

# Experiences of Homeless People in the Health Care Delivery System: A Descriptive Phenomenological Study

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**ABSTRACT** *Objective:* The objective of this research is to understand the experiences of homeless people with the health care system. *Design:* A descriptive Phenomenological research design is used. Phenomenology is the philosophical underpinning of this research. *Sample:* The purposive sample consists of 15 homeless adults. *Method:* Interviews were conducted, tape-recorded, transcribed, and then analyzed the transcripts using Colaizzi's descriptive phenomenological method. *Results:* 4 major themes emerged: (1) living without essential resources compromises health; (2) putting off health care until a crisis arises; (3) encountering barriers to receiving health care to include (a) social triage, (b) feeling labeled and stigmatized, (c) a nonsystem for health care for the homeless, (d) being treated with disrespect, and (e) feeling invisible to health care providers; and (4) developing underground resourcefulness. *Conclusions and Implications:* Although homeless persons articulated many problems in the health care system encounters, they also described their own resourcefulness and the strategies they employ to manage being marginalized by society and the health care system. An increased understanding of health care experiences from the homeless persons' perspective can guide public health nursing emancipatory actions.

Key words: access to health care, homeless health care, phenomenology, qualitative study.

Over three and a half million people are likely to experience homelessness within a given year (National Coalition for the Homeless, 2007; National Law Center on Homelessness and Poverty, 2007). In 2006, the demand for shelter increased 9%, with 68% of the cities showing an increase (U.S. Conference of Mayors, 2006). According to the McKinney Act (1999), people are homeless when they lack a fixed, regular, and adequate nighttime residence or have a primary nighttime residence that is (a) a supervised publicly or privately operated shelter; (b) an institution that provides a temporary residence for individuals intended

to be institutionalized; or (c) a public or a private place not designed for regular sleeping accommodation for human beings.

Most people who are homeless have suffered severe hardships such as physical and sexual abuse, childhood trauma, poverty, disability, and disease (U.S. Department of Health and Human Services, 2003; U.S. Department of Housing and Urban Development [HUD], 1999). Studies show that 25% of people who are homeless experienced childhood physical or sexual abuse; 33% had run away from home; and 27% had lived in foster care, a group home, or other institutions as children (Caton et al., 2000; HUD, 1999; Koegel, Melamid, & Burnam, 1995). While homeless people face many challenges, poor health is a very common problem, surpassed in importance only by a lack of shelter and the need for food (Wright, 1990). The health status of the homeless person is extremely poor when compared with the general population (Power et al., 1999). In addition, the National Coalition for the Homeless (2007)

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reported that lack of access to health care is a factor in becoming homeless. Being homeless not only damages the physical and mental health of people who are homeless, it also poses health risks for the entire population by contributing to spread of diseases such as tuberculosis and HIV/AIDS.

The most common acute ailments in the homeless population are upper respiratory infections, trauma, parasites, and skin ailments. Lacerations and wounds are the most common traumas, followed by sprains and fractures. Malnutrition and vitamin deficiencies are also observed. Environmental risk factors such as cold temperatures make homeless people more susceptible to frostbite and hypothermia (New York City Department of Homeless Services, 2005; Wright, 1990). The principal chronic disorders in the homeless population include hypertension, peripheral vascular disease, poor dentition, gastrointestinal disorders, and neurological problems (Wright, 1990). Homeless adults have high rates of vision impairment (37%), skin/leg/foot problems (36%), positive tuberculin testing (31%), and high blood pressure (14%) (Gelberg, 2000; Macnee, Hemphill, & Letran, 1996).

This article reports on a phenomenological study of the experiences of homeless people in the health care system. The results of the study are discussed and implications for public health nurses are included.

## Review of Qualitative Studies on Homelessness

A review of the literature revealed several qualitative studies that focused on the experience of being homeless. These studies include homeless persons' experiences in general, their perceptions of health, providers' perceptions, and health care experiences.

