is the general practitioner himself, and that there may be a dichotomy in general practitioners' attitudes and consultation behaviour towards the homeless. This has implications for medical student training and methods of primary care service delivery to homeless people.
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Keywords: homelessness, family practice, barriers, attitudes

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Introduction

Homelessness is poverty in its most extreme form. It is a significant problem in the European Union (EU), where approximately 3 million people have no fixed home and a further 15 million live in overcrowded accommodation.[1] Differences in social welfare and housing policies between EU countries make comparison difficult, but it would appear that homelessness is a particularly significant problem in Germany, France and the UK.[2] This may be a reflection of immigration trends since, for example, over 15% of the workforce in Germany are immigrants, many of whom are at the bottom of the socioeconomic ladder.[3] In the United Kingdom (UK) over 4.3% of all current heads of households in England have experienced a period of homelessness in the past decade.[4] Shelter, the UK homelessness charity, estimates that there are currently over 440,000 homeless people in the UK.[5]

The causes of homelessness throughout the EU are complex and multiple and include structural issues such as lack of affordable housing and lack of adequate social protection, and agency causes such as adverse childhood experiences.[6] In this context, access to healthcare is of secondary importance to access to housing and it is misleading to overmedicalise the problems of homeless people. However, homelessness does have profound implications for health.[7,8] Studies have shown that the mental and/or physical health of homeless people is considerably worse than that of the general population, with those at the extreme end of the housing spectrum suffering the poorest health.[9,10] For example, 25% of a sample of 715 homeless people in Paris recently reported having a severe physical health problem, and 12% as having schizophrenia,[11] similar prevalence rates to recent Spanish,[12] German[13] and UK studies.[14]
Previous work has shown that homeless people often have difficulty in registering with a general practitioner; in the UK rates vary between 26-84%.[15,16] Differences in health service funding mechanisms make comparisons across the EU difficult, but there is also evidence that homeless people in other EU countries underutilise general practitioners.[11] Registration in itself, however, does not necessarily equate with access to, or quality of primary care.

Primary care research on health and homelessness has been rare at the national level and almost non-existent at the European level.[17] The findings of the limited previous work suggest a number of different barriers to primary care for homeless people, such as practice features of inflexible appointment systems and officious receptionists, disincentives within 'the system' (such as the lack of financial inducements), and workload implications.[18] A small number of studies have also highlighted the problems created by stereotypical views of the homeless as a reason for general practitioners' reluctance to provide care.[19,20] There is, however, little general consensus on the major barriers to providing primary care for homeless people, despite the prevalence of homelessness and associated morbidity and mortality.[21,22] This study therefore aimed to explore in detail the barriers to healthcare for homeless people in the UK from the viewpoint of the general practitioner.

Method

Subjects and settings

Previous research in the area of barriers to care for the homeless has often involved a predominantly positivistic survey approach. However, since the topic of barriers to healthcare is a potentially sensitive issue that is still relatively unexplored and poorly understood, the more flexible and reflexive hypothesis-generating method of the semi-structured interview was utilised, an approach that has been recently encouraged in this area of research.[23] Depth interviews with general practitioners working in urban and semi-urban areas of Birmingham were undertaken between August 1995 and April 1996. In view of the exploratory hypothesis-generating nature of this research, it was felt important to include GPs with a broad range of personal and practice-demographic characteristics as interviewees. A table was therefore constructed of the 350 GP principals in the Birmingham Family Health Authority Area stratified by variables potentially relevant to the study, such as age, gender, years in practice, practice list size and Townsend score. The Townsend score is based on four variables taken from the 1981 Census selected to represent material deprivation: unemployment, car ownership, home ownership and overcrowding. It is considered to be the best indicator of material deprivation currently available.[24] GPs were then randomly selected from within each group. Letters inviting GPs to take part were initially sent to 22 GPs, 20 of whom agreed to take part.

