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Perspectives of Social Barriers to Accessing Health Care Insurance among the Homeless Population

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Abstract

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Pharm. D, LECOM School of Pharmacy, 2008

Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
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Abstract

Access to healthcare services and healthcare insurance has been considered problematic for many populations in the United States. Despite many efforts to solve these issues, there is a significant gap in research related to the perceptions of the population experiencing homelessness associated with the social barriers they face with access to health insurance and health care. The behavioral-ecological framework best suited this study. In this qualitative descriptive study the perceptions of a sample of 10 individuals experiencing homelessness, who accepted to sit for 60-minute interviews, were investigated. Purposeful sampling was used to identify these individuals, whose age 18-60 years old, who met the U.S. Department of Housing and Urban Development's definition of homeless and tried to access health care insurance within the last 12 months. Data were collected using semistructured interviews in a face-to-face setting. Using Braun and Clarke's six steps for thematic analysis, the transcripts from the interviews were coded and analyzed, extracting six themes that assisted in answering the posed research questions. These findings included that the population experiencing homelessness (a) having an inability to prioritize their health-related decisions, (b)facing an inability to interact successfully with healthcare providers, (c) having difficulties in health care follow-up and scheduling of appointments, (d)are unable to acquire accessible assistance and resources, (e) carrying negative attitudes and behaviors about their health, and (f) resources fail to assist by reaching out to them. The potential impact for positive social change involved increasing the availability of healthcare information and resources through public organizations for easy access.

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Dedication

This dissertation is dedicated to the memory of my father, Damin Abukhalil, who has always inspired me to further my education and pursue my doctoral degree, however; was unable to see my graduation. He is the reason I am where I am today. This is for him. I will not forget my mother, Rashiqa Abukhalil, who dedicated herself taking care and encouraging my ten siblings and myself to see eight of us with a doctorate degree. I dedicate this to my brothers and sisters who have always been supportive and inspiring in every way possible. I also dedicate this to my wife, Amal Rajabi, who has encouraged me all the way and whose encouragement has made sure that I give it all it takes to accomplish my dreams and finish what I started. To my children Damin, Bisan, Sham, and Mohammad who have been affected in every way possible by this journey. Thank you to my chair, Doctor Cheryl Anderson, and committee member Doctor Earla White who guided me throughout the entire process and kept me on track.

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Chapter 1: Introduction to the Study

Access to health care is often based on having health insurance. In the United States, not all individuals have access to health insurance (Singer, 2020). Individuals experiencing homelessness may be eligible for health insurance coverage through Medicaid (Vickery et al., 2018). Access to health care is complicated for many, including the people experiencing homelessness. Homelessness is one pressing issue that needs to be addressed due to the negative implications, not just to the people experiencing homelessness, but also to the people and communities around them (Murphy & Eghaneyan, 2018). With economic constraints, the population experiencing homelessness often faces the challenge of supporting their basic needs (White et al., 2018). These challenges extend to difficulty in accessing health needs, which range from basic medicine to hospitalization insurance (Vickery et al., 2018).

There is a great deal known about the population experiencing homelessness, health care access, and societal challenges in terms of providing appropriate care. There is a paucity of information, however, from the population facing homelessness about their perspectives surrounding health care access. I sought to fill that gap by presenting the insights of people experiencing homelessness in one area of the midwestern United States. Exploring the lives of the people experiencing homelessness may lead to positive social change by providing relevant information that may enlighten health care leaders and policy makers regarding the possible struggles and problems this population faces.

The remaining sections of Chapter 1 include an overview of the study. I discuss the background of the study, the statement of the problem, the purpose of the study, the research questions, the nature of the study, the theoretical framework, the significance of the study, assumptions, the scope and delimitations, the limitations, and definitions of key terms.

Background

Homelessness, which is generally the state of having no habitation for a short period or repetitive instances and prolonged period, is often connected to traumatic events, such as being released from incarceration, domestic violence, physical and sexual assault, rape, job loss, and housing eviction (Fowler et al., 2019). Persons experiencing homelessness with mental health issues are subjected to discrimination and stigma (Mejia-Lancheros et al., 2020).Individuals who experience homelessness are at a greater risk of being hospitalized, with a greater mortality rate compared to that of the general population (Wadhera et al., 2019). The risks and issues individuals experiencing homelessness face have been the basis for research on this topic.

Disparity in healthcare access exists between the uninsured and the insured. Access to healthcare is important for all individuals, including the population experiencing homelessness (Dickins et al., 2020; Lapinski, 2019). Scholars have claimed that vulnerable populations experience significant social barriers to health insurance access (e.g., Brown, 2017; Pendyal, 2020; Self et al., 2021; Winetrobe et al., 2016). For example, among the barriers to access of mental health services for youth experiencing homelessness are stigmatization, lack of awareness, and administrative requirements (Lapinski, 2019). Transportation discrimination, cold, and bureaucratic cultures of healthcare systems are also significant barriers to healthcare access (Wille et al., 2017).

Stigma as a social barrier to the access of healthcare and possibly health insurance services has been highlighted in the research (Pendyal, 2020). According to a recent study, uninsured adults experiencing homelessness have poorer health care access and outcomes than other homeless and nonhomeless adults (White et al., 2018).

The gap in the research that I sought to fill is that little is known about the perceived social barriers to access to health insurance among adults experiencing homelessness. Therefore, there was a need to examine the perspectives of individuals experiencing homelessness regarding social factors that may impede them from accessing healthcare insurance. Ultimately, examining the population experiencing homelessness's perceptions of social barriers to the access of healthcare insurance in detail may help to establish measures to mitigate the effects of these barriers on the health outcomes of the population experiencing homelessness.

Problem Statement

It was not known how individuals experiencing homelessness perceive social barriers and their access to health insurance. People experiencing homelessness are of concern when accessing healthcare insurance as well as healthcare services because cost is the main barrier to acquiring a health insurance policy. It is plausible to affirm that uninsured citizens, such as uninsured homeless people, have fewer odds of receiving services for major health conditions and preventive care in comparison to those who are insured. Most uninsured people who seek medical services are likely to face unaffordable medical bills, which can translate into medical debts (Fryling et al., 2015). People experiencing homelessness face many health issues, multiple challenges to accessing basic healthcare needs, as well as lower income that places them at a higher risk for being homeless, remaining homeless, and, ultimately, experiencing a delay in medical care and treatment.

Purpose of the Study

The purpose of this qualitative study was to explore homeless people's perspectives of possible social barriers to obtaining health insurance. Understanding the perspectives of homeless people surrounding social barriers to health insurance may provide information to the government and the relevant stakeholders in the health sector regarding the measures to put in place to meet health insurance access needs for the homeless population.

Research Questions

RQ1:What are the perspectives of homeless people toward social factors that hinder access to health care insurance?

RQ2:What are the perspectives of homeless people toward social factors that enable access to health care insurance?