Table 1 reviews qualitative studies on homeless adults. Montgomery (1994), Lafuente and Lane (1995), and De Forge, Zehnder, Minick, and Carmon (2001) did not address health care issues for the person who is homeless. Jezewski's (1995) study focused on the nurses and how they facilitate health care for homeless persons. Hunter, Getty, Kemsley, and Skelly's (1991) study was beneficial in addressing the health providers' interpretations of the problems in health care for the homeless, but does not address the homeless person's interpretations of the problems in health care. McCormack and Gooding (1993) addressed what health means to the homeless person but did not address the individual's experience with

the health care system. Wen, Hudak, and Hwang (2007) addressed the "welcomeness" and "unwelcomeness" in past encounters with health care providers. This was a much more specific question than in this author's study. Daiski (2007) study explored views of homeless people on their health and health care needs in Canada but did not explore their experiences with the health care system.

This qualitative literature review shows growing data about the health problems of homeless people and issues of access to care; little is known about the experience of being ill while homeless and the experience of receiving health care services from the perspective of homeless people particularly in the United States. This qualitative study looked at the health care experience through the eyes of the homeless person using descriptive phenomenology, a valuable method for nursing research (Beck, 1994).

## Methods

### *Research design*

This study of homeless persons' health care experiences used a qualitative research design: descriptive phenomenology. Husserl (1962, 1970) provided the philosophical underpinning for phenomenology. The aim was to examine a phenomenon as it is experienced by individuals and to directly describe it without considering its psychological genesis or causal explanations. The focus was on the subjective experience of the person who is homeless when trying to obtain health care. Phenomenology requires a new way of looking at things; it requires researchers to step out of their own experience with all of its predispositions and prejudices and to learn to see what stands before them with fresh, naïve eyes. This phenomenological study provides thick, rich descriptions of homeless people's health care experiences that foster an understanding of this phenomenon.

### *Setting and participants*

The setting for this study was a free clinic for homeless people located in an inner city area. The main lobby and community room looked like an emergency waiting area, except that almost everyone had plastic bags filled with their possessions. Nursing staff at the free clinic assisted in recruiting participants by identifying clients who met the inclusion criteria and were willing to participate in the study. To be included in the study, participants had to be 18 years of age or

TABLE 1. *Qualitative Studies on Adult Homeless or Homeless Health Care Experiences*

Author	Design/research question	Sample	Method	Analysis/results
Hunter et al. (1991)	What are health care providers' perceptions of health care experiences of the homeless?	Purposive sample of 122 homeless service providers	Descriptive study	Providers were sympathetic to the homeless and viewed them as entitled to social and health services; cost and discharge as barriers to health care; lack of motivation for self-care and inability to follow through were barriers; stigma was not seen as a problem.
Hodnicki, Horner, and Boyle (1992)	What are women's experiences when homeless?	Convenience sample of eight homeless women	Ethnography	Heightened awareness, guarding, identification of needs, and strategies for resolution.
Baumann (1993)	What are the experiences of homeless women with dependent children?	Purposive sample of 15 women with dependent children who were referred to an emergency shelter	Phenomenological method	Seven themes of homelessness were presented, including maintaining boundaries, maintaining connections, fatigue/despair, self-respect, lack of self-determination, lack of privacy, and mobility.
McCormack and Gooding (1993)	What does health mean to the homeless person?	Convenience sample of 29 individuals who were homeless and used hostels and shelters to rest or obtain food	Phenomenological study	Themes showed health meant: satisfying basic human needs, having no illness-related complaints, doing the work of health, fulfilling a functional role, having a positive self-image and outlook, being fit, having a support network, eschewing the use of addictive drugs, having good hygiene, and structuring the day.
Montgomery (1994)	What are the strengths of homeless women?	Purposive sample of seven women who were identified by shelter staff as women who are or had once been homeless	Grounded theory	Personal strengths included stubborn pride, positive orientation, moral structure, clarity of focus, and stoic determination. Interpersonal strengths included participation in community, positive perception by others, opportunities to contribute, unity and bonding, and commitment to personal relationships. Transpersonal strengths included religious beliefs, rationality tested through trial, creation of self, and finding purpose in helping others.