As the analysis progressed, the importance of the GP as a barrier and the differences in attitude and behaviour between GPs became more overt. GPs were therefore recruited to represent and clarify themes emerging from the data. The nurse practitioner for the homeless in Birmingham was instrumental in suggesting three GPs who were actively working with and two who were known to avoid working with homeless people, all of whom agreed to be interviewed. Such theoretical sampling is a specific type of non-probability sampling, in which the objective of developing the theory or explanation guides the process of sampling.[25]

Interviews

Homelessness was defined according to the widely agreed definition used by the UK-based homelessness research organisation Access to Health as 'a lack of decent, safe and secure housing' [26] and therefore included rough sleepers, single homeless people and homeless families. Data were collected using a topic guide developed from discussions with general practitioners at a local medical unit for homeless people and from a systematic review of the relevant literature. The major themes in the topic guide were training, views of the homeless, practice policy and initiatives for providing primary care for the homeless. All interviews were conducted by HL, a part-time general practitioner and research fellow in the department of general practice, who attended a depth interview training course and was supervised during a number of pilot interviews at the start of the project. Interviews lasted between 30-60 minutes and were conducted in the general practitioners' surgeries. They were audiotaped and fully transcribed. Data gathering and analysis were performed simultaneously and 25 general practitioners were interviewed before no new themes emerged from each interview and data saturation was therefore felt to have been achieved.[27]

Analysis

The interviews were analysed using the Framework method[28] of manual analysis developed by Social and Community Planning Research (SCPR). This method of manual analysis uses a grounded theory approach[25] and involves a systematic, dynamic comprehensive process of sifting, charting and sorting interviews according to key issues and themes. The interview transcripts were read independently by the first author and two other researchers (one a primary care academic and the other a behavioural scientist) and ideas on emerging themes were compared and modified until an agreement was reached. Since the goal was to generate primary care-orientated concepts of the barriers to care rather than generalisable findings in a statistical sense, results are not presented numerically. However, a broad indication is given of the number of subjects who demonstrated or expressed each theme. A number of reliability and validity checks were carried out.[29] All transcripts were read by three researchers and disconfirming evidence was actively sought. Extensive field notes were kept. All general practitioners were also sent a summary of the findings and asked to comment.

Results

Seven of the respondents (28%) were women, 4 (16%) were non-white, 5 (20%) were singlehanded practitioners, 13 (52%) were in fundholding practices and 9 (36%) were in training practices. The average list size was 7000 (range: 2000 to 14500.) The average age of the interviewees was 44 years (range: 30-62 years) and the average length in

Table 1. Barriers to providing primary care for homeless people.

Medical education and training
- Medical school training/contact/experience
- Postgraduate training/contact/experience

Consultation style
- Expectations of success
- Perceived role of the GP
- Feelings engendered in the consultation
- Ability to tolerate uncertainty
- Perceptions of power sharing in the consultation

Practice factors
- Role of the receptionist/training
- Practice workload/time

The system
- National policy: housing policy
- Secondary care actions: response of secondary care and accident and emergency departments
- Social services: communication with and speed of access to social services

practice was 13 years. The Townsend scores of the wards ranged from -3.9 to 7.8.

Commonly held views about barriers

During the interviews, general practitioners mentioned a wide range of different issues as barriers to providing primary healthcare to homeless people (table 1). There were a number of barriers mentioned by nearly all the general practitioners interviewed. All had experience of working with homeless patients during their clinical work, but said that homelessness was rarely mentioned during undergraduate or postgraduate training, creating a perceived barrier of a lack of factual knowledge about homelessness. Homeless people were also often perceived as costly in terms of practice time. There was also a general consensus that barriers were created by poor communication between health and social services, particularly in terms of difficulty in contacting people out of hours. Previously highlighted barriers to providing primary health care, such as a lack of practice flexibility and practice finances, were however rarely mentioned as barriers to care. In further contrast to previous studies, all general practitioners said their receptionists would not be involved in the decision to register or refuse registration to a new patient. Some general practitioners did however mention the need for practice and receptionist training to ensure that receptionists did not make value judgements on appearances (box 1).

As the data gathering and analysis progressed, the pivotal importance of the individual general practitioner as a major barrier became clearer. This realisation was a slowly evolving process, aided often by 'hunches' written in the field notes. For example, one general practitioner talked extensively about the communication barriers erected by homeless people, describing them as a waste of time. Another spoke with equanimity about the early deaths faced by many rough sleepers despite medical care but was enthusiastic about her role in caring for homeless people. A third described his discomfort in terms of feeling helpless and hopeless when faced with a homeless patient.

