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## PROFEEDBACK POLICY BRIEF

# HEALTHCARE FOR PEOPLE EXPERIENCING HOMELESSNESS

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## Introduction: The policy problem

Healthcare provided to people experiencing homelessness (PEH) represents a challenge for public healthcare systems at the system level, but also to professionals who provide the outpatient healthcare to PEH (Lester, Wright, & Heath, 2002). The usual healthcare systems settings aim at the majority population, which makes it difficult to reach by PEH. Social exclusion leads to underutilization of healthcare by these people (Nagy-Borsy et al., 2021) and results in seeking medical help only in urgent situations (Luchenski et al., 2018). These issues on both the demand and supply side of healthcare lead to underutilization of healthcare, repeated emergency care (Pleace, 2023), and high mortality among PEH (Aldridge et al., 2018).
What makes this policy brief important is the fact that there is a lack of evidence on the health and healthcare of PEH provided by evaluations (Omerov, Craftman, Mattsson, & Klarare, 2020).

## Market and government failures in providing healthcare services

Healthcare systems are designed to provide diverse services through a complex network of institutions, organizations, and processes. However, they often fail to address access barriers for PEH. These people have low demand for healthcare services (Omerov et al., 2020; Pleace, 2023). Despite being cautions against healthcare segregation, which may create parallel systems that risk to exclude PEH permanently, this challenge remains prevalent (O'Carroll, Irving, O'Neill, & Flanagan, 2017).
Healthcare for PEH often fail to align with the principles of patient-centred healthcare and alternative solutions are sought. Non-profit organizations (NGOs) react to the failure of both government and market to provide healthcare to PEH and provide healthcare to this target group (Enich, Tiderington, & Ure, 2022; Pleace, 2023). To address this gap, NGOs often step in to fill these service shortfalls, providing targeted healthcare outreach to PEH through combined social work and professional healthcare teams. This practice, termed "structural compensation," functions alongside the public healthcare (Omerov et al., 2020; Trummer et al., 2020).
Such an approach to PEH has advantages, but also weaknesses. The effectiveness of these outreach approaches stems from their capacity to overcome obstacles associated with mainstream healthcare by meeting patients in their settings and recognizing their specific needs (Kopanitsa et al., 2023). While beneficial for PEH, these parallel healthcare approaches come with limitations as well (Routhier et al., 2022). Outreach programs often depend on exogenous funding, volunteer support, or do not cover all areas (Trummer et al., 2020). The inconsistency in delivering these services

underlines the need for targeted outreach to PEH requiring medical care (Davies & Wood, 2018). However, these services usually react to critical situations. For PEH, repeated use of emergency services helps them to stay alive but does not enhance health and quality of life.

Health insurance plays a crucial role in improving access to healthcare, particularly by facilitating outpatient care and lowering common access barriers (Kushel, Vittinghoff, & Haas, 2001). EU countries apply universal healthcare, making health insurance access more available. Nevertheless, there are still disparities in coverage persist across EU member states (Trummer et al., 2020). PEH are legally entitled to basic or emergency healthcare, even without paying contributions to the public health insurance systems, with additional pay-for-service healthcare options available (Verlinde et al., 2010). However, despite the availability of these services, the healthcare needs of PEH remain unmet. It has consequences in their reduced life expectancy of only 45 years, and mortality rate ten times higher that of the general population (Aldridge et al., 2018).

