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Translating Universal Health Care for the Homeless:

Barriers and potential facilitating factors for accessing health care amongst street dwellers in India

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Abstract

Urban health policy has remained a neglected area in India, and amongst the urban poor, the homeless remain the most deprived, neglected and stigmatized group. While they suffer from a large burden of disease, there are a variety of reasons that prevent them from accessing the available health care services – particularly in the public health sector. These barriers have been poorly understood and documented. This report, based upon a detailed study of homeless participants in New Delhi, India, seeks to highlight the systemic changes that would be required within public health systems to enable street dwellers to avail of their services and realise the conceptual ambit of ' health for all' in the context of homeless persons.

Keywords: Street dwellers; urban poor; urban homeless; health care services; barriers; facilitating factors; access; qualitative studies; New Delhi; India

Translating Universal Health Care for the Homeless:

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V. Prasad[2]

I. Introduction

The Universal Declaration of Human Rights (UDHR) of 1948 states in its Article 25 (1) that, “Everyone has the right to a standard of living adequate for the health and well being of himself and his family, including food, clothing, housing, medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control” (UN, 1948:5). These rights are often denied to the poor in general, and the homeless are the most vulnerable, least powerful and most invisible amongst them.

Despite a rapid economic growth in the last decade, India has failed to do correspondingly well in improvements in health indicators (Horton and Das, 2011) and much of this failure is attributed to the inequitable systems of health care that currently exist in the country (Reddy et al, 2011; Balarajan et al, 2011). Significantly, the country is engaged in a vibrant debate of how to take 'universal health coverage' (UHC) forward in the forthcoming 12th Five Yearly Plan (HLEG, 2011; Srivatsan and Shatrugna, 2012) such that it can cater to the health needs of the entire population in an equitable way.

Urban health too has been a vastly neglected area in India in terms of health policy, health status and availability of public health systems. This is despite the fact that health indicators amongst urban slum dwellers are often far worse than in rural areas (Saxena, 2007; Public Health Resource Network (PHRN), 2010) and that a third of the poor population in India live in urban areas (Supreme Court Commissioners, 2008; PHRN, 2010). The neglect of urban health in policy is best exemplified by the fact that whereas there has been a significant response by government to provide for rural health needs through its flagship program; the National Rural Health Mission (NRHM) (GOI, 2005), a proposed National Urban Health Mission (NUHM) (GOI, 2008) is yet to be finalized.

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[1] This report is based upon a detailed study undertaken by the author in New Delhi as part requirement for a Msc. in Public Health from the School of Public Health, Faculty of Community and Health Sciences, University of the Western Cape, South Africa. Using a qualitative approach 18 adult street dwellers (both male and female) were individually interviewed – along with 6 key informants working in the public and non-governmental health sector. This was accompanied by a process of observation. The results were analyzed by identifying recurrent themes associated with barriers and facilitating factors for access to health care by the homeless, following which a set of recommendations related to the homeless, were developed so as to inform those working in the public health sector.

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Amongst the urban poor the most marginalized and socially invisible are those living on the streets. The urban homeless in India are a highly heterogeneous group of persons ranging from recent migrant workers to people suffering from a variety of disabilities (including mental illness) – many of whom survive through begging. Existing laws against begging criminalize the homeless and prevailing public opinion sees the homeless as "vaguely dangerous and intractably on the wrong side of the law" (Mander, 2008:4) rather than as persons suffering from some of the severest forms of human rights violations. Many factors inhibit the homeless from approaching public health care services. Derogatory behavior and discrimination by health care providers is a common finding along with other socio-cultural barriers, such as illiteracy, difficulties with speaking the local language, isolation and unfamiliarity with the local area and the lack of family carers to assist during hospitalization. However, significant structural barriers are also likely to exist that inhibit the homeless from using public health care services. These include the lack of money to pay the required user charges, facing long delays and a lack of proof of identity and address.

The experience of agencies working with the homeless suggests that although the homeless spend substantially on health care services (including on medicines), they are reluctant to use government health care services which are far less expensive and are, in fact, meant to be free for persons who fall below the poverty line (BPL[3]). BPL persons are also eligible for free services in select corporate and private hospitals that have been given considerable concessions by the government for land use in return. However, this system of 'free beds' in private hospitals is functioning poorly with much resistance by the private hospitals in admitting poor patients and providing entirely free health care (Jha, 2011). A government insurance scheme; Rashtriya Swasthya Bima Yojana (RSBY) has only very recently been introduced for persons below the poverty line to allow them to access accredited private health facilities (Kumar et al, 2011). Getting this insurance requires proof of residence and would be almost impossible for a homeless person in India in the present circumstances.

