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Anti-oppressive social work as a tool to reduce barriers to access health care services for homeless people

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ABSTRACT

Based on research findings on the experience of homeless people living in shelters with the use of health care services, this article shows how oppression can negatively affect the access of the homeless to health care. The acquired data shows that oppression associated with the status of a shelter user creates barriers to health care access – and not only in terms of financial barriers. In their narratives, the communication partners verbalized the oppression by doctors, other health care staff and patients. The aim of this paper is, on the basis of partial data from research, to discuss the possibilities of using anti-oppressive social work as a way to reduce the barriers to access to health care services in a given target group. The output of our article consists of proposed implications for social work practice.

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Introduction

Homelessness is an extreme form of poverty and a highly topical issue worldwide. Living in temporary forms of housing and on the street is often accompanied by a variety of health risks. Daiki [1] points out that the situation of homelessness is interlinked with health, which cannot be reduced simply to physical health. What is seriously threatened is the mental health of a homeless person, which can be affected by distress from the current life situation.

The health issue of homeless people is still little explored in the Czech Republic. Published papers [2] often

emphasize the poor health of homeless people as a result of their indifference, negative and irresponsible approach to health, lifestyle and low health literacy. This perspective views the health of homeless people as their own fault. The transfer of possible structural causes of problems to an individual level makes this group guilty of their social problems. Although equal access to treatment and health care for all groups of patients, regardless of their social status, solvency or ethnicity is one of the most important criteria in the assessment of health services organizations [3], in our research we have identified in narratives of communication partners barriers to access to health services.

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At the same time, oppression can be understood as the use of power or authority by a ruling group towards a group that is not endowed with power in an unfair, burdensome or cruel way. The anti-oppressive approach understands oppression as intersecting and intermingling in its individual categories (e.g. social class, race, socio-economic status), none of which can be understood as inferior [4].

This paper aims – based on partial data from the research survey, which understands the oppression and the resulting discrimination as important factors in reducing access of the shelter users to health care services – to discuss the possibilities of using an anti-oppressive approach in social work that would lead to the reduction of these barriers while contributing to the health improvement of homeless shelter residents.

The context of the health situation of homeless people

In the Czech Republic, a systemic solution to the issue of homelessness is still missing [5], and oppression as a barrier to accessing health care services is given little attention. This is related to the fact that a structural grasp of the topic of homelessness and exclusion from housing is not sufficiently developed in Czech social work, nor at the level of academic or professional discussion [6]. Also, Glumbíková et al. [7] point out that there is no comprehensive study in the Czech Republic on the health of shelter residents. The following barriers to access to health care for homeless people have been identified in their research: (a) financial reasons [7], (b) oppression (“labelling”, stigmatization) by physicians [7, 8], (c) distance [7, 8]. Essentially, their results are consistent with the results of international research that identified access-related barriers to health care services for shelter users. The main barriers included oppression [9], poor financial situation [9], and distance or accessibility of services [10]. Another described barrier is the problem of transport to health care facilities due to lack of finances and support in terms of accompanying and making an appointment with a doctor.

Theoretical foundation

In our text, we proceed from social constructionism, which understands social reality as a social construct created by interaction, communication and language. Constructionism insists that we take a critical approach towards the obvious (and thus taken-for-granted) ways of understanding the world [11].

Parker and Hefner [12] state that individual socially constructed categories (e.g. a homeless, a Roma, a woman) not only intertwine in a given social and historical context, but they in fact contribute (at different levels) to the creation of inequalities. In the case of homeless people it means that by losing their home they are also losing certain protections against oppression. In the context of the above, we also understand the oppression to be socially constructed. What we mean by the oppression is the use of power or authority by a ruling group against a group that does not have power, in an unfair, burdensome, or cruel manner. As a result, a disadvantaged group lacks the rights

commonly available to a majority society [13]. Oppression is therefore of a structural nature. All forms of oppression interact with each other and their influence may differ, but they have a common dimension, and that is precisely the “oppression” [14].