Conceptual Framework

I adopted the behavioral-ecological framework as the conceptual framework for this study. One tenet of the behavioral-ecological model is that healthcare navigation is an ecologically informed process that is influenced by various factors, such as healthcare insurance, healthcare access, the individuals, and the environment surrounding those individuals (Ryvicker, 2018). All of these factors play a prominent role in decision making with respect to healthcare insurance use. The model encompasses the convergence of several factors governing the access of healthcare insurance, including the availability of services, affordability, transportation, and social support to facilitate decision making, healthy behaviors, and treatment adherence. Moreover, healthcare consumers require an increasingly high set of skills and health literacy to navigate the complexities of healthcare coverage, including choosing and communicating with healthcare providers, weighing treatment options, and scheduling and follow-up. Notably, the behavioral-ecological model is a better fit than the behavioral model because the navigation processes underlying the behavior model's relationship (i.e., individual characteristics such as predisposing, enabling, and need factors that influence access to healthcare) are implicit (Ryvicker, 2018). According to the behavioral-ecological framework, however, the aforementioned individual characteristics are among the myriad of factors that influence the processes of navigation through which people respond to opportunities and constraints in managing their health and accessing healthcare insurance(Greene, 2017)

The behavioral-ecological framework was highly relevant to this study because the model encompasses both the structural circumstances shaping healthcare opportunities and the navigation healthcare consumers must undertake to access healthcare insurance(Greene, 2017). Healthcare navigation refers to the set of dynamic processes through which healthcare consumers respond to healthcare needs, pursue opportunities, and manage constraints to maximize the likelihood of obtaining healthcare insurance and, ultimately, gaining positive health outcomes (Ryvicker, 2018). These processes occur in the context of intersecting economic, biomedical, environmental, and psychosocial conditions, and the impact of these processes differs from one consumer to another based on race and ethnicity, cultural norms, preferences, and expectations. The behavioral-ecological framework best suited this study because the model notably helps to address barriers to navigation that vulnerable populations face in their quest for healthcare insurance. The vulnerable population featured in this study was persons experiencing homelessness. This model helped to reveal various factors that hinder or facilitate the population experiencing homelessness in accessing health care insurance.

Nature of the Study

In this study, I used a descriptive qualitative approach. For this descriptive qualitative research approach, I utilized open-ended interviews for data collection. I conducted open-ended interviews with persons experiencing homelessness with different backgrounds, Including race and ethnicity, education level, social status, and gender. I explored the research questions during the interviews using an interview guide and follow-up questions aimed to elicit more detail and clarity from participants. I also conducted the open-ended interviews on a selected number of healthcare practitioners and professionals working with both private and public health insurance entities. I then thematically analyzed the data acquired from the open-ended interviews to establish the perceived social barriers to accessing healthcare insurance among the population experiencing homelessness as well as measures that could be put in place in the future to mitigate these barriers.

Definitions

Health insurance: Health insurance refers to medical coverage that keeps individuals protected from financial implications of undergoing medication or treatments related to health issues (Zahi & Achchab, 2019).

Homelessness: Homelessness refers to having no permanent location of habitation that is meant for human beings (Fowler et al., 2019).

Social barriers: Social barriers refer to obstacles that hinder contact with social networks and minimize social interactions (Berkowsky et al., 2018).

Assumptions

Several aspects of the study were assumed to be true to complete the examination of the subjects. My main assumption for this study was that participants provided accurate and honest responses regarding their perceptions of social barriers to health insurance access. To address this assumption, I reminded the participants to answer the questions as truthfully as possible. I assumed that the self-identification of participants as a person experiencing homelessness was authentic. I also assumed that different participants had different experiences and perspectives, and thus, there would be differences among the participants' responses. Finally, I also assumed I would be able to uncover themes and patterns in the participants' lived experiences.

Scope and Delimitations

The scope of the study involved the exploration of perceptions of individuals experiencing homelessness regarding access to health insurance. I did not explore other phenomena outside the boundaries of the problem of this study. The study also included the interpretation of these perceptions within the context of the purpose of the study. I did not include perceptions of other aspects of homelessness for this research. I did not include non-homeless populations, as is defined in the sampling frame of the study.

Limitations

Several limitations were inherent in this study. The main limitation was that I could not generalize the findings outside the population of interest. With a small sample size, qualitative studies are commonly nongeneralizable (Kim et al., 2017) Nevertheless, I discuss the methodology in detail so that replication of the study to another group of individuals may be easy and possible for future researchers in related fields. Moreover, the study's findings directly address the research questions posed. I also ensured that the sample size was large enough to attain data. Moreover, I chose the criteria for inclusion in the study to ensure that participants had experiences that made them knowledgeable and able to provide the information needed to address the research questions and purpose of the study.

My own personal biases and opinions regarding the phenomenon and problem of focus in the current study presented as another limitation. To minimize researcher bias, I acknowledged any expectations and personal opinions regarding the outcome of the study so that I was cautious of these biases, especially when interpreting and analyzing the results of the study. Finally, a limitation of the study was the inability to generalize the results from the analysis of the lived experiences of transgender women.

Significance

This study was significant because it helped to fill the literature gap on efficient and effective approaches adapted to address the social barriers to access to health care insurance, that people experiencing homelessness, experience in the United States. The findings of this study have the potential to aid the government and relevant stakeholders in the healthcare sector in developing policies to assist in mitigating these perceived social barriers and, consequently, increasing medical insurance coverage among people experiencing homelessness in the United States. Additionally, growth in the number of insured homeless individuals could potentially bridge the health care inequality gap which may, in turn, bring about social change. Moreover, by implementing effective healthcare policies to address the perceived social barriers, more people experiencing homelessness may find access to affordable health care services and resources for avoiding medical debts, which are social-economic problems (Pacheco & Maltby, 2017). Ultimately, the study's findings can guide future research on related topics.

Summary

In summary, the problem of the study was that it was not known how people experiencing homelessness perceive social barriers and access to health insurance. Therefore, the purpose of this qualitative study was to explore the perspectives of peopleexperiencing homelessness toward possible social barriers to obtaining health insurance. To address this problem, I generated a research question for this study focused on the perceptions of individuals experiencing homelessness who tried accessing health care insurance. I adopted the behavioral-ecological framework as the conceptual framework for this study. In Chapter 2, I discuss the relevant literature regarding the gap and phenomenon of focus. In Chapter 3, I present the methodology and research design used for the study, including the sampling and population, the recruitment method, the instrumentation used for data collection, the data collection process, and the process for data analysis. In Chapter 4, I present the study’s findings. Finally, in Chapter 5, I discuss findings and present the themes extracted from the data. Further, I discuss the implications from the data analysis, recommendations for future research, the limitations found within the research, and overall conclusions.

Chapter 2: Literature Review

In Chapter 2, the review of current literature, I present an exhaustive investigation into the available peer-reviewed articles surrounding people experiencing homelessness and their access to health insurance coverage. In the first section of this chapter, I introduce the search strategy used to secure the needed articles. Next, I present an in-depth discussion of the conceptual framework. I then discuss the historical context foundational to this study. Finally, I provide the underpinnings of the prevalence of health insurance among the population experiencing homelessness in the United States.

The purpose of this qualitative study was to explore the perspectives of people experiencing homelessness toward possible social barriers to obtaining health insurance. It was not known how the social barriers the population experiencing homelessness faces when accessing healthcare insurance services in the United States can be limited. Various researchers have examined how medical insurance and other obstacles affect health outcomes, particularly for vulnerable populations like the population experiencing homelessness (Osei Asibeyet al., 2020; Pendyal,2020). Some barriers hinder people experiencing homelessness from acquiring health insurance through the Affordable Care Act (ACA; Fryling et al., 2015). Researchers have found that a lack of knowledge on ACA qualification criteria and financial status are the main barriers to medical care insurance (Fryling et al., 2015). Notably, people experiencing homelessness are half as likely to seek medical attention compared to persons with homes (Kaduszkiewicz & Bochon, 2017). Other researchers have found that uninsured patients prefer free clinic services (Kamimura et al., 2016). Although researchers have studied the issue of health insurance in close reference to the health outcomes, there is limited literature on efficient and effective approaches available to change the social barrier to medical care insurance. Notably, past researchers failed to thoroughly examine how social barriers to medical insurance affect healthcare outcomes in terms of what group of patients, through which intervention, and in what scenarios. It was reasonable to affirm that there was a need for a study to examine feasible techniques that can be adopted to limit the social barriers individuals experiencing homelessness face when accessing healthcare insurance services in the United States.