**Table 1: Pro and con arguments for stand-alone PEH health care**

| Universal health care | Stand-alone PEH health care |
|---|---|
| + Universal health care fails to align with the principles of patient-centred healthcare in case of PEH | + Capacity to overcome obstacles associated with mainstream healthcare |
| + Helps PEH to stay alive | + Meeting patients in their settings and recognizing their specific needs |
| + PEH are legally entitled to basic or emergency healthcare | |
| - Healthcare staff is not aware of a patient's homelessness upon discharge from the hospital | - Depend on exogenous funding, volunteer support, or do not cover all areas |
| - Does not enhance health and quality of life. | - Inconsistency in delivering these services |

**PEH problems to access healthcare**

PEH face numerous obstacles to accessing healthcare, including issues with patient identification, scheduling appointments, stigma, hygiene, psychological barriers, treatment costs, medication availability, and insurance coverage (Davies & Wood, 2018). These health system inequalities often lead to inadequate treatment for PEH (Omerov et al., 2020). The healthcare services are designed and structured to serve housed, mobile individuals rather than the PEH and posing a problem of unavailability to those who does not fit these characteristics (Lyon-Callo, 2000). Such hidden barriers prevent PEH from recognizing the need, seeking and accessing healthcare services, and afford them (Ashcroft & Adamson, 2022, p. 145).

Healthcare access is shaped by the enforcement of specific regulations and the practices (or gaps) of service providers. Most general practices and other healthcare sectors rarely record patients' housing status (Routhier et al., 2022), leaving PEH frequently unaccounted for standard health information systems (Aldridge et al., 2018). Healthcare staff often only become aware of a patient's homelessness upon discharge from the hospital. Being not fitting to public systems adds additional barriers, because these systems often impose additional requirements, such as a permanent address or cash payments (Trummer et al., 2020).

## Healthcare staff problems

The issues with providing healthcare to PEH are not only on the side of the patients, but also on the side of the healthcare staff. Healthcare staff encounter challenges in treating PEH, who are often seen as requiring substantial time and resources (Lester et al., 2002). Limited training and awareness about homelessness among healthcare staff reduce their ability to navigate patients to relevant social services (Rodriguez, Arora, Beaton, Fernandes, & Freeman, 2020). PEH are usually unable to assess their health status and relevant needs accordingly assess their own health needs (which is valid for a general population, but in PEH it is combined with additional obstacles) (Nagy-Borsy et al., 2021). Consequently, healthcare services are typically sought only during emergencies, with follow-up care being rare. Data on hospitalizations indicate that homeless individuals are admitted at six times the rate of the general population, especially for acute, hospital-based interventions (Brown et al., 2022; Kushel et al., 2001; Trummer et al., 2020).

**Table 2: Demand and supply problems in PEH access to universal health care**

| Demand | Supply |
|---|---|
| - Seeking medical help only in urgent situations | + PEH are legally entitled to basic or emergency healthcare |
| - Incapability to scheduling appointments, hygiene, psychological barriers, treatment costs, medication unavailability, and insurance coverage | - Healthcare services are designed and structured to serve majority population, which is housed, mobile individuals |
| - Healthcare services with follow-up care being rare | - Healthcare sectors rarely record patients' housing status |
| - Social exclusion leads to underutilization of healthcare | - PEH seen as requiring substantial time and resources |
| | - Limited training and awareness about homelessness among healthcare staff |
| | - Incapability to patient identification, and stigma |

## Evaluation case

In our policy brief, we use the case study of an intervention from Czechia. In this country, the healthcare system experience similar challenges as in other countries like aging. Moreover, in Czechia the situation is influenced by a relatively high PEH share on population, which puts Czechia at the fourth place in EU. PEH do not utilize the right to healthcare treatment because of bureaucratic and organizational issues (Kavková & Kottnauerová, 2018). Thus, PEH are in similar situation as in other countries – suffering under multiple diseases and disorders, underutilization of healthcare utilization, leading to low life expectancy (Kavková & Kottnauerová, 2018).