Lafuente and Lane (1995)	What is the lived experience of homeless men?	A purposive sample of 10 homeless men	Giorgi's phenomenological approach	Major themes identified were rejection, uncertainty, and social isolation.
De Forge et al. (2001)	What are children's perceptions of homelessness?	Convenience sample of 14 school-aged children currently living in a shelter	Phenomenological study	Five themes: I am not homeless, I like living in a shelter sometimes, living in a shelter is hard, stop the violence, and I need approval.
Wen, Hudak, and Hwang (2007)	What was your experience of "welcomeness" or "unwelcomeness" in past encounters with health care providers?	Purposive sample from 5 Toronto shelters to obtain 17 homeless men and women	Interpretive content analysis	Most perceived their experience of "unwelcomeness" as acts of discrimination.
Daiski (2007)	What are the effects of homelessness on health from homeless people's perspectives? Which strategies will improve their health most effectively?	A convenience sample of 24 participants experiencing homelessness was recruited in one Canadian city in 2005	Descriptive exploratory semistructured interviews and observational field notes. The data were transcribed and analyzed using thematic content analysis to identify patterns in the data Lincoln and Guba (1985).	Participants described their health and health care needs in a holistic sense. They reported concerns about physical illnesses, mental health, addictions, and stress. Shelter life promoted spread of diseases and lacked privacy. Violence was rampant in shelters and on the streets, leading to constant fear. There was emotional distress over social exclusion and depersonalization. Participants wanted to work and to be housed, and yet felt trapped in a dehumanizing system.

older; homeless; oriented, able to speak English; and had tried to obtain health care in the previous year. The researcher explained the purpose of the study, the study procedures, and that the interviews would be tape recorded. Participants then signed an informed consent form. This study was approved by the Institutional Review Board of the University of Connecticut and the Health Care for the Homeless site board and director.

### ***Data collection procedure***

Each participant interview lasted between 30 and 60 min. The researcher asked each participant, "Tell me a story about a time when you got care at a hospital, emergency room, or clinic." Interviewing participants was difficult at times due to the transient nature of homeless clients. A few participants left during the interview to have cigarettes or coffee and did not return. Others stopped talking as soon as the tape recorder was turned on. This group was not included in the study. A follow-up probe was often helpful: "Tell me a story about a health care experience that stands out in your mind." Other nondirective, reflective techniques were used to encourage the participants to give full accounts of their experiences. At the end of each interview, participants provided basic demographic data—age, ethnicity, and gender. New participants were interviewed until data saturation was achieved, that is, until the quality, completeness, and amount of the information was sufficient and no new themes were elicited in the interviews. A total of 15 participants were interviewed. Data saturation was reached after 12 interviews but three additional interviews were completed to make certain that no new themes developed. Participant interviews were audio-taped and transcribed and both the tapes and the transcripts were secured to assure confidentiality.

### ***Data analysis***

The data were analyzed using Colaizzi's (1978) descriptive phenomenological method to develop an essential structure of the phenomenon. The steps of this method were followed closely. In this method, the researcher read the transcription of each participant's interview and listened to the audio-taped interview multiple times to acquire a feeling for the participants and their responses. Next, the researcher underlined and extracted significant statements from the transcript that directly pertained to the investigated phenomenon: the homeless persons' health care experiences.

Third, the researcher formulated and wrote the meanings of each significant statement. These formulated meanings faithfully reflected the intent of the participant's statements, while they became increasingly abstract. This required a constant comparison among the original transcript, the statements, and the formulated meanings from all of the study participants. The fourth step in the analysis was to organize the formulated meanings into clusters or themes. To validate clusters or themes, the researcher compared them with the original interview and refined them to reflect the intent of the participants. This took several iterative cycles. Fifth, the researcher integrated the results of the data analysis into an exhaustive description of the phenomenon under study: the homeless persons' health care experiences. Finally, as a measure of the credibility of the research findings, the researcher asked available participants to read the exhaustive description to assure that it faithfully represents their experience as a measure of validity of the research findings. In this study, only one participant was found to read the exhaustive description once completed.