To date there has been no specific policy or program intervention on the part of the Indian government to reach out to homeless people and assist them to access public health services. However, the draft National Urban Health Policy (2008) offers some hope as it acknowledges that:

> […] a fraction of the urban poor who normally do not reside in slums, but in temporary settlement or are homeless, comprise the most disadvantaged section. Under the NUHM special emphasis would be on improving the reach of health care services to these vulnerable among the urban poor, falling in the category of destitute, beggars, street children….(GOI, 2008: 21)

This analysis of international and Indian experience with health care for the homeless seeks to explicate the barriers and potential facilitating factors that could impact the translation of this good intention to reality.

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[3] The Below Poverty Line status is a very important distinction in India since it forms the basis for targeting of services to the extremely poor in policy. Therefore, a BPL card holder would be entitled to greater concessions or free services such as for food, health and education. The BPL category is selected on the basis of periodic surveys but the methodology for this selection has been vastly criticized for causing huge errors of exclusion and inclusion. It is considered that the most poor tend to get left out the surveys and many powerful people get included. Even currently, the planning commission is under attack by 'civil society' for projecting a very low cut – off for the BPL category. The matter is in the Supreme Court pending judgment. Interested readers are referred to Mahamallik, M. and Sahu, GB. (2011). Identification of the Poor: Errors of Exclusion and Inclusion. *Economic and Political Weekly*. XLVI (9): 71-77 for further details.

The problems of Enumeration and Identification of the Homeless

On account of their invisibility, ensuring their identification amongst other categories of people who have been denied their basic rights becomes an important first step towards being able to intervene on their behalf. As a group working on issues related to homeless people in Europe puts it, “homeless and severely excluded people are usually invisible to traditional national statistic instruments and mechanisms” (FEANTSA, 2009:4).

It is estimated by a former UN special rapporteur on the right to adequate housing, that there might be over a billion homeless people in the world (Kothari et al, 2006). The numbers are likely to be the highest in Africa, Asia and Latin America, but with substantial numbers in the developed world as well (youthXchange, 2009). It is also commonly acknowledged that official counts suffer from severe under-reporting and that data from developing countries is very scanty (youthXchange, 2009). The WHO Commission on Social Determinants of Health (CSDH, 2008) states in its final report that more than 2000 million people live in life-threatening and health-threatening housing and living environments.

Where India is concerned, the 2001 census suggested that there are 1.94 million homeless people, 0.77 million of whom live in cities and towns (Supreme Court Commissioners, 2008). However, there are likely to be many more than counted. The number of homeless people counted in the capital city of Delhi by this census process, for example, was 21,895 (Rai, 2008). However, a headcount conducted in 2000 by Aashray Adhikar Abhiyan (an organization working with the homeless in Delhi) found 52,765 homeless people in the city, and it was estimated that for every one they could count there were one or two homeless people that escaped their enumerators. Similarly, in 1985 the Delhi Development Authority estimated that the houseless population of Delhi in 1995 would be 1 percent of the total population. By this estimation, the homeless in Delhi would be about 0.15 million in 2008 as per 2001 census figures for the total population in New Delhi (Rai, 2008). Thus, the numbers of homeless persons in India are a significant proportion of the population, and suffer from gross underreporting. This has implications on whether policy makers would consider their health problems significant enough as a public health problem to construct special health programs for them, and allocate such programs sufficient financial resources.

II. Health and Homelessness: a Two-way Relationship

> It is remarkable that so little is known about the lived experiences of those without a home: why do they live on the streets, how do they survive; how do they manage to sleep, where do they bathe; what do they eat, what work they do, do they access public services? (Supreme Court Commissioners, 2008: 54)

Unlike Europe and the USA, very little published material exists about the health status, health-related experiences and/or the access the urban homeless in India have to health care.

‘Homelessness’, or the lack of shelter has obvious implications upon health; it usually signifies extreme poverty, exposure to violence and abuse and vulnerability to environmental conditions. Apart from the lack of shelter, homelessness is also associated with constraints in access to the basic human requirements of safe water, sanitation and safe and adequate food – without which the homeless are particularly vulnerable to ill health. Interestingly, whereas shelter is understood to be a key social determinant of health in the CSDH report, the impact of the *lack of shelter* or *homelessness* on health does not specifically find mention. The CSDH report, nevertheless, encourages all health personnel to have the knowledge and skills to work with other social services, especially in the provision of shelter for the homeless (CSDH, 1992). Similarly, while the WHO has detailed the relationship of housing with health in its report ‘Health Principles of Housing’ (WHO, 1989) it has not specifically detailed the relationship of health to homelessness. Notwithstanding the lack of special attention by the WHO, agencies working specifically with the homeless have shown that a very high disease burden exists within the population of homeless persons.

