1996 MARK ABRAM'S PRIZE WINNER

Health care and homelessness in Birmingham

Dr Helen Lester

The winner of the 1996 Mark Abrams's prize was awarded to Dr Helen Lester at the SRA Annual Conference. A synopsis of the article is printed below.

Three million people have been declared homeless in the UK in the past decade. Homelessness has profound health implications – illnesses are often presented late, are more severe and are often rare in the general population. My interest in the health care of homeless people stems from involvement with a medical unit for single homeless people in Birmingham. It has often struck me that I'm talking to people with real health needs, who could be registered with a local GP rather than travelling across the city to the Medical Unit. However, previous work has shown that homeless people often find difficulty in registering with a GP. Rates vary between 26-84%. The aim of my study was therefore to examine the realities and reasons behind the low registration rates from the view of the GP.

A qualitative approach was used – depth interviews with 25 GP key informants with a range of experience across Birmingham. Gaining access to this 'elite' group was not as difficult as expected, perhaps because of my position as an 'insider'. Transcripts were analysed using the SCPR Framework method. Of the 1113 factors mentioned in the transcripts, 579 (52%) were directly related to the GPs' attitudes and behaviour, 183 (17%) to patients, 225 (20%) to practice factors and 126 (11%) to the 'system', highlighting the importance of the GP characteristics.

There were a number of features and views common to all the GPs interviewed. Looking after homeless patients was a universal experience and medical training was perceived as being narrowly medical, with homelessness, if mentioned, there only in the context of an illness. There were however, many areas of training, beliefs, attitudes and behaviour towards homeless people that revealed consistent differences of opinion between GPs. It appears that GPs can be divided into Active or Passive categories depending on their degree of involvement with the homeless and then as Positive and Negative depending on definable characteristics such as assumptions and consultation style. For example, Positive GPs held more realistic views and emphasised the human qualities of the homeless. They felt that homeless people were open, straightforward, and grateful for treatment received. In contrast, Negative GPs described homeless people in a stereotypical way and felt that they didn't want to listen, to open up or even be treated.

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The major difference between the Positive and the Negative GPs appeared to be their attitude and behaviour within the consultation. Positive GPs described the consultation in terms such as 'fun, challenging, rewarding, enjoyable'. In contrast, the Negative GPs described the consultation in terms of feeling helpless and exploited, frustrated and irritated. They had few expectations of success either in medical or social terms and therefore felt the whole consultation was a waste of time. Positive GPs stressed the role of the GP in making the consultation work which might involve recognition of aims and treatment, and considerable perseverance. They preferred a more mutualistic approach to the doctor patient relationship. They acknowledged the uncertainty that can be associated with caring for homeless people – the problems of mobility and the lack of continuity and accepted a longer term view of modifying health seeking behaviour.

There was also general agreement among the Positive GPs on the need for a firm and consistent approach, particularly with people with addiction problems, and the value of networking. In contrast, the Negative GPs felt their role was confined to the physical problem only and that health education and social problems such as issuing housing letters or liaising with a probation officer or social worker were outside their remit. Their actions tended to fall into one of two categories – either being overly perceptive or 'giving in'.

If the GP is a major barrier to providing primary care for a rapidly growing section of our society, then this work has implications for the delivery of health care to homeless people as well as selection and training of future GPs. There is considerable evidence that students entering medical school for the first time already possess some of the characteristics and conservative attitudes of doctors in practice. This research has shown that the Negative GPs were more likely to hold stereotyped views of the homeless than the Positive GPs.

I would therefore suggest medical schools need to address the area of values training and behaviour change within curriculum planning and aim to provide greater direct experience in areas of health care such as homelessness where there is still significant associated stigma. If the GP himself is a major barrier to providing health care, then I would suggest that policies which encourage mainstream primary care for all homeless people will be hard to achieve in the short term.

Provision of an integrated service – specialist units which can provide good primary care but which also aim to encourage reintegration of the homeless into mainstream services, is perhaps the most appropriate form of health care delivery for homeless people.

Equity of access for homeless people may still be some way off – but I hope that the results of this research are a small step in the right direction.