Literature Review Search Strategy

To begin the search strategy to find relevant literature, I searched various library databases. I used the following search engines and catalogs: ACA, Medline, PubMed, CINAHL PLUS, and Google Scholar. I utilized the following key search terms: *Social Barriers*, *Healthcare Insurance*, *Homeless Population*, and *Healthcare access post-ACA*. I chose these terms to enhance the generation and retrieval of peer-reviewed journal articles, which are relevant to the problem, concepts, and questions of the proposed research. I uncovered a total of 96 peer-reviewed references in this review of the literature. Among these references, 83 were published from 2017 to date, while the remaining 13 sources were published before 2017. The aim of using current sources was to keep the study and problem as up to date as possible. Some older references were, however, examined and included for establishing the historical contexts of the theoretical framework. During the search, Boolean operators were adopted, including AND, OR, and

NOT. These Boolean operators were significant as they enabled me to generate dissimilar keyword strings for the retrieval of relevant studies (see Jiang, 2019).

Conceptual Framework

I adopted the conceptual framework of the behavioral model for the homeless population. Various theorists developed of the behavioral model, including Pavlov, Watson, and Skinner (Greene, 2017). Theorists of the model argued that human behavior is learned and, therefore, new behaviors can be acquired, or the learned behavior can be unlearned (Greene, 2017). More importantly, this model highlights the measurable aspects of human behavior (Gehlert& Ward, 2019). For behavior to be learned, it must be observable. This model emphasize show to act or respond to a particular issue.

Based on this model, access to medical health insurance is perceived as a function of enabling, need, and predisposing factors. Predisposing factors represent parameters which influence an individual's tendency to seek medical care health insurance services (Gehlert& Ward, 2019). Additionally, enabling factors represent parameters that impede or facilitate an individual when seeking access to medical care health insurance. Need factors represent parameters for which an individual is likely to need health insurance coverage (Greene, 2017). It was plausible to affirm that this model could be used to further evaluate various factors that hinder or facilitate the population experiencing homelessness in accessing health care insurance.

I used this model to facilitate an in-depth understanding of behaviors, opportunities, and intentions among the population experiencing homelessness. Gehlert and Ward (2019) indicated that the model helps to foster the acquisition of comprehensive insight pertaining to homeless people because it treats homelessness as a phenomenon that exists through a process that is marked by temporary and proximate intentions. Scholars have concluded that homelessness does not only stem from involuntary life experiences, but is also linked to behavioral intentions (Gehlert& Ward, 2019). This model holds that once behavioral intentions are determined, these intentions trigger alterations in actual and perceived opportunities for homeless people's behaviors. I used this perspective as a basis for supporting the argument that homeless people's behaviors and attitudes are associated with diverse social behaviors.

The model also proved expedient for this study given that it provided a platform upon which researchers can determine whether the health behaviors of homeless populations vary based on cultural identities and racial or ethnic backdrops. Researchers have also indicated that the framework serves as a reliable tool for understanding the disparities in healthcare predispositions among homeless populations (Gehlert& Ward, 2019). Variations may be observed based on racial or cultural backgrounds. Thus, the model was critical for the current study given that it allowed me to investigate homeless people's health beliefs and demographic features. I used the framework to consider components such as community resources which were indicative of factors expected to enable homeless populations to achieve better livelihoods. Further, researchers have defended the use of this model in studies that dealt with homeless populations because it served as a formidable platform upon which scholars comprehended the population's need factors in relation to their evaluated and perceived health statuses (see Greene, 2017). The embodiment of these components in the framework made it essential for fostering in-depth insight into homeless populations.

Review of Relevant Literature

Prevalence of Health insurance

Inequality in health insurance coverage is a major problem affecting millions of Americans, particularly those from low-income and homeless populations (OseiAsibey et al., 2020). Economic inequality is a major cause of insurance inequality, thus highlighting the prevalence of health inequality in the United States. Homeless families and individuals are vulnerable to health inequality. OseiAsibey et al. (2020) conducted a systematic review to gain evidence on health problems and the use of health services by homeless adults and discovered a range of mental and physical health problems and underutilization of health care services by this population group. The authors failed, however, to address differences in the prevalence of health problems and health service utilization rates among the various subgroups of homeless adults. Lee et al. (2020) focused on elderly persons aged over 55 years with a history of homelessness. The authors examined the relationship between having insurance coverage and securing unsubsidized housing among this population group.

Researchers have attempted to assess the clinical and individual factors contributing to gaining health insurance and securing residency. For instance, Osei Asibey et al. (2020)observed that gender; age, mental health conditions, and physical disabilities were significantly correlated with securing health insurance among the homeless population, suggesting that only persons with a specific individual and clinical condition are considered eligible to enroll in federal and state insurance programs (Osei Asibeyet al., 2020). These results affirm the inequality in health insurance coverage against homeless and low-income populations. Seo et al. (2019) examined differences in health care access in community health centered between patients with continuous Medicaid coverage and those with insurance gaps. The authors found that while both groups of patients needed a similar level of care over the past year, those with insurance gaps reported difficulties in accessing health care services when compared to patients with continuous Medicaid coverage for CHC patients (Mongelli et al., 2020;Morel, 2019). Overall, continuous Medicaid coverage can eliminate barriers to care. The study underscored the need to eliminate insurance inequality among the population to increase access to healthcare.

Various researchers have examined the role of healthcare insurance in bridging the healthcare gap to ensure that homeless people can obtain the same health services as the general populace. For instance, Alderwick et al. (2019) examined the role of Medicaid in addressing California and Oregon residents' social needs. Noting the role of Medicaid in supporting low-income Americans, the authors identified that the program was uniquely positioned to support social interventions. The study results confirmed that Medicaid funds were invested to support direct social services, including capacity building health care initiatives, legal support, housing, and food security programs, which are expedient for bridging the health gap for the population experiencing homelessness. Community factors and the local health system, however, influenced the implementation of these Medicaid social interventions. Based on the study's results, the authors provided critical insights into developing working approaches in reducing health and health insurance inequality to improve health among the population experiencing homelessness.

Recently, researchers have evaluated inequality among people experiencing homelessness and noted that growing inequality in wealth and income is hampering health and insurance inequality in the country (Cleveland, 2020). The researchers recommended tax reforms to reduce income inequality. In a similar study conducted in France, Morel (2019) examined how discrimination and social inequality influenced emergency care access. The results of the ethnographic study revealed the existence of social selection practice in emergency care delivery. These studies affirmed the connection between economic and social inequality with access to health insurance and medical care (Cleveland, 2020; Morel, 2019).