Studies in the USA and UK suggest that common conditions such as infections, respiratory disease, gastrointestinal problems, fits and loss of consciousness are more prevalent among homeless people than the general population (McMurray-Avila et al, 1998; Findlay et al., 2010; Snyder et al., 2004, Quilgars and Pleace, 2003). Physical injury is also reported to be common amongst the homeless. For example, in his review of data available on homeless persons from various studies conducted in cities of US and UK, Findlay et al. (2010) reported that homeless people were 13 times more at risk of assault than the general population. They also find that 38-59 percent of homeless people were found to have multiple health problems.

Alcohol dependence and substance misuse are common amongst the homeless and they are 8 to 11 times more likely to suffer from mental illness than others (Findlay et al., 2010). The single most common disorder amongst homeless persons in US has been noted to be substance abuse (McMurray-Avila et al, 1998). According to a fact sheet of the National Center for Family Homelessness (USA), presenting a collation of research findings on the homeless; mothers experiencing homelessness were found to have three times the rate of post traumatic stress disorder and twice the rate of drug and alcohol dependence as other women. In addition, about 50 percent of mothers interviewed in another study had experienced a major depressive episode since becoming homeless (National Center on Family Homelessness, 2008).

Although there is lack of precise data from India, a survey of 340 homeless people in four cities of India in a report titled ‘Living Rough’ (Mander, 2008) states that 100 percent of respondents in every city reported major health problems in the past year, and 56 percent were advised hospitalization but did not go to hospital. Similarly, the Health Initiative Group for the Homeless (HIGH), a coalition of organizations including Aashray Adhikar Abhiyan and Institute of Human Behavior and Allied Sciences founded in 2000, reports from a survey of 2955 homeless respondents in New Delhi that “A high proportion of homeless people were suffering from serious respiratory ailments including tuberculosis, acute and chronic infections, skin diseases and diarrheal diseases” (HIGH, 2003: 26).

Conversely, health issues may be the *reason* for homelessness in the first place. Mander (2008) suggests that while extreme poverty remains the main cause of homelessness, mental illness, mental retardation and stigmatizing illnesses are also contributing factors that precipitate homelessness. This dialectic relationship between health and homelessness is also referred to by other authors (FEANTSA, ud; Findlay et al, 2010; Quilgars and Pleace 2003).

However, while an extensive report on human rights to housing in the Indian context (Kothari et al, 2006) provides a comprehensive list of structural causes of homelessness, health issues do not find specific mention.

While analyzing the causes of homelessness from the accounts of the participants, a recent study (Prasad, 2011) demonstrates the downward slide to a state of homelessness from pre existing vulnerability due to poverty, and the reasons for such a decline. Most of the participants, it finds, had been pushed into homelessness by factors ranging from expenses on health, demolition drives by the government, to simply becoming too old to work and be able to pay rent. In two cases from a sample of eighteen; homelessness was directly caused by the expenses from a catastrophic illness. Both affected were workers who suffered an accident and could not pay for orthopedic prostheses, resulting in permanent and severe disability and loss of livelihood. Out of pocket expenditures on health care were also found to perpetuate homelessness by exhausting savings and resultant sale of assets such as homes and sources of livelihoods as in the case of a homeless woman who had to sell her already mortgaged house as well as the rickshaws belonging to her family to pay for care for her baby daughter in public hospitals. While the high incidence of catastrophic illnesses pushing people below the poverty line has been discussed in general by other Indian authors; Selvaraj and Karan (2009) and Balarajan et al (2011) put the figure at 39 million each year, this factor has not been reported in previous studies as a specific determinant of homelessness in India. This report confirms the fact that catastrophic health events do indeed bring about a loss of homes and livelihoods, relegating the victims to a lifetime of homelessness and beggary.

A sudden illness is known to seriously deplete the savings of poor people in India, in the absence of equitable access to health care; an illness termed 'catastrophic' by the Macroeconomic Commission on Health set up by the Government of India (MCH, 2005:71). The same commission recommends that

> [...] a basic safety net [should be]…provided to shelter vulnerable populations from impoverishment due to catastrophic care [sic] (MCH, 2005: 88]

Reddy et al (2011) in the recent Lancet Series titled *India: towards universal health coverage* go on to say that costs of health care are a leading cause of poverty in India today. It would be safe to say that costs of health care also may lead to homelessness amongst the poor in India.

Expenditures on basic Survival and prohibitive costs of health care

In terms of human rights, the study by Prasad (2011) demonstrates an overarching violation of rights as defined by the UNDHR; the rights to "a standard of living adequate for the health and well being of himself and his family, including food, clothing, housing, medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control" (UN, 1948:5). The lack of social services is evidenced by the fact that no participant held a BPL card (which could have led to access to free health care services) and only one was able to avail of a pension. None of the homeless participants had any kind of health insurance.