### ***Scientific rigor***

In qualitative research, scientific rigor is measured by credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). Credibility ensures that the phenomenon was accurately identified and described. In this study, three activities assured credibility: the audit trail; the iterative comparison of statements, formulated meanings, and the exhaustive description; and the review of statements and formulated meanings by study participants. Transferability demonstrates the application of the findings from this study to the larger study population. Dependability is the attempt by the researcher to account for multiple and changing conditions. In this study, interviews were conducted until data saturation occurred. Finally, confirmability is similar to the concept of objectivity in quantitative research designs. In this phenomenological study, confirmability was achieved when the researcher "bracketed" her preexisting knowledge to position herself to see the phenomenon through the eyes of the study participants. In addition, the researcher made a careful note of her reactions soon after interviews in a journal to identify and omit bias from the data analysis. Finally, a sample of the interviews was analyzed by another researcher

TABLE 2. *Selected Examples of Significant Statements of Homeless Persons Experiences With the Health Care System and Corresponding Formulated Meanings*

Significant statement	Formulated meaning
I had no insurance . . . so I joined the (names hospital) hospital HIV study. And I belonged for four years so I have an appointment with them also this week.	When homeless persons have no insurance they would volunteer for research studies to get needed medical care.
With the (health care system experience) . . . as I feel was malpractice. I feel like I was being used for a guinea pig. You know, I mean if you want to experiment, please don't experiment on me. I'm not a subject.	The homeless persons felt like part of an experiment while in the health care system, like they were animals or research subjects.
I waited near the window for 15–20 minutes before finally somebody even saw me. I was right in front of the line. And a nurse came over and said to me . . . I told her I had been waiting about 20 minutes before anybody even said anything to me, you know I am standing there with my cane trying to hold myself up and I was in a lot of pain, and she said oh, we didn't know really know what you were here for. We didn't know if you wanted some emergency treatment or what. I said, well, I am standing here at the emergency window, what in the hell did you think I was doing here? . . . I don't know if it is not caring or ineptness.	The homeless persons felt invisible. They felt ignored or not noticed while in the health care system.
Prescriptions . . . they are expensive. Prescriptions are like \$80. \$40. And being homeless, you can't really afford those prescriptions. And that's how a lot of the times when you get sick, you know, you can't go to a doctor . . . um . . . just like for things like the common cold, you can't go to the doctor.	When trying to obtain prescriptions, homeless persons found that the cost of health care inhibited utilization of health services.
Like I was paralyzed in '79. Put to the hospital with no insurance 'cause I was working in an amusement park and they discharged me way to early. Subsequent I suffered severely from it and still do because of the treatment was like you have no coverage? Thank you. Good bye.	The homeless persons described feelings of not getting the treatment they needed and being discharged prematurely when they still felt a need for health services.
When you get to the hospital, it seems like they already know that you're homeless if you're coming that way, you know, with a voucher.	Homeless persons felt "labeled" as homeless by the health care providers.

and compared with the researcher's analysis to assure as much bias-free description as possible.

## Results

The final, purposive sample consisted of 15 people who experienced attempting to access health care while homeless. There were 6 males and 9 females. Six of the participants were African American; 1 Latin American; 1 biracial; and 7 Caucasian. The ages ranged from 22 to 75. All were using the free medical clinic for the homeless and all had tried to obtain health care in places other than the free clinic while being homeless.

After analysis, 253 significant statements of homeless person's experiences with the health care system were identified and given corresponding 46 formulated meanings. Table 2 provides selected examples of significant statements and corresponding

formulated meanings. The formulated meanings were then clustered around four themes; one theme had four subthemes. Table 3 gives examples of how formulated meanings were grouped into themes.

The themes that emerged from the analysis of the formulated meanings were: (1) living without essential resources compromises health; (2) putting off health care until an emergency arises; (3) encountering barriers to receiving health care; and (4) developing underground resourcefulness. Encountering barriers to receiving health care included five subthemes: (a) social triaging; (b) being labeled and stigmatized; (c) the noncare health system; (d) being treated with disrespect; and (e) feeling invisible to health care providers. All four themes and five subthemes were experienced by each of the participants but some of the participants focused more on one theme than another.