Prevalence of Poor Health and Low Life Expectancy among the Homeless

Researchers have strongly suggested that acute homelessness is linked to complex health problems within the population experiencing homelessness. Notably, this trend has escalated in recent years due to a lack of policies that are specifically designed for the population experiencing homelessness (Pendyal, 2020). Whereas researchers have focused on this particular contributing factor, it is also important to note that other factors, like the self-rating component, contribute to the prevalence of poor health among people experiencing homelessness. Commenting on the self-rated health factor, Wille et al. (2017) believed that instead of attending hospitals to acquire proper medical care, individuals experiencing homelessness opted to determine their health status by considering the absence of disease symptoms or the lack of severity of such symptoms as being indicative of their wellness. Whereas these two approaches provided insight into the prevalence of poor health, considering both self-rated health and the absence of health policies among the homeless led to more comprehensive insight (Bhatena, 2017). With the absence of policies to assist the population experiencing homelessness, researchers found that over 80% of individuals experiencing homelessness felt that healthcare services were not affordable (Sritharan & Koola, 2019).Bhatena (2017) and Sritharan and Koola (2019) found that within the population experiencing homelessness, the inability to afford healthcare prompted questions related to the amount of acute health issues this population may be suffering.

Researchers have indicated that people experiencing homelessness are more prone to acute health problems owing to their engagement in drug abuse(Bhatena, 2017). Over 74% of individuals experiencing homelessness used illegal drugs like marijuana, heroin, and cocaine, which explains why over 65% of recorded homeless deaths have been associated with acute health problems due to drug overdose (Kenning et al., 2017; Pendyal, 2020). In an attempt to explain the significance of such statistics, Kenning et al. (2017) argued that the life expectancy of people experiencing homelessness has declined based on the persistent use of drugs despite the underlying prolonged medical conditions. It can, therefore, be implied that the poor health of the population experiencing homelessness was expected, owing to the influence of drug use on their already worsening health conditions. On the other hand, Klop et al. (2018) believed that the decline in health and persistent shortened life expectancy was further aggravated by street culture. Street people use drugs and alcohol to escape the harsh realities of their homeless situation and use substance consumption as a replacement for pain or medicinal help. Affirming that these compounded factors were to blame for the poor health and death rates among this population, Sritharan and Koola (2019) indicated that the risk of individuals experiencing homelessness dying prematurely was almost five times that of individuals not considered homeless. The tendency of several individuals experiencing homelessness to share the same roof underpinned the need to observe the ability to access preventive or primary medical services.

Additionally, researchers have shown that poor health outcomes among the population experiencing homelessness were associated with a relatively high medical need, but this population failed to access the necessary preventive or primary healthcare services. Attempting to shed light on this phenomenon, Carroll et al. (2017) argued that although individuals experiencing homelessness have relatively higher levels of healthcare needs, they can seldom afford to pay for such services, much less pay for transportation to these medical facilities. Carroll et al. further suggested that homeless individuals' poor health was aggravated by their inability to meet costs associated with obtaining medical health. Notably, the homeless could not acquire health cards, integrated health services, and medical prescriptions, which immensely escalated their worsening medical conditions and drastically reduced their life expectancy (Mongelli et al., 2020).The inability to acquire such health-related amenities continues to pose grave challenges to the homeless populations' health despite the fact that social and health policies have always dictated that they should be entitled to health-related benefits (Mongelli et al., 2020).

Prevalence of Healthcare Insurance among the Homeless

The homeless are among the most marginalized people in the world (Wille et al., 2017).. The United States has large numbers of people experiencing homelessness, with a larger percentage being male (Wille et al., 2017). Children and women, however, represent a substantial percentage of people experiencing homelessness. People experiencing homelessness suffer numerous threats to their health, including risk for mortality, alongside the financial challenges for obtaining the needed health services(Wille et al., 2017). Several researchers in the United States have identified the prevalence of a lack of health insurance among the homeless, which is responsible for lower odds in accessing healthcare. Osei Asibeyet al. (2020) revealed that homelessness was associated with numerous damaging problems for individuals and communities alike. The experience of poor health among the homeless is related to the condition and environments in which they live (Wille et al., 2017). Access to health care and usage is often beyond homeless individuals' means, particularly in terms of accessing health insurance. According to Osei Asibeyet al. (2020), most countries' health systems are weak, and most clients pay out-of-pocket for services.

Very few countries have private health insurance schemes Osei Asibey et al. (2020) . Most insurance schemes require paying before accessing services Osei Asibey et al. (2020). Osei Asibey et al. (2020) conducted a systematic literature review on literature published between January 2018 and February 2019.The authors revealed that people experiencing homelessness suffer from various health problems. Further, Osei Asibey et al. highlighted the underutilization of health services, such as health insurance, due to socioeconomic barriers. Based on these findings, future studies should consider a different study approach when studying the population experiencing homelessness. For instance, more research is necessary on the underutilization of health insurance services that were noted as critical for the population experiencing homelessness (Cleveland, 2020). Bhathena et al. (2020) further supported the findings from Osei Asibeyet al. by concluding that most people experiencing homelessness are uninsured, leading to numerous health problems and the inability to access affordable and quality health care.

There are numerous health insurance programs available to the homeless, including Medicaid, Medicare, and other public programs (Edward et al., 2018). Medicaid is helpful to low-income individuals because it enables them to access health care services (Edward et al., 2018; Fryling et al., 2015). Medicare serves the elderly aged 65 and over, regardless of disabilities (Gallardo, 2020). Individuals experiencing homelessness also benefit from other programs offered by public hospitals, including those targeting migrants and Native Americans (Gallardo, 2020).

Coverage for health insurance among the homeless varies. Chronic health conditions and the inability to access health care services are the precipitators of homelessness (Dupéréet al., 2012). Joseph (2017a) found that approximately 45% of the population experiencing homelessness had health insurance compared to the rest of the general population. Being able to pay for health insurance implies that one can access great levels of health care; therefore, researchers have documented the overuse of emergency departments and unmet health care needs among the homeless. This rationale stems from the high prevalence of uninsured health among the population experiencing homelessness (Wille et al., 2017). Health insurance has also been noted as a proxy for income-related resources, which explains the prevalence of high rates of uninsured among the homeless.

In the United States, the prevalence of homelessness is more pronounced in urban areas. According to the United States Department of Housing and Urban Development, Florida has the second-highest number of homeless individuals after California, with approximately 7% of adults over 60 years experiencing homelessness in the state (Tsai & Gu, 2019). In Hillsborough County, 14.3% of individuals were homeless and had no health insurance coverage (Dupéré et al., 2012).Martinez-Donate et al. (2017) examined the relationship between transitioning from homelessness into subsidized housing and having health insurance. Based on the results, a high number of people aged 60 and older were more likely to be uninsured and homeless.

Additionally, the association between homelessness and health insurance supports the Medicaid coverage gap. An average of 5million Americans experiencing homelessness are included in this gap, meaning that they do not qualify for Medicaid and, simultaneously, the money they make is not enough to buy health insurance premiums available in the marketplace (Ganuza& Davis, 2017; Seo et al., 2019). Considering age, however, adults over 55, regardless of homelessness, have wider access to Medicaid and Medicare health insurance programs (Joseph, 2017a). Baggett and Kertesz (2020) investigated the intersection between homelessness and medical psychiatric illnesses. A homeless person is one who does not have a regular place to spend the nighttime and lives in a shelter or a place not designed for human habitation. Baggett and Kertesz

(2020) indicated that individuals experiencing homelessness are frequent users of emergency health services. In San Francisco, approximately 40% of the homeless use emergency health services at least once a year (Bhathena et al., 2020). Similarly, in New York, patients experiencing homelessness are less likely to have a physician or a regular source of ambulatory care (Gusmano et al., 2017). Gusmano et al. explained that this is why the population experiencing homelessness utilizes a significantly higher number of ambulatory emergency services as compared to the general population.