Prevention of homelessness is an important part of any comprehensive strategy to provide health care for the homeless (Quilgars and Pleace, 2003). For this to be done effectively, it must be understood that the lack of social security in general, and expenditures on health in particular, often push people into as well as perpetuate homelessness.

According to Mander (2008), 75 percent of homeless people earned less than Rs 100 ($ 2) a day in his sample of 340 homeless persons from four cities in India including Delhi. He also notes that for 50 percent the reason for becoming homeless was extreme poverty. Since poverty seems to be one of the major causes of homelessness, expenditures on basic needs such as food and health care would certainly be expected to have a bearing on the perpetuation of homelessness apart from leading to it, by depleting the resources that could have otherwise led to rehabilitation.

The report 'Living Rough[4]' (Mander, 2008) shows from studies done in four cities of India, that homeless people spend a large amount of their entire daily earnings on basic needs. For example, 50 – 90 percent of daily earnings may be spent on food alone despite also taking some charity meals. It was also found that 5.4 percent of those studied were paying for drinking water, 33.3 percent for defecation and 22.6 percent for bathing.

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[4] This is a compendium of 4 studies and review articles on homeless people in India prepared on behalf of the Planning Commission of India

However, little data is available on their expenditure on health specifically and only anecdotal accounts provide a glimpse of the hardships faced by homeless people with respect to being able to access health care. For example, the Delhi City Report (Rai, 2008) of 'Living Rough' states that in four cases where hospitalization was required the respondents could not afford the treatment and that even though most of the homeless people visited a government hospital they had to spend a considerable amount of money on their treatment, ranging from Rs. 500 to 4000[5] (approx $10 to $800 – with over 75 percent of homeless people earning less than $2 per day as described above).

As early as 1946, the Bhore Committee report (GOI, 1946), that laid much of the foundations for the notion of 'Health for All' in India, stated that no one must be denied health care because of inability to pay for it; a principle that the Indian State has further reiterated through some of its subsequent policies and programs. The National Rural Health Mission (NRHM); government's flagship program promises "social security to poor to cover for ill health linked impoverishment and bankruptcy" (MOHFW, 2005: 21) as a priority, and recognizes "Large out of pocket expenditures even while attending free public health facilities- food transport, escort, livelihood loss etc." (MOHFW, 2005: 21). It further states that "economically catastrophic illness events like accidents, surgeries need coverage for everyone especially the poor" (MOHFW, 2005: 21). This has largely been implemented by making services free for persons categorized as BPL while progressively increasing user fees have been levied for others on most services within the public health system. No corresponding stated policy exists for urban areas, though what is followed in practice is largely supposed to be the same.

However, many authors (Rai, 2008; Prasad, 2011) note that user fees had been demanded from homeless persons who required hospitalization but could not afford treatment. It was observed that the costs of treatment at government hospitals for homeless patients had ranged from Rs 500 to 4000 and up to 10,000 in free beds attached to private hospitals. The fact that user fees often marginalize the poorest of the poor in general has been referred to by other authors also (Creese, 1997) as well as the report of the National Macroeconomic Commission for Health (NCMH, 2005).

Much has been written about the perils of the process of identification of BPL in India and its propensity for massive errors of exclusion (Mahamallik and Sahu, 2010). Studies clearly illustrate that the poorest of the poor; the homeless, are neither identified as BPL (Mander, 2008; Prasad, 2011) nor are they able to avail of the discretionary powers available with the health system for free care. The fact that they are not categorized as BPL also precludes insurance through the RSBY.

It can thus be argued that in the given situation, the existence of a comprehensive universally free public system of health care that does not require any cash transactions between the service providers and the users[6] would be best suited to the homeless for being able to surmount the barrier of prohibitive costs of care.

III. Barriers within Health Care Services

Access to social services in India is strongly related to factors of class, gender, caste[7] and education, and is difficult for poor people in general. As such, poverty affects all the social determinants of health as well as the

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[5] At the conversion rate on 22.9.2011 a dollar is equivalent to 49.03 Rs. This has been rounded off to Rs 50

[6] In other countries, such systems have been created through tax based or insurance based financing

[7] A system of social stratification where people belonging to 'lower' castes may be discriminated against

ability to access health care in case of illness. The prevailing situation of a highly privatized health care system and high out of pocket expenditures make access to health care difficult for all poor people in general. As described by Balarajan et al (2011) in a recent paper on health care and equity in India, costs of care may be a reason for the poor to forgo care altogether and this important barrier has been detailed above.