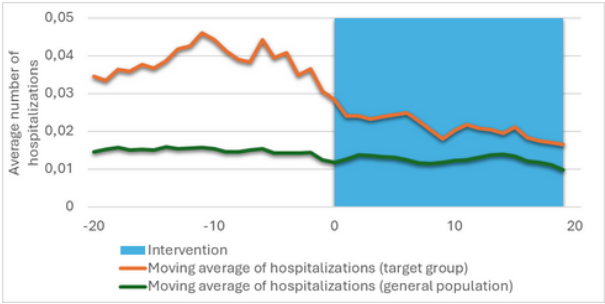
The project focused on homelessness as a factor of extreme social exclusion and poverty, and their effects on health in PEH. Moreover, by providing health and social services, it aimed at reducing overall treatment expenses paid from the public budgets. From the practical point of view, it aimed to ensure accessibility of health care for PEHs through the pilot operation of three clinics, while meeting the minimum scope of services and staffing, including support for outreach services.

The way the project coped with these issues was through interactions between health care staff and PEH to mitigate stigma, hygiene, transportation issues, distribution medicine. Moreover, it helped by equipping the healthcare professionals with skills needed to provide healthcare services to PEH. The third aspect of the assistance was mobile outreach and preventive measures with targeted health insurance reforms.

The intervention aimed to demonstrate the effectiveness of mobile outreach and preventive measures, while recommending targeted health insurance reforms to achieve public financial savings. In Czechia, the General Health Insurance Company of the Czech Republic, which insures most of the population, played a key role in this evaluation project (Bryndová et al., 2023). The project analyzed longitudinal data from the National Health Register (IHIS) to assess the intervention's impact. The outreach model for PEH sought to address structural compensation issues by integrating health and social services. Pilot general practices participated through grant support, jointly applied for with local NGOs offering social services. A notable innovation was the deployment of mixed mobile outreach teams, each comprising a social worker and a nurse.

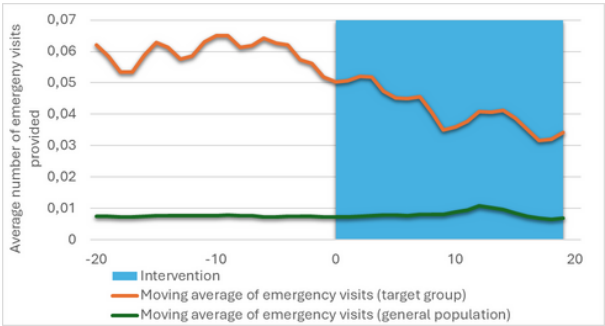
Figures 1 and 2 show the result of the intervention in a decrease in both hospital admissions and emergency visits. The downward trend before the intervention started is because the intervention started in two general practices in April and two in August. This is linked to the improved health status of the whole population in summer months, including PEH.

**Figure 1: Average number of hospitalizations**




*Source: Based on Šimon, Latečková, and Potluka (2025), the intervention started in the month 0; Numbers on axis x denote months around the start of the intervention.*

**Figure 2: Average number of emergency visits provided**




*Source: Based on Šimon et al. (2025), the intervention started in the month 0; Numbers on axis x denote months around the start of the intervention*

## Policy recommendations

### Positive effects of the intervention

- Intervention had a positive effect on hospitalization by 13.1 per 1,000 patients per month among the PEH (size of the PEH population was 3,417 people).
- Intervention had a positive effect on emergency visits by 16.1 per 1,000 patients per month among the PEH (size of the PEH population was 3,417 people).
- Outreach healthcare services help to prevent the development of chronic and severe illnesses that often require lengthy hospital stays and can lead to lasting disabilities.

### Positive effects of the intervention

- Introduction of two new codes to address the added time required for treating PEH by the Ministry of Health of the Czech Republic and the primary state health insurance provider.
- These codes specifically cover: (1) medical treatment provided by doctors to PEH, and (2) nursing care provided to PEH.
- The codes enable GP practices to provide care to homeless individuals with less dependence on external funding.
- The codes enhance accessibility to care at the initial GP practice level for homeless individuals.

We suggest that this model could be adapted by other countries with universal healthcare systems or in areas where NGOs are key providers of support services for the homeless. The observed declines in hospitalization and emergency visit rates from this evaluation may have broader relevance, particularly in regions where homeless populations experience high rates of hospital-based emergency and inpatient care.

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