Globally, there is a positive correlation between homelessness and the lack of medical care insurance. More than half of individuals experiencing homelessness in the United States have no health insurance (Martinez-Donate et al., 2017). Joseph (2017b) asserted that approximately 55% to 73% of federally funded health care beneficiaries are insured. The researcher collected data to explain why the lack of ambulatory care among uninsured individuals experiencing homelessness resulted in high rates of emergency department visits among the population experiencing homelessness. Besides seeking health care, individuals who were homeless were also likely to visit emergency departments for other needs such as food, shelter, and safety (Luo & Escalante, 2018). Luo and Escalante (2018) revealed that if these populations were provided with health insurance, they would have been less likely to visit expensive emergency departments. The high use of emergency departments by the homeless indicates the prevalence of uninsured among the population experiencing homelessness. It is also worth noting that, besides adults, children of parents with housing instability also have high health insurance gaps compared to the rest of the population.

Health insurance is crucial for children to access critical health services such as immunization, check-ups, and immunizations during the preschool years (Carroll et al., 2017). The high costs of living combined with low incomes have made housing unaffordable for most families. Housing instability and the utilization of children's health care reveal insurance gaps among children experiencing homelessness (Lee et al., 2020). Carroll et al. (2017) indicated that children who were homeless by the time they were 2years of age were more likely to be uninsured. Because homeless children experience more acute illness, the emergency department for common conditions has lower immunization rates compared to the homeless. Carroll et al. indicated that health insurance gaps were high among children whose parents have underlying housing instability problems or who were homeless (Carroll et al., 2017). Given the inadequate housing and uninsured population, the most promising policy is to maintain health insurance for children whose families are unstable. For instance, streamlined enrollment and renewal of public health insurance could help reduce the number of children or families not covered under medical insurance (Gallardo et al., 2020).

Following the implementation of the ACA, people who were previously homeless and lacked health insurance gained coverage. The core purpose of ACA was to expand access to health insurance coverage among those who fall through the cracks of public health insurance (Joseph, 2017b). Particularly, low-income individuals who constitute the majority of the uninsured people are the target of ACA. Before the ACA, most individuals experiencing homelessness were not eligible for health insurance coverage unless they could prove their qualification through complicated pregnancy conditions

(Carroll et al., 2017). Furthermore, individuals experiencing homelessness are more likely to experience disabilities but

have a harder time proving so because the inaccessibility to health care can mean limited medical evidence regarding their conditions. Under the ACA, however, health insurance coverage is now available for people experiencing homelessness

The Trump administration approved no exemptions for the population experiencing homelessness in states such as Ohio and South Carolina from losing health insurance coverage. Other states such as Wisconsin exempt people experiencing chronic homelessness from losing coverage (Freitas et al., 2019). Regardless of exemptions, however, those who qualify most of the time have trouble proving so, particularly when paperwork has reduced enrollment to the Medicaid program across the board, which is a challenge for the homeless who have no permanent address (Dickins et al., 2020). This explains why the homeless majorities are not covered under health insurance and have problems accessing health care services.

Researchers have explored the loss of coverage for such a vulnerable population given the capacity of the trend to worsen health outcomes (Abbott et al., 2017). The interruptions on coverage may result in increased use of emergency departments among the population experiencing homelessness. Also, loss of coverage can exacerbate health problems among this vulnerable population. Over 550,000 individuals in the United States are homeless on any given night (Omerov et al., 2020). The growing population of people experiencing homelessness in the nation indicates an increase in health complications such as communicable diseases and substance use disorders. The ACA expanded Medicaid eligibility (Karnick et al., 2019),consequently lowering the qualification for public health insurance coverage options. Further, the gap of uninsured people among the homeless decreased. Researchers have suggested, however, that the homeless are still without a regular source of primary health care (Martinez-Donate et al., 2017). There is a higher rate of emergency department visits among the homeless when compared to the rest of the population.

The lack of insurance is among the key barriers to primary health care. With approximately 35% of persons experiencing homelessness under sheltered locations, prioritizing health coverage over competing priorities is considered difficult (Karnick et al., 2019). Bhathena et al. (2020) documented the insurance coverage rate among the homeless. The authors included a sample population of both insured and uninsured individuals experiencing homelessness and collected data through interviews with individuals in this population. The findings indicated that financial considerations were a key factor in determining whether one was insured or not and whether they would return to seek primary health care from a certain provider. Participants noted that insurance positively affected homeless individuals' ability to seek medical services. In contrast, those who are uninsured experience ineligibility for treatment outside emergency departments. Policy efforts to address health insurance barriers to the use of ambulatory health services are imperative to reducing health care costs and improving long-term health among the homeless (Van Natta et al., 2019). Following the implementation of the ACA, stakeholders are supposed to find new strategies that will reduce the high uninsured rates among the homeless (Luo & Escalante, 2018). When the homeless access health insurance, they regularly utilize primary care instead of emergency departments. Furthermore, insurance provides them leverage in multiple care teams and access to primary health care.

The increase in uninsured rates among the population experiencing homelessness has been a challenge for accessing health care services. Although the ACA expanded eligibility, some U.S. states have still not adopted the program. Seo et al. (2019) found that lack of coverage among the homeless decreases their chances of accessing health care services. Particularly, the authors focused on the ability to access services among those with Medicaid and without insurance within the last 12months of coverage (Seo et al., 2019). Patients with insurance gaps explained having difficulty in accessing medical care and services such as dental care, completion of referrals, and prescription of drugs. When comparing the insured and uninsured, the latter are more numerous, highlighting this population's inability to access even the most basic health care services (Seo et al., 2019). Notably, those who were uninsured experienced more difficulties compared to those under Medicaid. Following the high number of uninsured people within vulnerable populations, including the homeless, some changes were made to impose work conditions as an eligibility criterion for Medicaid (Bhathena et al., 2020). Research findings suggested that such policies continue to create barriers for accessing medical coverage among the homeless (Seo et al., 2019). Furthermore, a significant number of homeless individuals lack sustainable jobs and sources of income.

Oral disease is one of the health problems the population experiencing homelessness faces. In the United States, people living under abject poverty conditions are more prone to dental complications and loss of teeth than the general population.Freitas et al. (2019) investigated oral health variables ranging from tooth loss and missing teeth. For participants who reported missing all of their teeth, most claimed that it was difficult to access dentures due to a lack of health coverage from insurance service providers. In the study, the participants included 350 homeless individuals aged 58 and above. Based on the findings, over 93% were missing a tooth (Freitas et al., 2019). Most of the participants who tried to access dental health care in the previous 6monthswere unable. Part of the reason for the inability to access dental health care is attributed to a lack of health insurance coverage among this population (Dupéré et al., 2012). This study highlights yet another health care disparity, dental care, that the homeless population faces.

Many homeless people lack health insurance coverage. The ACA did not provide dental care coverage until recently. Changes in the ACA policy in 2014 saw the inclusion of dental coverage (Vuillermoz et al., 2017). The expansion, however, has not yet improved oral health in this population because only a few service providers accept the Medi-Cal coverage from the homeless (Omerov et al., 2020), limiting the number of people they can serve. Based on age, most people who are less likely to be uninsured are the elderly. On this ground, it is plausible to assert that there is an urgent need to increase access provision of restorative and preventive dental care among the homeless. Also, the high number of uninsured people reveals a large gap that exists terms of coverage compared to the rest of the population.