TABLE 3. *Examples of Theme Clusters and the Associated Formulated Meanings*

3a Social triage	<ol style="list-style-type: none"> <li>1. Without health insurance, the homeless persons could not get health care.</li> <li>2. The focus of the ER seemed to be the paperwork.</li> <li>3. The system was seen as lots of red tape.</li> <li>4. Homeless person was asked to go elsewhere when it was discovered there was no insurance.</li> <li>5. Without financial coverage, the homeless person was denied surgery.</li> </ol>
3d Being treated with disrespect	<ol style="list-style-type: none"> <li>1. Felt talked down to by doctors and nurses.</li> <li>2. Health providers were perceived as rude.</li> <li>3. Feelings of being treated awfully.</li> <li>4. Patient requests were not acknowledged.</li> <li>5. Confidentiality of the health care encounters lacking.</li> </ol>

**Discussion**

***Theme 1: Living without essential resources compromises health***

For many homeless people, access to the basic means of maintaining health was lacking. They lacked shelter, clothing, healthy food, phones, and transportation. Homeless people have no toilets, showers, washers, refrigerators, stoves, or medicine cabinets. One participant stated “Living out on the streets, it’s not easy because your immune system gets so shot because you’re not eating properly, you’re not sleeping properly.” Another talked about clothing, “It’s not easy if you don’t have the proper clothes to wear or you haven’t been able to get your hair cut in two years and, you know, your hair is shabby looking.” A homeless woman stated, “(You) need decent clothes to go out and look for a job.”

Participants described the lack of healthy food, “I’m hoping that Mary will let me go over to where she took me before and got me some more can goods and food from that church.” There is a “catch 22” related to lack of resources; the homeless participants diagnosed with heart disease, hypertension, or diabetes could not obtain the healthy foods that would decrease their risks from the complications of those diseases.

Even when participants were able to get to soup kitchens to eat, they described the nature of the food as, “Potatoes, deep fried and they’re all greasy. I can’t eat that.”

***Theme 2: Putting off health care until an emergency arises***

Participants spoke of their dependency on emergency rooms to address their health care needs. “Well basically, I’ve been using emergency rooms or anything because I don’t have the money to pay for anything else.” Participants talked about waiting out the signs and symptoms until they were very sick to get health care, “I don’t chase down doctors—unless I’m very sick or somethin’ wrong with me and nothing’s wrong with me. They run up bills and, I see no point in wasting doctors’ time when they could be treatin’ somebody sicker than me.” “I couldn’t go to any specialist or anything like that. So I just had to sit home, with no money, no insurance, no nothing . . .” Another participant responded,

He (the doctor) said that you’re in your forties. You supposed to have a pap smear and mammogram and all those things. I said well screw that. I don’t have no cancer or breast cancer people in our family. And what do I need the pap smear? I don’t have no sex.

The participants described trying to take care of themselves. “It’s tough because when you have no medical coverage, you gotta try to take care of yourself without trying to see a doctor or anything because you’re too scared.” One participant stated, “Hospitals are so expensive that . . . I meant when I do get sick I try to avoid it. I mean I try to take care of myself best I can.” Participants’ concept of health was close to the concept of surviving. “I’m healthy. It’s not like I’m dyin’ or anything.”

***Theme 3: Encountering barriers to receiving health care***

Participants encountered five significant barriers to receiving health care: social triaging, a nonsystem for health care for the homeless, being labeled and stigmatized, being treated with disrespect, and feeling invisible to health care providers.

***Social triaging***

Triage is the process of sorting access to scarce health care resources by some criteria. Usually used in disaster situations, providers triage patients according to their health care needs and their potential for survival. The term social triage is used here to describe sorting access to health care according to the homeless person’s ability to pay.

Participants described health care as a commodity. Without insurance papers, participants could not

get medical care. When they had no money, participants had no health care. One participant described this experience related to prescriptions and lack of money for services:

I've had to have my teeth pulled and stuff and if you need prescriptions filled, if you ain't got the money, you might as well just take the prescription and tear it up cause you ain't gonna get it filled without health care . . . can't get the prescriptions unless you got the cash.

If they made it into the system, participants were rushed or discharged prematurely once their social status was discovered.

Often when they entered the emergency rooms or hospitals, participants were trapped in a paperwork maze. "Things are so much documentation." "There's so much paperwork and so much, I don't know if red tape is the right word for it, so much procedures I had to go through in order to get it (medical treatment) that it makes you not even want to get it." Another participant needed help with the paperwork. "How do you call this stuff . . . paper, I don't understand it. I gotta take it to somebody else to figure out for me. They figure it out and I take it back to them, right? They still give me a hard time. Yeah, they do."