Box 1. Commonly mentioned barriers.

- When I was at medical school there was no specific teaching about homelessness. It was mentioned in the context of TB and that was it. (AP3)
- The mixture of physical and social problems often takes longer to sort out than the average patient. (AP1)
- Trying to get hold of someone from social services can be a nightmare. Last time it took me over an hour and I don't know how many 'phone calls and messages to speak to someone. Trying to get them after 5 is impossible and that's often when you really need to talk to them. (PN2)
- It's a terribly difficult job being a receptionist, and they try to cope with situations where 6 phones are ringing and there are 46 patients in the waiting room and somebody gets aggressive. I think we do need advice and help and support for reception staff for coping with homeless patients. (AP4)

Further analysis of the general practitioner characteristics identified two distinct groups, each sharing many experiences, attitudes and behaviours towards the homeless. Of the 25 general practitioners there were 15 with a cluster of characteristics that indicated a more positive disposition towards the homeless and 10 with a cluster of characteristics that indicated a more negative disposition towards them. There was also a further distinction within these two groups of general practitioners into those that were actively engaged and those that were passively involved in working with the homeless, with 11 GPs indicating an actively positive, 4 passively positive, 6 actively negative and 4 passively negative disposition towards homeless people.

General practitioner characteristics

Descriptions of the homeless

Positively disposed general practitioners emphasised the human qualities and commented that it was possible for anyone to become homeless. In contrast, negatively disposed general practitioners appeared to view homeless people as difficult, untrustworthy timewasters. Most also made a distinction between the 'deserving' and the 'undeserving' homeless, the latter being primarily the younger homeless and those with addiction problems, whose homelessness was perceived as self-inflicted (box 2).

Power in the doctor/patient relationship

Most positively disposed general practitioners described the homeless as powerless people. Demanding behaviour was viewed as an extension of their life circumstances. Many described homeless people as having low expect-

Box 2. Descriptions of homeless people.

- If somebody comes in a bit smelly and grubby and a bit drunk you automatically assume that they are not intelligent, but really they are just normal people who have gone and got divorced or you know, have no job and for other very simple reasons. They still have their pride you know. If only we could shake our preconceptions off and be a bit more friendly to them and say, well, would you like a cup of tea? Our outsides might be more acceptable but our insides are all the same. (AP6)
- Some of these families are not those that you would generally regard as having a problem with homelessness. A couple of them quite shocked me. I mean one is the woman who runs the playgroup round the corner- it's the playgroup my little boy went to. It never occurred to me that she might be homeless. (AP5)
- They just stand on street corners with their whippets. (AN1)
- Long ago you didn't get people coming up to you and asking for money because they had a certain amount of pride I think. They do now, they are quite aggressive at times. The younger homeless ones you get now I have very little sympathy for because they decide to be that way. (AN4)

ations within the consultation and of being grateful for treatment. If they were demanding about the need for an immediate appointment, this was perceived as secondary to their inability to access the health service in the usual way, for example by telephoning to make an appointment, or because they were in crisis.

Negatively disposed general practitioners often saw homeless people as more powerful than other patients and as sometimes having the 'upper hand' in the doctor/patient relationship. They knew what they wanted and were perceived as demanding in terms of their prescription requests, often did not comply with treatment, and on occasions left the practice area after the doctor had spent some time and effort on their care (box 3).

Consultation style

The most consistent contrast between positively disposed and negatively disposed general practitioners appeared to be in their individual consultation style. Positively disposed general practitioners enjoyed the consultation. Negatively disposed general practitioners, in contrast, had few expectations of success in either medical or social terms.

Within the consultation, positively disposed general practitioners stressed their role in making the consultation work, aimed to practise proper medicine despite the restrictions imposed by homelessness and tried to help with access to the social aspects of care. They acknowledged the uncertainty that can be associated with caring for homeless people, and accepted a long-term view of modifying health-seeking behaviour. There was also general agreement among the positively disposed general practitioners on the need for a firm and consistent approach. In contrast, the negatively disposed general practitioners felt their role

Box 3. Perceptions of power.