As noted above, oppression is one of the major barriers to access to health care services for homeless people. In this context, Martins [15] describes a feeling of “labelling” of the homeless shelter residents and their stigmatization, condemnation by doctors, disrespect, and “invisibility” of this population in relation to healthcare providers. Homeless people can thus be perceived as guilty of their own health situation (and so do not deserve any treatment or therapy), as people who are dirty, as those whom the doctors are squeamish about. The situation of certain groups of homeless people, e.g. women, is specific. Research shows that women almost never use medical services. In their case, another factor influencing the use of health care is shame about their own appearance and health condition [16].

Materials and methods

The research was carried out in 2017 as part of a project of the student grant competition called: Health and Use of Health Services by the Residents of Shelters. The research aimed to find out how the shelter residents perceived their health, health services, and how the topics of health and health services are reflected in their narratives. We presented partial research data when we chose a qualitative research strategy for the above-mentioned research objective.

The selection of communication partners was intentional (purposeful) through the institution of shelters [17]. The basic research sample was homeless shelter users. Pursuant to Section 57 (1) of the Act No. 108/2006 Coll., on Social Services [18], as amended: “*Shelters provide temporary residential services to persons in an unfavourable social situation associated with a loss of housing.*” It offers the following basic activities: (a) the provision of food or assistance in catering, (b) accommodation, (c) assistance in the application of rights, legitimate interests and in obtaining clarity in personal affairs.

A total of 30 communication partners from four different regions of the Czech Republic took part in the research, out of which 13 communication partners were women. All communication partners were current shelter residents, and half of them stayed in the shelter repeatedly. The communication partners were aged 20–66 (average age was 48); 25 of them were parents with a total of 52 children, with a current length of stay in a shelter from 1 month to 4 years (the average length of the current stay was 7.5 months).

The data was collected using a semi-structured interview. A validation technique for data collection was a focus group of six shelter residents: four women and two men. Within the semi-structured interviews and focus groups, we used the following set of questions: What does “health” and “to be healthy” mean for you? Can you describe

the development and current status of your health? What do you do to be healthy? What does a healthy lifestyle mean for you? What helps you to stay healthy? How do you use health services? What is your experience with health services?

The data was analyzed using the constructivist grounded theory by Charmaz. We used open coding, which consists of creating code searches in data [19].

From the point of view of the limitations of the data obtained, it can be said that the data was based on the direct statements of the communication partners, and there could have been a tendency toward social desirability during the interviews. The authors are aware that the presented data come from a qualitative research survey and so they cannot be generalized.

As part of the research implementation, we have followed the Ethical Principles in Human Research, adopted by the APA in 2010 [20].

Results

The results of the research (although only partial data) are categorized into two fundamental categories for the sake of clarity. The first category is “not going to a doctor”, and the second is “reasons not to go to a doctor”.

The phenomenon of “not going to a doctor”

In their narratives, communication partners emphasized the so-called “not going to doctors”. Their visits were often associated only **with serious illnesses**. “I’ve had six strokes, I’m destined to go to the doctor for my whole life. Before that I didn’t go much...only when something went really wrong” (Male CP = Communication Partner 10, 60 years old). Communication partners reported that they visit health care providers only if they have an acute health problem, and sometimes not even with such a condition. Seeing a doctor is thus influenced by the subjective perception of the current state of health, where the care is mostly sought by those who feel the worst. **Prevention** is completely missing: “I don’t use preventive examinations unless I’m completely K.O., so no... Because I don’t even care ... I’m not active, I always start becoming interested only when something starts to hurt...” (Male CP 7, 51 years old) and it is a common phenomenon **not to go to see doctors if one becomes sick**. “No. So, when I’m sick, then... I don’t go to see any doctor, no. I treat myself. I take a pill, for instance, well... nasal drops and such. Unless I’m really sick, I don’t go” (Female CP 9, 30 years old). Avoiding healthcare can occur at any point in the continuity of the disease, including prevention. Detection of disease, observation of symptoms and the interpretation of their significance depend on the seriousness of the symptoms felt [21].