Homelessness is associated with adverse health outcomes. Accessing health care correlates to improved health, while homelessness correlates to poor access to health care. In a recent study by Omerov et al. (2020) concerning HUD housing in the United States, the results indicated that homelessness was associated with low insurance rates and, consequently, unmet health needs. Furthermore, people with limited economic resources and homelessness placed a high priority on basic needs compared to health care (Abbott et al., 2017). Therefore, if the government were to aid in housing assistance for the homeless, access to health care would be improved in numerous ways. First, the provision of housing would have a stability effect that would allow people to focus on other needs, such as health insurance, as opposed to focusing on a basic need, such as shelter (Simon et al., 2017). Secondly, there would be an income effect because reduced housing would free up the financial resources that could then be used to pay for health insurance coverage. Simon et al. concluded that housing assistance for the homeless would lower the uninsured rates among this vulnerable population. Furthermore, because Simon et al. used a sample population of adults aged 18-64, the results can be generalized. The findings from this study could be helpful for policymakers in evaluating the need to provide affordable housing and, consequently, reducing the number of uninsured people.

The emergency department is the main health care provider among the homeless in the United States. Such reliance indicates that the homeless population poses a challenge to medical care service providers. Martinez-Donate et al. (2017) argued that the dependence on emergency services alludes to the health insurance gaps presenting the medical care sector. Although they may need primary health care and health services, including insurance, the homeless face other significant barriers. Pathways to becoming homeless are complex and triggered by circumstances such as loss of jobs, domestic violence, and release from incarceration (Luo & Escalante, 2018). Although the conditions may vary over time, researchers have found that homelessness and health insurance coverage are related (Abbott et al., 2017; Luo & Escalante, 2018). This explains why quite a significant percentage of homeless individuals use the emergency department instead of ambulatory care. The core reason is the lack of insurance. Abbott et al. (2017) indicated that the homeless are more dependent on emergency departments and experience repeated visits. The high rate of uninsured persons experiencing homelessness explains the discrepancy. For example, the lack of knowledge regarding the ACA was high among the homeless as compared to their housed counterparts (Martinez-Donate et al., 2017). As a result of the barriers, it is evident that persons experiencing homelessness are less likely to be aware of affordable health coverage.

The lack of awareness among this population has increased the gap between insured and uninsured persons in the United States. Notably, the current population experiencing homelessness has aged in comparison to circumstances30years ago. Today, the median age for people experiencing homelessness is 50 and will continue to rise (Abbott et al., 2017). Although the elderly represent the highest number of individuals experiencing homelessness, the prevalence of homelessness among younger people has been on the rise. Depending on the availability of resources and employability, younger people are more likely to find themselves on the streets (Joseph, 2017b). This economic challenge places them at a higher risk of sexual violence, HIV infections, and mental health complications. The work criteria for Medicaid eligibility has left many young people experiencing homelessness uninsured due to the high rates of unemployment. Future research should focus on ways to curb factors that have led to an increase in the prevalence of homeless cases and, consequently, uninsured persons (Freitas et al., 2019). Research findings imply that a correlation exists between homelessness and medical care insurance.

Homelessness As a Barrier to Medical Care Insurance

Housing instability and homelessness play a critical role in hindering access to healthcare insurance in the United States. Salhi et al. (2018) revealed that the majority of the people experiencing homelessness in the United States rely on emergency departments as their health care providers due to a significant number of factors barring them from accessing the primary care they desperately need. The researchers also revealed that the number of emergency department visits by the homeless have increased by approximately 44% between the years 2005 and 2010, with approximately 75% of the population experiencing homelessness consisting of males with no health insurance. Additionally, the older adults experiencing homelessness of the study sample, whose median age was 58, were found to have poor access to dental care despite having an undeniable need for it, according to a study carried out by Freitas et al. (2019) on a sample of 350 adults experiencing homelessness over the age of 50 in Oakland, California. The researchers also revealed that most participants lacked health insurance and that Medi-Cal did not incorporate access to dental care until the enactment of the

ACA in 2014, which initiated the expansion of the Med-Cal insurance to cover basic adult dental benefits. It should be noted, however, that even with Medi-Cal's recent wider coverage with additional adult dental benefits, many dentists continue to limit the number of Medi-Cal patients to whom they provide their services. Housing instability inclusive of homelessness, frequent moves, and eviction are major factors contributing to children's insurance gaps (Carroll et al., 2017). This problem can be mitigated by streamlining insurance enrollment and renewal processes such as delinking insurance renewal from mailing addresses, among other measures (Dror et al., 2016). From the above discussion, it is clear that the prevalence of health care insurance among the homeless in the United States is very low, and homelessness plays a key role in barring the homeless from accessing health care insurance.

Various researchers have attempted to shed more light on how homelessness acts as a barrier to health care insurance. The following are aspects of homelessness that bar persons experiencing homelessness from accessing health insurance in the United States: high poverty rates, inequality, low health literacy levels, incomplete perceptions of health, linguistic and educational disparities, lack of transportation, and cultural norms surrounding health behaviors (Lee et al., 2020). Other key factors include documentation status, negative attitudes, skepticism/mistrust of the health care system, and the stigma associated with homelessness (Duque, 2020). In the following section, I explore the above-mentioned factors in detail to establish why homelessness is a hindrance to access to healthcare insurance in the United States.

High Poverty Rates, Homelessness, and Health Insurance

Poverty contributes to homeless individuals' inability to pay for health insurance, as the cost of insurance requires money that they barely have. Most people experiencing homelessness have unreliable to nonexistent sources of income, forcing them to live on the streets as they cannot keep up with the constantly rising housing costs (Bouyer, 2020; Chang, 2019). Additionally, individuals experiencing homelessness find it challenging to secure basic needs such as food, shelter, clothing, and transportation, among others, due to their limited financial resources (Cook et al., 2017). Thus, the inadequacy of resources at hand, as attributed to poverty, forces the homeless to prioritize their psychological and safety needs over any medical attention they may require. Therefore, these competing priorities act as a barrier to primary care access for the homeless. Affordability of healthcare services plays a crucial role in determining whether the homeless may access the healthcare they need. Gallardo et al. (2020) affirmed this sentiment by examining 17 healthcare providers in Houston, Texas. Fifty-three percent of the providers identified the cost of healthcare services as a barrier to poor youths experiencing homelessness (Gallardo et al., 2020). The authors also revealed that due to the high costs of some health services, such as psychiatric medication, dental, and vision services, these services were inaccessible to youths experiencing homelessness in Houston. Duque (2020) echoed the sentiment of affordability of health services by the homeless by affirming that 6% of children below the poverty line were uninsured, as indicated by survey data released by the National Center for Health Statistics in 2014. It has been established that financial incentives are a strong motivator for clients experiencing homelessness seeking HCV rapid testing in San Francisco (Masson et al., 2020). Thus, high poverty rates are apparent among persons experiencing homelessness in the United States, jeopardizing their ability to obtain health insurance due to high costs and competing priorities.

Social-Economic Inequality

The homeless inequality can be expounded by defining the equity of access to the medical framework, which is a phenomenon that stipulates the distribution of healthcare services based on need rather than sociodemographic characteristics. Further, the framework is based on three core beliefs: (a) healthcare is a human right, (b) healthcare resources are limited, and (c) healthcare policy must allocate the said resources equitably (Hanratty, 2017; Joseph, 2017a). Researchers have also revealed that inequality is a significant barrier that the homeless experience, especially in terms of the availability of primary care facilities (Gallardo et al., 2020). Additionally, researchers have revealed that most homeless depend on free clinics and safety net clinics for their healthcare (Cleveland, 2020). On the other hand, the funding amounts available to the said clinics are determined by health policy and enforced by the healthcare for the Homeless Program under the Health Resources and Services Administration (Gusmano et al., 2017).