- Many of them are holding onto the edge of society by their fingertips. We have to help them access services because when they come they are often in crisis and we need to fit them in as an emergency even if that emergency isn't strictly medical. (AP4)
- I think they are more demanding and likely to ask for all sort of things. We had one lady and she used to come and create mayhem in the surgery by demanding appointments and by asking for carrier bags full of polytar shampoo! (AN5)

should be restricted to physical problems, and that health education and social problems such as issuing housing letters were outside their remit. Many also found the uncertainty of providing healthcare for homeless people difficult. Their actions also tended to fall into one of two categories, either being overly prescriptive or 'giving in' to demands that they felt compromised their professional role (box 4).

The origin of attitudes

The positively disposed GPs cited parental and other familial influences, and medical role models who influenced them to provide primary healthcare for homeless people. Extracurricular activities before and during medical school such as voluntary work with a housing organisation and helping out at Christmas projects were mentioned more frequently by positively disposed GPs than negatively disposed GPs. The majority of positively disposed general practitioners also had postgraduate psychiatry experience and experience of working with homeless people. However, half of the negatively disposed general practitioners also had training posts which involved working with the homeless, suggesting that experience alone, while valuable, is not the main determining factor in a general practitioner's disposition (box 5).

Discussion

General practitioners mentioned a number of barriers to providing primary healthcare for homeless people. In contrast to previous work, the barriers most frequently mentioned related to aspects of the doctors themselves, such as their training, perceptions of homeless people and consultation style. Other factors relating to the practice (such as the role of the receptionist and practice workload) and to aspects of 'the system' (such as local policy and communication across the primary/secondary care interface) were also mentioned as barriers, but less frequently. The importance of the GP as a barrier may have been overlooked because most previous work has been quantitative in nature when hypothesis-generating qualitative methods such as semi-structured interviews are perhaps more appropriate for this area of research.[23]

Limitations of the study

Although good qualitative research practice was striven

Box 4. Consultation style.

- The fact that the health needs are so real is rewarding. What else did I qualify for if I am not going to address things like that? (AP5)
- I guess I'm resigned to the continuity problem. Because they keep moving address you worry a great deal about people who you think are quite sick, and then they don't come back to you, and that's difficult, but you accept that it's part of the population. I accept that men I see may look 60 and are often 45 and will often die at a very young age. (AP9)
- I think I am unlikely to effect a 180 degree change in this person's lifestyle after two consultations, so maybe I should go for like a five degree change in their interstellar pathway over a decade. (AP10)
- I've got this feeling that I just won't get anywhere, and I feel that the time I spend is wasted. (PN1)
- I prefer to try to get out of the social demands. I tell them that I concentrate on the medical side of things. (AN2)
- Tomorrow morning I don't know where this person will be because you see you can't maintain continuity. It's hard work keeping track of all those people when you know you can't chase them up and you are reliant on them and they won't make appointments and they turn up as and where they want. (AN3)
- I'll give him help if I can, but if I can't give him help or he is not prepared to accept the help I give, then I get rid of them. (AN4)
- The trouble is, it doesn't matter how much you shout at them, they will come to you and they know that in the end I will probably give in and say all right. (AN5)

Box 5. The origin of attitudes.

- I have always had an interest in the underdog. I think these things often come from ones parents. My mother was a midwife in the back streets of Brighton in the 1930's and I guess some of it came from there. (AP8)
- I didn't appreciate the problems that people had or the reasons why they'd actually ended up in that situation until I worked in a unit for homeless people when I was a trainee. I thought there might be more just drifters and dossers but most of them had had pretty horrendous life experiences. (AP6)

for during this research with, for example, data collection and analysis carried out simultaneously and interviews being continued until no new themes emerged, the relatively small sample size of 25 GPs also limits the scope of the analysis. The results and discussion therefore represent an attempt to construct theoretically informed conclusions that are generalisable only on the grounds of logical inference. All the general practitioners interviewed worked in the same city; however, the general practitioners interviewed were representative of a broad range of GPs in the UK in terms of gender, age, practice size and population deprivation. Both the fact that four (16%) of the GPs were from an Asian ethnic group and the gender divide of 28% women reflect national statistics for primary care.