However, within the broad category of the ‘poor’, there are various sub categories; such as the homeless, characterized by specific vulnerabilities that face specific barriers to accessing health care;. Despite a high burden of disease the homeless are found to be wary of approaching health care services for a variety of reasons. Whilst these reasons are described in a variety of geographical settings and amongst different age and sex groups in developed countries, the commonalities suggest that they may have universal relevance and relationship to homelessness per se rather than to their more specific contexts.

The reasons quoted from other countries range from characteristics of the facilities themselves, such as insulting behavior of health care providers, inconvenient timings and high costs (Quilgars and Pleace, 2003), particular characteristics of being homeless - such as the absence of a fixed address (Findlay et al, 2010; Quilgars and Pleace, 2003), a lack of literacy and inability to fill in forms (Quilgars and Pleace, 2003), and a lack of financial assistance such as insurance (Hudson et al., 2010). Characteristics such as lack of transport, high degree of mobility (Findlay et al, 2010), an unsettled lifestyle and mutual distrust between the health care providers and the homeless (Findlay et al, 2010; McMurray-Avila et al, 1999; Quilgars and Pleace, 2003) further cause barriers to health care and follow up.

A recent qualitative study of 24 homeless drug-using young adults in Santa Monica, USA found that both structural barriers (e.g. limited clinic sites, limited hours of operation, priority health conditions, and long wait times) and social barriers (such as the perception of discrimination by uncaring professionals) contributed to their failure to access care (Hudson et al., 2010).

Even in European countries where health care is organized systematically and is relatively equitable as compared to India, FEANTSA notes the barriers experienced by the homeless as stigma, discrimination, inability to furnish a permanent address and other details, lack of continuity of care, difficulty in accessing drug and alcohol services, lack of knowledge about entitlements and financial obstacles (FEANTSA, 2004).

Additionally, an evaluation of services for the homeless in Scotland highlights negligent behavior amongst medical professionals as well as the neglect of their own health by the homeless as a result of low self esteem. In particular, drug and alcohol dependency and mental health problems have been correlated with poorer health seeking behavior (Quilgars and Pleace, 2003).

The health systems presumed in the analysis above, such as having a geographical (district-wise) catchment area for facilities, and widespread drug and alcohol services for the homeless do not exist in India. The two main reports cited previously; ‘Living Rough’ and the HIGH report; Health Care Beyond Zero, provide many insights through their case studies of the difficulties faced by homeless people in this regard. For example, Mander notes that the homeless “found the government hospitals unwelcoming, discriminating because of their unclean unwashed bodies, and expensive (because of the costs of medicines and sometimes illegal charges by the public health practitioners)” (Mander, 2008:27). The HIGH report offers greater detail on health issues and mentions cost being the major reason that the homeless fail to access government hospitals. They also find not having proof or residence and the attitude of health care providers as a barrier. Further, they relate that it takes a long time to get attended to in public facilities and add a unique insight; how the lack of family support for care during hospital admissions becomes a barrier (HIGH, 2003).

While the barriers described in literature are a combination of both structural and socio-cultural barriers, structural causes are likely to predominate in India (Prasad, 2011). High costs of care, even in the government-run (public health) system and the failure of the system to be able to cater to a population that is mostly illiterate, has a high burden of disease and does not have fixed residence and attendant family emerge as the main potential structural issues. These are then likely to compound the general problems with quality in public health systems such as long delays and complicated procedures that poor people are often not able to comprehend.

Quality and universal access to health care

The issues of quality of health care services for the poor in India and relationship to access are not well documented, especially from the point of view of the users. As Balaji et al put it "In India, quality in health care is not well understood, with insufficient evidence to infer how it affects equity" (2011: 508). However, they do note that the poor in urban settings are more likely to visit private practitioners who are not "sufficiently competent" (2011: 509). They further discuss the connections between dissatisfaction with quality and a preference for the private sector by the poor and conclude that these factors lead to the poor people getting a poor quality of services.

The problems of quality within both the public sector and the private sector in India are well described and analyzed in the Report of the Macroeconomic Commission on Health (WHO, 2005) which concludes that "the private sector has by and large failed to provide quality care at a reasonable cost" (:126). Thus, if the quality of services in public health systems improves, it is likely that the homeless will be more motivated to seek care from the public health system.

Amongst the general poor, this preference for the private sector is reflected in high OOPE, whereas for the homeless, it may reflect in not seeking care at all or delaying attempts to access care, as suggested by the reports from four cities of India in the report 'Living Rough' (Mander, 2008). Prasad, (2011) notes that at face-value, homeless persons seemed to distrust free services within public health facilities despite recognizing their necessity. However, it is argued that since free services (such as drugs) are made available only for the very poor, and not used by the rich, the interpretation the homeless often make is that services, drugs and consumables used by those who can afford to pay must be of better quality than what is given to them free. Their perception is supported by other authors who also feel that the poor do in fact get poorer services at the same facility (Kennedy et al, 2009).