Reasons not to go to a doctor

Communication partners cited several reasons for not going to a doctor. The most frequently mentioned were circumstances or obstacles limiting access to medical care

in the form of financial impossibility. **Financial reasons** included concerns about total costs and payments for travelling to the doctor’s office. “And given my financial situation, I went there yesterday at my own expense, there and back. Well, it’s about one hundred and twenty crowns, with a return ticket. And understand... it’s two thousand two hundred crowns a month... that is quite a sum...” (Male CP 8, 41 years old). The money issue also appeared in relation to **taking medication or the use of medical aids**. “Well, now I have run out of the medication, I’m waiting for money to arrive, because I can’t afford it as of now...” (Female CP 6, 66 years old). “They made some false teeth for me, because I don’t have my own teeth anymore, so... but I don’t wear them, because the paste costs a hundred and fifty crowns... do you think I have that kind of money? I don’t!” (Male CP 6, 60 years old).

Another barrier in failing to seek medical services was **distance**. The distance was often related to the fact that shelter users’ general practitioner was in the place of their original residence. Communication partners stated that transportation was difficult, or the distance was too great. “No, no. I still have that doctor in O. I have to arrange for this here first” (Female CP 2, 20 years old). “I can get to the place on my own now and don’t get lost. The only problem is that it is so far away. If I took a ride... but I go on foot, well, that’s hard... my foot then hurts a lot” (Male CP 4, 58 years old). Overcoming this distance can be associated with both financial burdens and mental and physical exertion. The role of time or sense of direction also play their part here. **Psychological problems** are also a perceived barrier to access to doctors. Communication partners reported that problems with mental health (e.g. depression, severe anxiety) prevented them from going. “When I had those depressions and such, I wouldn’t even go to see a doctor at all” (Male CP 8, 41 years old). “Well, the anxieties... they prevented me from going to the doctor” (Female CP 6, 66 years old). This corresponds to the previous findings that people with serious psychological distress are more likely to avoid health care or lack the motivation to seek care. This specific barrier to the non-use of healthcare services was represented by some communication partners as follows: “So, I just had to go to a shelter because it was quite bad because of this... it took me a long time to want to be with some people again... I didn’t go anywhere... not even to that doctor” (Female CP 15, 27 years old). A lower use of health services complicates the life situation of victims. Avoiding medical help can, in these cases, strengthen their isolation and worsen their psychological problems. Examples of suicidal thoughts in their statements are evidence of this. “I’ve had thoughts of death in the past, I would then have all the peace at least, I really had enough troubles” (Female CP 5, 36 years old). A certain barrier to the treatment of psychiatric illnesses may also be children, in particular the need to look after children and the fear of their removal from a family in case of long-term hospitalization. One communication partner described a case of children being removed from her custody when she suffered from severe depressions and her situation was assessed as “being unable to care for children”. Later she spent “a long time in a psychiatric hospital” and her children were temporarily placed in another family.

Missing or incomplete medical documentation is often a major problem with provision of medical care.

These administrative barriers are more a case of system deficiency and may lead to the loss of a personal physician. Some communication partners described it as follows: *“They just wrote down that the card was missing... and that I didn’t have any doctor”* (Male CP 13, 41 years old). *“They couldn’t find that card. They called an archive, and they found nothing at all. So I have had no doctor ever since. Nobody at all”* (Male CP 12, 40 years old). Finding a new doctor remains complicated as a result of the current situation in the health care sector, where both specialists and district physicians are in short supply. Communication partners have also often reported that they have a problem with finding a doctor at all. *“The thing is that all the doctors are full and don’t accept any new patients. They accept new patients, for example, thirty kilometers away from here. But to go that far with a high temperature... I do not like pain and my teeth... it’s not my strong point, and when you open your mouth and a dentist gets in there, you need to feel... that you are in good hands”* (Male CP 16, 55 years old).