Additionally, because clinics deliver tailored care for the population experiencing homelessness, the unavailability or inadequacy of funding to these clinics renders the homeless group disadvantaged in terms of equity of access to medical services. Hence, the unavailability of free and safety net clinics due to funding in the United States makes it difficult for the homeless to access the primary care they deserve (Kino &Kawachi, 2020; Koh & O’Connell, 2016). This inequality is also highlighted because specific populations of the homeless experience more difficulty accessing healthcare than others. Remarkably, subpopulations of the homeless, such as males, individuals with mental illness, and ethnic minorities, experience inequality when accessing healthcare services due to system-embedded prejudice (Cleveland, 2020). Thus, policymakers must identify the above-discussed disparities and ensure the allocation of resources equitably to cater to the needs of the most vulnerable and at-risk population: the homeless.

Low Health Literacy Levels and Incomplete Perceptions of Health

Navigating health insurance and healthcare options requires significant health insurance literacy. Although several preventive services are exempt from out-of-pocket costs, as stipulated in the ACA, many Americans remain unaware of this provision and its implication for the overall cost of healthcare services (Tipirneni et al., 2018). Health insurance illiteracy is even more amplified among persons experiencing homelessness in the United States. Fryling et al. (2015) affirmed this notion by revealing that persons experiencing homelessness have less knowledge of the ACA, poorer understanding of the qualification criteria stipulated by ACA, and limited access to phones and the internet. The authors interviewed 650 subjects who presented at the emergency department of an urban county level 1 trauma center during daytime hours. Twenty-two percent (*n* = 134) of the participants were homeless, and 26% of the persons experiencing homelessness revealed that they had never heard of the ACA.

Additionally, 70% of the persons experiencing homelessness opined that they were not aware if they qualified for Medicaid. Their poor understanding of the qualification criteria accounted for 30% of the barriers to insurance enrollments reported by uninsured and people experiencing homelessness. Fryling et al. (2015) also revealed that 91% of the persons experiencing homelessness unsure of their qualification for Medicaid reported an income of < 138% of the poverty level, which qualifies them for Medicaid enrolment. Unfamiliarity with health insurance programs such as Medicare and Medicaidis correlated with the less effective utilization of healthcare services and, consequently, poorer health outcomes, emphasizing the importance of health literacy(Ghaddar et al., 2018). From the above discussion, it is clear that low literacy levels and incomplete perceptions of health are highly prevalent among persons experiencing homelessness in the United States. This phenomenon presents a barrier to this population's ability to acquire healthcare insurance.

The level of health literacy and perceptions of health among marginalized Americans are critical factors for the attainment of health insurance. Researchers have proven the importance of health literacy in understanding the United States' highly complex healthcare and insurance system. Levy and Janke (2016) used a large sample of community-dwelling adults to evaluate the connection between health literacy and difficulties in access to care (Levy & Janke, 2016). Consistent with previous research, the authors found that persons with little health knowledge are more likely than those with high health literacy to disregard or delay seeking necessary care. Therefore, in addition to insurance inequality, there are other barriers to healthcare access, such as health literacy. Hence, reducing insurance inequality must be accompanied by other factors, such as health literacy.

In a similar study on racial/ethnic health literacy, Muvuka et al. (2020) focused on African American communities. The results indicated that 58% of African American adults have low health literacy compared to 28% of whites. These groups cannot navigate and understand the technical guides and cost-sharing terms used in health insurance and calculate deductibles, co-pays, and co-insurance. Kino and Kawachi (2020) assessed whether health literacy boosted the utilization of health care services following the expanding health insurance coverage. The authors affirmed that health literacy and insurance promote the uptake of health services. Given such a correlation, it is imperative to determine the influences of homeless people's literacy and health-related insurance coverage.

Researchers have examined how literacy affects health insurance coverage. For instance, research into literacy and awareness of the ACA among the vulnerable Hispanic group revealed deficient knowledge of the ACA among this population (Ghaddar et al., 2018). The authors attributed this low knowledge of ACA to the low levels of health insurance literacy in this community. The results suggested the significance of promoting health insurance literacy to reduce health and insurance inequality among the underserved Hispanic community. Edward et al. (2018) utilized a descriptive survey and semi-structured interviews to assess how health and health insurance literacy impacts access to care and health insurance among the Spanish-speaking communities in Massachusetts. Similar to related studies, Edward et al. confirmed that most Hispanic/Latinos reported inadequate health and health insurance literacy.

Consequently, uninsured persons with low health literacy are less likely to access health care. The results imply that a significant portion of the Spanish-speaking population in Massachusetts has no access to health care. The study is relevant as it provides a link between health and health insurance literacy with the insurance status of this population. In a qualitative study focusing on African American immigrants in Canada, Woodgate et al. (2017) also found high uninsurance rates and poor access to primary care services in this population group. Notably, literacy levels among members of this population have also been associated with the corresponding impacts caused by educational disparities.

Linguistic and Educational Disparities

Linguistic and educational disparities are social determinants that negatively affect homeless individuals' ability to access quality primary care and health insurance in the United States. The said aspect is even more negatively amplified with persons experiencing homelessness who are immigrants and whose English proficiency is poor. This notion is supported by Hoshide et al. (2011), who affirmed that linguistic and educational barriers hinder the homeless from acquiring insurance, as healthcare in the United States is presented in extensive and complicated paperwork that is also difficult to understand. This level of difficulty, in turn, discourages persons experiencing homelessness with limited English proficiency and low levels of education from accessing healthcare insurance in the United States(Lapinski, 2019). Samra et al. (2019) echoed this notion by conducting a convenience sample survey between June and August of 2014 (Samra et al., 2019). The researchers recruited 200 patients in a primary safety-net hospital in Northern Los Angeles County and revealed low English proficiency and literacy levels,as65% of the participants endorsed Spanish as their primary language. Low levels of formal education were also evident, as portrayed by the fact that 47% of the respondents had not completed their high school level of education (Samra et al., 2019). Therefore, the above discussion affirms that linguistic and education disparities are predominant aspects associated with persons experiencing homelessness in the United States and are more common among the immigrant groups of the homeless. The abovementioned disparities pose a substantial barrier to the homeless person's ability to access primary healthcare and health insurance coverage.

Lack of Transportation as a Barrier to Healthcare Insurance

Lack of transportation is one of the bureaucratic barriers experienced by persons experiencing homelessness in the United States when seeking healthcare services. Transportation is a crucial aspect of healthcare delivery as patients must travel from their residence to healthcare centers and back to access the required services. Transportation is not perceived by the homeless as a priority because of other competing needs, such as food and shelter (Canham et al., 2019). Thus, transportation as a cost can be perceived as a no priority by homeless people due to their limited financial resources and competing needs. Around 5.8 million people in the United States in 2017 experienced a delay in medical care due to lack of transportation, as per the data obtained from the National Health Interview Survey (Wolfe et al., 2020). Wolfe et al. highlighted that minority groups such as Hispanic people, those living below the poverty threshold (inclusive of the homeless), people living with functional limitations, and Medicaid recipients were more likely to report a lack of reliable transportation as a barrier to the access of healthcare services.