The methodology of the interviews with the GPs precludes the possibility of making definitive statements about the nature of the relationship between GPs and homeless people, since consultations were not directly observed. However, although there are also potential problems in the relationship between professed attitudes and behaviours, it does increasingly appear that measures of prejudicial attitudes correlate well with measures of behaviour in a wide variety of situations,[30] suggesting that GPs' expressed attitudes may be reflected in their actions. It is also not possible to comment about the consistency of the two identified styles of consulting from this study. However, Byrne and Long's work on GPs' styles[31] and Stewart and Roter's study of primary care communication patterns[32] suggest that many doctors develop and maintain a consistent style of consulting.

A number of well recognised validity and reliability checks were used to increase the generalisability of the findings to other urban centres in the UK. For example, all the GPs involved in the interviews were sent a summary of the findings as a member-checking exercise. Eighteen of the 25 GPs replied to the letter, and all agreed that they felt they fitted into one of the two basic categories. After the GP interviews had been completed, semi-structured interviews were carried out by HL with over 40 homeless people in Birmingham asking for their experiences of primary care.[33] The findings of these interviews were consistent with those of the GP interviews reported here, and stressed the importance of the GP himself as a potential barrier to accessing healthcare, increasing the validity of the findings.

General practitioner typologies

Calnan suggested that general practitioners can be divided into those that see a broader role for the general practitioner and place an emphasis on the social aspects of care, and those that see a more traditional role and focus on organic illness.[34] This study resonates with this literature in terms of describing two typologies of general practitioner with consultation styles that broadly equate with a social and medical approach towards care. However, it also extends the analysis to provide a more fine-grained description of two general practitioner types. Although it may be uncomfortable for primary care clinicians to consider that they themselves may be a major barrier to providing primary care for homeless people, there is a precedent for classifying GPs as predominantly positively or negatively disposed towards patients: the literature on primary care for drug addicts.[35,36] It appears from this work that the beliefs and attitudes that surround the issue of homelessness may, similarly, be sufficiently strong to create a dichotomy of behaviours that may act as a barrier to primary care for homeless people.

Conclusion

This study has a number of implications both for medical student training and for planning primary healthcare

services for homeless people. The study found a dichotomy in GP attitudes and behaviours and that contact with homeless people can both increase as well as decrease negative attitudes.[37] Previous work has shown that, to be of lasting value, contact needs to be guided, structured and supported, and to impart stereotypic confounding information.[38] As a direct result of this work, a 20-hour experience-based educational initiative on homelessness for second-year medical students at Birmingham Medical School in the UK and a questionnaire measuring medical students' attitudes towards homeless people were developed.[39] Evaluation of the educational initiative found that it is possible to positively influence medical students' attitudes towards homeless people.

Perhaps issues of homelessness could be included as part of the core curriculum medical course, although this of course creates the problem of adding to the increasing load of the core curriculum and of trying to organise guided positive contact for a large number of medical students. Other areas of medical care where there may be an element of negative stereotyping, such as drug and alcohol services, mental health and HIV medicine, could also create a similarly compelling case for the inclusion of their speciality in the core curriculum. A compromise might be to encourage the use of special study modules in the undergraduate curriculum and perhaps legislate for each student to attend at least one module that challenges their attitudes. The increasing importance of communication skills training in many medical school undergraduate curricula should also provide opportunities to challenge stereotypes, to enable each student to reflect on their consulting styles and to actively consider behaviours that encourage patient participation rather than medical paternalism.

Although EU countries have different health and welfare policies on homelessness,[6] this research has highlighted some fundamental differences in medical attitudes and behaviour that may be of relevance in primary care service planning for homeless people in the UK and other EU states. In the UK there are three current models of primary care provision for homeless people: separate services, special schemes that assess and provide for people's medical needs and advocate on their behalf for access to mainstream primary care service provision, and fully integrated services.[19] This work suggests that, although not all GPs are equally prepared to provide quality primary care for homeless people, there may be many positively disposed GPs within mainstream practices where homeless people could be encouraged to register. It therefore supports the provision of specialist services for homeless people,[40] i.e. schemes that act as a bridge between separation and integration, opening up access to appropriate mainstream care and also providing direct transitional primary healthcare and social care services through actively interested GPs. ■

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