Oppression as a barrier to the use of health care services

Negative evaluations of the process or outcomes of seeking medical care are one of the other reasons homeless people avoid seeing doctors. The most frequently reported reasons for negative evaluations were factors related to doctors. A very serious and often verbalized reason for not seeing a doctor was the perceived **oppressive attitude of doctors**. This attitude had several reasons. Some communication partners attributed the oppressive attitude of physicians to their **situation of homelessness**. *“A parasite... So, the doctors just look at those people in a certain way... It is sometimes so unpleasant”* (Male CP 8, 41 years old). *“So they took me to O., where I had a surgery so I had to stay in the hospital for a few days... and the bandages fell off my leg and a nurse came to me to redress it and said to me: ‘You can fix it yourself, can’t you?’ I tried, but I am not able to do it.’ And she said, ‘Well, you’re lazy and clumsy’... just because I live in a shelter... I know she knew about it and that is why she called me names”* (Male CP 9, 56 years old). *“I’ll tell you directly that when someone’s life is in pieces, some doctors behave terribly. You’re just trash to them, and that’s terrible. I’ve experienced it a few times...”* (Male CP 6, 60 years old). Concerns about the oppressive attitude of doctors were expressed both in the sphere of interpersonal relations and in the area of quality of services provided.

The communication partners described that in both health services and in the contact with public they face oppression in relation to the loss of home. One of the communication partners added that **oppression of homeless people does not only exist on the part of doctors but on the part of society as a whole**. *“They are looking down their noses at us because some of them [the homeless] were walking around with a bottle in their hand, or they were sitting inside with a carton of wine... They were looking at how they [the homeless] sat outside the supermarket. These guys are usually not from here... and when people look, they make a mess... and how do we look then?”* (Male CP 2, 58 years old). Contemporary society is dominated by negative attitudes towards homeless people,

especially in the context of the attributing of individual causes of homelessness, i.e. in the context of the belief that the life situation of homeless people is self-inflicted and there is no influence of structural causes of homelessness (such as non-existence of the Social Housing Act or the housing fund privatization).

Some communication partners talked about oppression because of their **race**. *“I’ve experienced it so many times. Even though I’m not Roma, you can see it right away... even at the doctors, when a Roma woman comes in, the attitude is just different”* (Female CP 11, 53 years old). The breadth of causes for medical care avoidance in this target group has its own specifics. For this reason, it is important to ensure that reasons for avoidance are studied in these specific populations. Ethnicity in these situations is a structural barrier that the individual cannot influence. Another barrier was the perceived **oppressive view of people who are currently addicted to alcohol or have experience with this type of addiction**. *“I went to a psychiatrist, then I discovered, about half a year ago, that he was able to tell what kind of person he was dealing with. He said that I was an alcoholic, and that I should get out of there. Then I went to another psychiatrist, and he was quite hostile. Yeah, he’d just prefer to kill me, yeah. The best alcoholic is a dead alcoholic, he said... You know, I’m not surprised that the doctors look at you that way”* (Male CP 8, 41 years old). The above-mentioned points indicate the fact that the oppression inflicted on the homeless is intersectional in character, that is, the penetration and intersection of several levels of oppression occurs. In order to understand the life situation of homeless people and their (non) use of health services, it is therefore necessary to perceive all levels of oppression in terms of an anti-oppressive approach as interconnected [4].

However, one of the communication partners described a totally **anti-oppressive strategy**, which he experienced with one female dentist. *“So, for example, I respect that female dentist, I’ll go back to see her again... that’s probably what she said to everybody I talked to, Don’t worry about money, I’ll try charging everything from an insurance company, and she always tries to do something for free. I think she is a special doctor...”* (Male CP 2, 58 years old). From the point of view of the communication partner, the described anti-oppressive strategy appears to be an example of good practice in the provision of health services to homeless people.