Once they got through the paper maze, participants were often rushed or discharged prematurely when they still had need for services. One participant was discharged while in an altered state of consciousness: "I regained consciousness when they were putting the third staple in my head. And they let me go home, in and out of consciousness . . ." Another participant was assaulted after an inappropriate discharge from an emergency room at one hospital:

They (the emergency room staff) let me go with a man that I didn't even know and he was tellin' them he was my best friend and that he was going to take me home . . . when I woke up I . . . there were physical signs right away that I had been raped.

Another participant stated that the health care systems was, ". . . only allowed to keep you alive, we're not allowed to really do anything to help you if you ain't got health coverage and it's like hello? You got no health coverage, so we can't treat you? That's very scary."

### ***The non-health care system***

The participants spoke about the lack of quality in their experiences with the health care system. When asked to describe their experiences with the health

care system while homeless, many would laugh first or roll their eyes. There were often strong expressions of negative feelings toward the health care system. Some participants described getting the runaround. One participant described his health experiences as, "It's really terrible . . . it's unbelievable." Another said: "It's a gigantic monster." Still, another said, "Sometimes the experience is really rotten" and "it's just tough, very tough." A woman participant stated:

It sucks . . . straight, plain, English. It sucks. The system sucks. If I were rich it would be fine. But I'm a poor, black woman and it's hard. Being black is tough enough and then being a woman makes it twice as hard, so, yes, its sucks. That's the only way I can describe it to you.

One participant suggested, "You know it's a contradiction in terms of the emergency room. It should be called the non-emergency room as everybody knows."

### ***Being labeled and stigmatized***

Participants were labeled homeless and this stigma permeated their health care encounters. "When you get to the hospital, it seems like they already know that you're homeless if you're coming that way, you know, with a voucher." One homeless man said: "They know that you're homeless, so you must be broke."

Some participants tried to distance themselves from other homeless people to get better care. Participants described being treated differently because they were homeless. "There's always somebody that treats us different." Many participants felt that nurses did not trust them, "(the nurse) is talking to me like I'm lying to her: like I know what I had was just tryin' to get free treatment or something." One participant attributed her poor treatment to her homeless status, "Now I have an apartment, but (back then) I think they treated me (badly) mostly because I was homeless because you have to put in the chart that you don't have medical, you put down you're homeless . . ." Inferior treatment was related to homeless status. "My opinion is that it has to do with my being homeless 'cause that's the way she was talking to me."

### ***Being treated with disrespect***

Participants were often treated with disrespect. One participant stated, "different places will treat you awful when (you're) homeless." A homeless woman said, "just because you're sick don't mean they shouldn't respect you. Just because you lay in a hospital room

with a johnny robe on don't mean that you shouldn't be respected as a person." Another stated, "I would like to be treated with . . . respect and care." A participant said, "They don't treat you like you're a human being. On the ward I was on, the workers treat you like you're stupid."

The participants described being treated like animals. "For emergency care, I wouldn't send my dog (there). (Hospital) is called the kennel because it's like they do meatball triage." One participant stated, "There a couple of (hospitals) I wouldn't send my dog to but like the emergency room was a joke." "(The hospitals) treat you like cattle."

Participants reported that their treatment was experimental. "I feel that they, like I said, was experimenting with me because they gave me these shots that weren't really efficient enough." One participant said he can understand that they are learning, "but I don't want to be the target of their experiments . . . I feel like I was being used as a guinea pig . . . if you want to experiment, please don't experiment on me."

### ***Feeling invisible to health providers***

Participants were not noticed, ignored, or invisible in the health care system and this only reinforced their lack self-worth. One participant described doctors and nurses this way, "They don't really pay attention to you." Another participant stated, "I waited near the window for 15–20 minutes before finally somebody even saw me." A woman participant reported that she went to the emergency room with two other homeless people from the shelter a few times and, "the three of us were being completely ignored while everybody else was already being sent to the back or wherever."

The participants feared permanently remaining homeless and the loss of self. The experience of being homeless was described by one participant as "a big black hole." "I need to get out from under here (being homeless). It sucks you up like a big black hole. The (homeless) come down and lose all kinds of hope. You just watch the people walk by you and they don't even know that you're here."