It is possible that the existence of a universal system of free health care that is equally available for all rather than targeted upon the poor would increase user confidence where the poor are concerned over and above the benefits from belaying the costs of care. Universalization provides a quality of care to all irrespective of class, removes the requirement and difficulties for specific identification and also removes the not unwarranted suspicion that if only the poor are to get a free service in India, they will most likely receive a poor service. Additionally, international evidence also supports the fact that universalization of free services (paid for through taxation) ensures that a pressure is kept up on the quality of services by people who are more powerful and articulate than the illiterate and most poor (Hennigan, 2010).

IV. The Health System's Response to Homeless Persons

Specific health programs have been set up in Europe and US by NGOs and governments working separately or in partnership, which can be analyzed to identify facilitating factors that would allow better access to health care by the homeless. Examples are available from Austria, Portugal, Scotland and U.S and some of these are described in the FEANTSA (2004) report on 'How Health Professionals can Work towards Meeting the Health Needs of Homeless People'.

The Scottish government has been running an extensive health program for the homeless which has also been well documented and formally evaluated (Quilgars and Pleace, 2003). The evaluation strongly suggests that services for the homeless must include strategies for prevention of homelessness itself, such as close coordination with other agencies for housing and employment. In terms of direct interventions by the health system, a very helpful framework is developed by the authors as follows:

1. Adaptations of the existing system: through providing a link worker at the level of the facility, discharge arrangements for post-admission care and special training of medical personnel
2. Primary health care services: through outreach as well as fixed locations, including facilitation through health workers
3. Specialist services: for mental illness and drug abuse which need to be of high quality, tolerant, flexible and individually tailored. Dental services, podiatry and physiotherapy are also recommended as additional specialist services.
4. Health Promotion: including peer group learning, in settings such as on the street, in hostels and shelters.

It should be noted that the program in Scotland is backed by political, legislative and social changes and that special legislation exists for protecting the rights of the homeless.

A significant symposium paper from the U.S (MacMurray-Avila, 1998) details the changes necessary in clinical practice to improve access by the homeless. The authors also identify nine general principles for facilitating health care for the homeless: the importance of outreach, respect for the individuality of each person, cultivation of trust and rapport between service provider and client, flexibility in service provision, including location and hours of service, as well as flexibility in treatment approaches, attention to the basic survival needs of homeless people which may be their first priority rather than health care, the importance of integrated service provision, clinical expertise to address complex clinical problems, including access to specialized care, need for programs combining housing with services and finally, a longitudinal perspective that ensures continuing care. The authors consider outreach to be best delivered through formerly homeless people and also advocate the use of multidisciplinary mobile teams (MacMurray-Avila, 1998).

The emerging discipline of 'street medicine' refers to the delivery of health care services in the locations where the homeless are to be found and is centered on medical outreach teams. In an analysis of eight street medicine initiatives in various cities of the US, authors find the best practices to be the use of mobile clinic vans, keeping electronic medical records, collaboration with community clinics and hospitals, and provision of comprehensive social support (Howe et al, 2009). They also suggest two short-term outcome measures for such programs, namely, patient engagement and patients' subjective assessment of their well-being.

Thus, the facilitation described in literature ranges from relatively limited interventions through mobile units to the provision of comprehensive care including GP, nursing and specialist services such as drug and alcohol workers, dentistry, podiatry and opticians. Desirable health services for the homeless include features of outreach to engage clients in treatment, respect and trust, flexibility in service provision; including location and hours of service, convergence with social housing and social care services as well as flexibility in treatment approaches; including clinical expertise to address complex clinical problems and access to specialized care. Most of these facilitatory strategies focus on the structural barriers that inhibit access by the homeless. However, the strategies of training of health care providers, health promotion and encouraging participation intervene in socio-cultural barriers as well.

In the Indian context, it is a small number of NGOs that provide enabling interventions specifically with homeless persons to facilitate health care (Prasad, 2011). It is notable that the interventions correspond to some features listed above, such as having health workers for outreach, running basic health services and facilitating referrals for advanced care. They seem to provide a most valuable service that ranges from identification of the sick, to treatment, referral, facilitation of care in public hospitals, post discharge rehabilitation, follow up and safekeeping of records. They also often pick up the entire out-of-pocket costs of care. While many of these facilitating factors have been recognized in studies with the homeless from other countries, the requirement for an accompanying person seems to be an Indian phenomenon having been mentioned only by Indian authors (HIGH, 2003, Prasad, 2011).