These barriers and associated negative experiences contribute to exclusion from standard medical care. This may lead to worse health outcomes and greater utilization of acute and expensive types of services such as emergency care.

Discussion

Anti-oppressive approach as a way to mitigate/eliminate oppression and barriers of access to medical care

The results of our research confirm that barriers to access to medical care may not only be of financial or health

nature. Communication partners put a great importance on the oppression in their narratives.

In the context of the above, the authors of the article assume that in social work with homeless people it is important to emphasize the anti-oppressive approach (AOP) that seeks to reduce or eliminate oppression and discrimination in the context of structural inequalities that affect human lives [22]. The anti-oppressive approach has the potential to remove obstacles, such as the already mentioned cultural differences between healthcare providers and potential clients or providers of hostility or resistance.

For the current practice of social work, the authors of the article agree with Legge [23] that an anti-oppressive approach is a popular model. Despite the declared popularity of AOP in the current practice of social work, its implementation in public/state social services continues to be marginal. It is necessary to strengthen the anti-oppressive approach in social work in the environment of Czech shelters, especially in cases of homeless mothers [7].

The AOP key principles, perceived by the authors of the article in accordance with Danso [13], are: self-reflection of the client, assessment of the client's experience with oppression, client empowerment, cooperation/participation of the client in the solution, and minimal intervention by a social worker. By empowerment, according to Staub-Bernasconi [24], we can achieve targeted support of individuals, groups, and communities so that their needs can be met [10] and they get what they did not have access to, but which they are entitled to.

Regarding the shelter clients, it makes sense to the authors to mention the need for activation (in the sense of "agency"), i.e. to give them opportunity to express their opinion and to get involved/participate [13]. Through their involvement/participation they become part of the solution process, and have the opportunity to state their opinion, thus increasing their power [25]. This can be done in a number of ways, for example at an individual level, in the form of a "peer" worker who has the same life experience. In the case of homeless people, a peer worker can be a person who has actually been through the shelter as a client.

At the macro level, the authors believe that it is desirable to involve people with a certain power in society, such as politicians, managers, and public figures to address the situation of clients. An example of good practice is the Curry-Stevens [26] research, which tried to explore how to persuade these persons to encourage system change and social justice in terms of mitigating the oppression.

With regard to the mentioned barriers of communication partners, the method of advocacy of clients' rights, according to the authors, should be offered in the sense of enforcing the rights of recipients of social work at different levels. A more effective use is offered in situations where clients are not legally empowered because of their age, serious illness, status or other serious disability. In the context of this, the authors believe that the supporting factor in AOP becomes the critical reflexivity and self-reflexivity of oppressive mechanisms. It includes a targeted, systematic, and continuous awareness of one's own positions, assumptions, knowledge and routine prac-

tices as well as other barriers and their impact on the social work performance on the part of each social worker. The implications for social work are provided by Beddoe et al. [27], who talk about supervision as a forum for a reflective learning process that enables a social worker to participate in developing best practice.

The above-mentioned should be applied not only in the practice of social work, but also in the educational process – where the future social workers are prepared for practising their profession.

Conclusion

In their narratives, communication partners from homeless shelters reflected/described barriers to the use of health care services. One of the most accentuated barriers was oppression. Due to perceived oppression we consider it important to emphasize the importance of an anti-oppressive approach and its instruments in social work with the target group and its implications for the social work practice and education of future social workers. Taking into account the key principles of AOP, offered methods of social work are also derived. Apart from the necessary changes at the system level, classical individual social work is perceived as useful. The use of these approaches in the practice of social work cannot be without the appropriate education of students of social work, and also the inclusion of AOP elements in the scientific and research activities in social work.

Conflict of interest

The authors have no conflict of interests to declare.

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