### ***Theme 4: Developing underground resourcefulness***

Homeless people used underground resourcefulness to get what they needed. This homeless population experienced underground resourcefulness (Martins, 2003). In the mainstream culture, underground resourcefulness is a strategy that may be considered

illegal or unethical, used by marginalized persons or those distanced socially to survive (Leffers et al., 2004). Underground resourcefulness strategies were sometimes activities not sanctioned by the society or the health care system. Participants shared medications or modified doses to make the medications last. Participants volunteered for research studies, such as an antihypertensive study or an HIV/AIDS study, to get health care. "Practicing white lies" involved the use of deception to get medical care. Participants told providers what they believed the providers wanted to hear. Sometimes illegal measures were taken to get medical care:

My boss said to me you got to get that tooth fixed. So I had to illegally use my significant other's ex-significant other who is dying. She had full blown AIDS. I had to use her card to get my tooth fixed. So I had to do something illegal to get my tooth fixed to keep my job up.

One participant feigned symptoms of unconsciousness to get treatment: "The person's unconscious so they have to take them in so you really don't know . . . unconscious, no ID, so you treat people. You're going to have to treat a lot of unconscious people."

Numbing the pain of their existence with alcohol and drugs was also a form of underground resourcefulness. One participant stated, "Basically, I got involved with a lot of drinking a few years back. I mean I always drank. But I had nothing to do. I was basically losing everything anyway so it didn't matter. Just numb the pain. Help me sleep." One woman participant used illegal drugs when she was not able to get prescribed drugs: "I was using drugs at the time and coke was like my way of . . . I didn't have no other way. I didn't take medication I was gin' crazy. I had my kids with me . . . so I was self medicating myself with coke." A few participants were involved in survival sex to get the money to continue their use of drugs and alcohol: "What they don't understand is when we were getting high, we were stealing and we were doing what we had to do to get the money. I would steal. A lot of people would turn to prostitution." Some homeless adults chose jail to be resourceful, "You can either go to jail . . . maybe institutionalized, or you can die . . . thank God for jail."

## **Conclusion**

Being homeless is difficult enough but accessing health care while homeless is even more daunting.

Homeless people experience high rates of poor health. Perhaps worse than poor health itself are the barriers to accessing even minimal health care. Lack of insurance and the ability to pay are significant barriers to health care. Often health providers view homeless people as misusing the system and this attitude biases care. This qualitative study explored the health care experience from the eyes of the homeless person. Building on this knowledge, many opportunities can be identified to improve health and nursing care for the homeless.

First and foremost, homeless people, simply by virtue of being human, deserve respect while seeking health care. Currently, health professionals reflect societal values in their encounters with the homeless. The patient with higher social status receives a very different reception than the homeless or the marginalized patient. There are two separate and not equal systems of health care. The findings of this study will assist nurses to understand how this form of oppression affects health and well-being among the homeless. Snow, Anderson, and Koegel (1994) suggest that nurses attend to reporting the voices of the homeless; nurses can then advocate for the health needs of the homeless in the health care system. The homeless need access to health care and a voice in that care. Universal access to health care is extremely important to all.

Secondly, nurses can choose to document the strengths of homeless people and to build on those strengths rather than focusing on "helping victims overcome their problems" (Banyard, 1995; Baumann, 1993). To focus on the homeless person's problems disempowers them. Nurses can support their interpersonal strengths and the appropriate survival strategies of homeless people. Nurses can show unconditional positive regard and respect by recognizing the right of all people to participate in decisions about their own health care.

Finally, public health nurse advocacy is essential for changes in the socioeconomic and structural levels that created this socially unequal situation. Homelessness is a complex social problem; its solution requires national policies that increase affordable homes, education, and jobs, as well as health care as a right especially services for mental health, substance abuse, and family violence. Nurses need education on understanding the plight of the homeless person to decrease their frustration in caring for this population. Understanding their histories and life challenges

since childhood may help to improve nurses' attitudes about caring for the homeless person.

This study increases the understanding of the nature of the homeless people's experiences in dealing with the health care system and health care providers. Such an understanding demands more humanistic and empowering approach to care for the homeless and other oppressed and marginalized populations.

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