In many ways, the social organizations play the role that would otherwise have been performed by family members, friends and other social contacts during periods of illness, such as helping with transportation, financial assistance, accompaniment to hospital, linking up with contacts within the health system for ease of access and so on. Other micro networks also existed that offered the participants social support and enabled access to health care services in small but significant ways.

Social Capital: facilitation through social relationships

These supports may be discussed within the framework of social capital to analyze their implications for facilitating access to health care services for the homeless. Social capital is a term that has been understood and applied variously by various authors (Macinko and Starfield, 2001). Whereas some have seen social capital as a largely individual resource of supportive relationships based on trust and mutual assistance, and described social assets in terms of 'goodwill, fellowship, sympathy and social intercourse' (Hanifan, 1920, in Macinko and Starfield, 2001: 389) or 'bounded solidarity' (Portes, 1998: 8), others have seen it as a characteristic purely of groups of persons (Bourdieu, 1985) and described it in terms of organized relationships amongst groups related to recognition, approval and status.

It appears especially useful to apply the categorization of bonding, bridging and linking social capital (Szreter, 2002) in the context of facilitation for health care for the homeless. 'Bonding' capital refers to the networks of people with similar characteristics, (Putnam, in Szreter, 2002) who would have common problems and objectives and would gain strength by working together. However, one must be able to leverage advantage for one's own self and community through linking and bridging social capital which refers to the connections between groups of varying characteristics, power and status.

Few studies with the homeless in India have commented upon the impact of such relationships upon the health of the homeless (Rai, 2008; Prasad, 2011). These have reported little social capital of the 'bonding variety', i.e., amongst themselves. One of them (Prasad, 2011) details this to report that the salutary effect of social capital was mostly found to be in the form of the links of homeless persons with people who had greater power or social stature; 'bridging' or 'linking' social capital, such as the health workers of the social organizations and acquaintances who had contacts within the health system and helped to refer or place homeless patients within a facility. No evidence was found of any participant being related to an association.

One of the reasons ascribed to the lack of social capital is that the homeless tend to drift from place to place. However, it is also probable that the lack of relationships and networks is related to extreme deprivation and not having resources to share. It can be postulated that the gap between the homeless and the health care service is so vast that it would take a ladder of 'bridging social capital' to cover it. Perhaps each social relationship can only cover a few levels in terms of the capacity to facilitate access to health care. This also explains why it needs the full-fledged institutional structure of an NGO to achieve results from the facilitation of health care. However, social capital may emerge as an important potential enabling factor for interventions with the homeless.

This approach; to facilitate associations and peer support groups of the persons concerned, has often been used by other vulnerable groups such as those with mental health problems, disability or affliction with HIV / AIDS to improve their access to health care (Stewart MJ, 1990; Stewart R and Bhagwanjee, 1999; Simoni et al, 2011; Masterson and Owen, 2006).

Groundswell, as described in its website, is a charity in UK that is facilitating user involvement and self-help organizations in the field of homelessness in the UK (Groundswell, 2006). It also attempts to “bring everyone together including policy makers, managers, front line staff and homeless people to create effective solutions to homelessness” (Groundswell, 2011: para 1).

The formation of peer support groups by people in situations of common vulnerability can be considered a structured form of bonding capital. However, networks and campaigns that include not only the homeless but other sympathetic members of the community with greater power can provide linking or bridging capital to facilitate access to health care. Such networks or campaigns that include participation of the homeless may become effective lobbies for getting better access to better quality services.

Interestingly, Butterflies, an NGO working with street children in New Delhi has a strong element of mobilization and creation of collectives amongst its strategies such as the formation of Bal Mazdoor Unions (Child Workers Unions) (Butterflies, 2011). This strategy may have potential for application to homeless adults too, for the purposes of acquiring better access to health care and has been tried in a limited way by some NGOs (IGSS, 2009).

V. Differing Health Objectives

An ambivalent relationship has been noted between the homeless and NGOs that are working with them to facilitate health care (Prasad, 2011, (IGSS, 2009:10) which is characterized by both a high level of dependence along with some resentment stemming from the power differentials between them. Similarly, it has also been noted that there were significant differences in and objectives between the homeless participants and health care providers (Prasad, 2011). While the health care providers were focused on clinical or public health goals, the homeless participants were often more concerned about issues related to their immediate survival or livelihoods, even at the cost of their health. This has been well described by other authors based on many years of experience in providing health care services for the homeless. Howe, Buck and Withers note that it may be required “to balance the patient’s goals (often broadly focused on immediate needs) with the practitioner’s goals (often more clinically focused) (2009:241). They confirm that “[homeless] patients also often function in a very present-centered survival mode that limits their ability to focus on future effects of medical problems” (2009:241- 242). Additionally, they remark upon the mistrust the homeless sometimes feel for the clinical practitioner. The two short term indicators they suggest to determine the quality of street medicine programs have been developed as a result of the understanding of the conflicts that may occur between the perspectives of health care providers and their homeless patients. These indicators, namely, patient engagement and subjective assessment of well-being have been designed to ensure that the heath care program on offer is patient-centered and that negotiations are carried out between the homeless and the organizations delivering health care to arrive at common goals. This “goal negotiated care” (2009: 245) ensures that the immediate needs of the homeless person have been identified and attended to, and that he / she has greater ownership on health related decisions. It is also said to counter helplessness; which the authors call a “learned helplessness” (2009: 245) and which could be akin to the helplessness noted in the study by Prasad, through greater self-efficacy.

Promoting participation; as a major strategy to counter homelessness and its associated disempowerment, has been part of the discourse on interventions with the homeless in other countries, especially in Europe (Paasche, 2010). Current practices of providing health care for the homeless in India have not included such patient-centered or participation strategies even though in general work with the homeless, the IGSS report recommends that "the program should be participatory where the homeless people are equal partners and take up the responsibility of ensuring that the efforts coming in remain consistent and that resources are shared equally" (IGSS, 2009:12).

The discussion above on the factors that may help or hinder access to health care services by the homeless in India lays the ground for the recommendations that emerge for public health policy and programs to allow better access to health care services by the homeless, especially to the public health system.

Recommendations for policy

1. The prevention of homelessness through greater attention to issues related to social justice, social security and labor rights must be given due priority in all policy advocacy related to homelessness.
2. The fact that costs of health care contribute to homelessness by leading to it and perpetuate it by exhausting the savings of the homeless needs to be acknowledged and dealt with through the public health policy and programs.
3. The lack of identification of the homeless as extremely poor persons must be corrected with urgency. The state of homelessness should be taken to be a non negotiable criterion for the BPL list[8] and special effort needs to be made to ensure they are counted.
4. The quality of services desired by the homeless from the public health systems may be best achieved by universalizing free health care and removal of user charges.

Recommendations for Public Health Systems

1. Outreach to the homeless must be made an essential part of the public health care system in urban areas.
2. Primary health care centers must be made available at sites within the areas inhabited by homeless persons.
3. The attending doctors and staff must be made to go through a specific sensitization and training program to ensure respectful behavior towards the homeless and a proper understanding of their specific requirements.
4. Free referral transport needs to be provided between the primary centers and the public hospitals.
5. Sufficient numbers of trained social workers need to be deputed at the hospital to escort the homeless through the various processes.
6. A government order needs to be circulated to instruct the hospital authorities to admit homeless persons without proof of address or attendants.
7. The costs of care need to be completely free for the homeless in both the public facilities as well as the free beds in the private hospitals. This must include the costs of drugs and consumables.
8. An attendant should be made available to the homeless persons who do not have accompanying carers for the full duration of the stay in hospital.

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[8] This has just been accepted in principle for the on-going socio-economic and caste census 2011

9. Services need to be made available for post discharge care in the areas inhabited by the homeless. These could be arranged by dedicated space in the government run shelters for those who have been discharged after admission. The outreach health workers could provide the human resource for this function as well.
10. Nutritional support is required for pre admission and post admission periods and this can also be facilitated through the health workers.

Recommendation for Facilitating / Service-Providing social organizations

1. Involved NGOs should consider advocacy for public health systems that cater to the homeless as detailed above.
2. The intervening NGOs need to devise ways of better information to the homeless about the various health and social services that exist and their rights upon them. This could be a medium term empowerment strategy.
3. They may also apply the criteria of patient's engagement and subjective assessment of their own wellbeing to the health programs they are running themselves. This would involve processes of negotiation to arrive at common health goals with the homeless patients.
4. They should also consider the addition of longer term empowerment strategies to their interventions with the homeless that enhance social capital, such as creating associations and self help groups

Finally, as the CSDH puts it the "unequal distribution of health-damaging experiences is not in any sense a 'natural' phenomenon but is the result of a toxic combination of poor social policies and programs, unfair economic arrangements, and bad politics" (CSDH, 2008: 1). It is hoped that current discussions around the universal access to health care in India will acknowledge the truth of this statement with respect to the health conditions of the homeless, the struggles which they have to undergo to access health care, and the many denials of the right to health that they encounter in their battle to survive against so many odds. Only then can they sufficiently influence policy makers to take appropriate measures for a universalization that truly corresponds to health for 'all'.

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