Additionally, the United States' lack of affordable and reliable transportation impedes medical treatments for the homeless, which exacerbates their chronic conditions and results in increased use of emergency department services (Ganuza& Davis, 2017). Luo and Escalante (2018) showed that 60% of Medicaid beneficiaries who had previously used one or more ED visits had difficulty accessing transportation. From this discussion, it is clear that the lack of access to affordable and reliable transportation by persons experiencing homelessness in the United States poses a serious barrier to this population's ability to receive medical treatment and maintain their health status.

Cultural Norms Surrounding Health Behaviors

Cultural norms and beliefs play a significant role in determining which health practices are embraced by a particular group of people and which ones are perceived as taboo. Thus, these beliefs may be barriers to accessing healthcare services, as specific cultural stipulations may discourage or forbid access to otherwise essential healthcare services (Siersbaek et al., 2020). Researchers have also noted that cultural norms surrounding health behaviors are a significant barrier to access to quality healthcare worldwide (Annor&Oudshoorn, 2019). The problem is further amplified for disenfranchised groups such as immigrants, refugees, and the homeless seeking health services in America. Additionally, the problem is more aggravated among homeless immigrant persons because they already experience other critical challenges in their bid to accessing healthcare services. Woodgate et al. (2017) highlighted the plight of Somali refugees in Western Canada with being uncomfortable and hesitant to seek health services from male physicians because their culture prohibits them from undressing and showing their private parts to men. The depiction of the cultural norm as a barrier to healthcare access was also highlighted in the study when an Ethiopian refugee failed to eat and drink for 3consecutive days in the hospital, despite having had given birth. The unfortunate event was attributed to the fact that the food offered by the hospital was foreign to her, and thus, she could not eat it. Hence, the above-discussed scenarios affirm that cultural norms may pose a significant barrier to the access to primary care and health insurance coverage by the persons experiencing homelessness whose cultural beliefs conflict with healthcare practices in the United States.

Negative Attitudes, Skepticism/Mistrust of the Health Care System

Negative attitudes, like skepticism or mistrust, of the health care system is a contemporary issue that affects disadvantages groups' ability to access quality healthcare. This problem is further aggravated among minorities, such as African Americans, who are said to have historically experienced discrimination in access to health care (Davis, 2017). The prejudices experienced by this group, in turn, continue to affect their contemporary attitudes when engaging with the U.S. healthcare system. African Americans' mistrust and negative attitude towards the U.S. healthcare system is portrayed by the reluctance of African American men to be screened for colon cancer, which results in increased mortality rates (Bouyer, 2020). Another scenario of negative attitude highlighted in this study entails the perception that African Americans fear the diagnosis of diseases, such as cancer. The situation is a contributing factor to delayed treatment of cervical and breast cancer, which also leads to increased mortality rates. The issue of mistrust and skepticism of the U.S. healthcare system is also apparent in American Indian communities (Wille et al., 2017). Willeet al. affirmed that due to the long history of discrimination and prejudices experienced by American Indians, some individuals in this group mistrust and are skeptic toward the services provided by the U.S. health system. In a study focusing on men from a disadvantaged neighborhood in Montreal, California, Dupéré et al. (2012) highlighted the men's reluctance to seek health services because they were embarrassed by their problems. The above-discussed scenarios highlight how negative attitudes, mistrust, and skepticism of the health system are detrimental factors when accessing health care and insurance coverage in the United States. The problem is further exacerbated among homeless persons.

Researchers have examined homeless persons' perceptions of both health insurance and care providers. Researchers have investigated the facilitators, barriers, and lived experiences of Canadian homeless persons on access to health care (Ramsay et al., 2019). Using personal semi-structured interviews, the authors identified access cost and lack of trust in healthcare providers, among other factors, as critical barriers to accessing care for persons experiencing homelessness. The authors confirmedtrust and mistrust and insurance (i.e., affordability) in promoting homeless persons' access to health care. Using a survey, Brown (2017) assessed the attitudes of the homeless on health insurance and enrollment assistance. The researchers noted that health insurance for Americans experiencing homelessness is a critical barrier to accessing healthcare. The results suggested using facilitators to encourage and guide the homeless population's enrollment in health insurance. The results contradicted those of previous researchers who found significant distrust about enrolment facilitation. The confusion regarding enrollment is a concern that must be addressed to encourage health insurance enrolment (Levy & Janke, 2016; Omerov et al., 2020). The second concern to be addressed is the financial barrier. Overall, the homeless have positive attitudes towards facilitation and enrolling in health insurance. Dror et al. (2016) identified factors influencing the uptake of community-based health insurance schemes (CBHS) in developing nations. Consistent with earlier research, the authors found a positive correlation between enrollments and the following factors: the education of the head of household, household income, episodes of chronic illness, and female-headed households.

In a study of hired farmworkers in the United States, Luo and Escalante (2018) analyzed healthcare services by documented and undocumented workers. The researchers used data from agricultural workers' surveys between 200 and 2012. The results indicated that a significant proportion of undocumented workers are less likely to use the United States and foreign health services than documented workers. It was further established that the acquisition of health insurance among these employees significantly increases the use of health care services. This population group is more likely to patronage private clinics than their documented counterparts. Okoro et al. (2020) investigated African American women regarding their perceptions of discrimination in treatment due to race/ethnicity and socioeconomic status. The study results suggested that this population group is subjected to discrimination in healthcare based on race or ethnicity, stereotypical assumptions such as sexual misbehavior, and socioeconomic status. Bouyer (2020) examined the skepticism component of perceptions among African Americans with type 2 diabetes mellitus. Effective management of diabetes can reduce hospital stays and disease complications. Considering the poor management of this disease among the African American population group, Bouyer argued that medical skepticism could influence the management and health outcome of diabetes. The results, however, revealed no correlation between medical skepticism and management of diabetes in African Americans.

Researchers have examined poverty as a barrier to using social and healthcare services during a crisis. Dupéré et al. (2012) observed that the poverty-stricken men in Montreal, Canada, tend to avoid seeking health and social services even in times of need. The researchers found that these men are reluctant to seek health and social services due to three key reasons: nature of the problem, nature of provided services, and some face difficulty seeking these services. It was still vital, however, to determine how the attitudes, mistrust, and skepticism of the health system play out among these men. Researchers, such as Wille et al. (2017), have investigated the barriers to healthcare among homeless American Indians (A.I.). Wille et al. noted that the A.I. population faces multiple barriers compounded by homelessness while seeking healthcare for mental and other health conditions. The homeless A.I. identified obstacles to healthcare access as unreliable transportation, discrimination, phone accessibility, and the health system's bureaucratic culture. Service providers identified mistrust, discrimination, and access to care as the major barriers for this population group. Still, Bhatena (2017) observed that the population experiencing homelessness faces insurmountable barriers to accessing health care. The author, however, classified these barriers into personal, bureaucratic, financial, and programmatic barriers. Due to these barriers, the population experiencing homelessness group delays seeking health care until immediate health intervention is necessary, such as in emergency cases.

Documentation Status

Documentation status of the immigrants in the United States, especially the homeless, is a detrimental barrier in their efforts to seek medical services and healthcare insurance. This situation is attributed to the ACA of 2010 imposing federal restrictions on persons without legal documentation from benefiting from Medicaid, among other national health insurance reforms (Ghaddar et al., 2018). The said restrictions prevent ineligible immigrants from accessing the health services they require, jeopardizing their health. Although some subnational jurisdictions have been altered to accommodate ineligible immigrants, few immigrants took advantage of the provision (Sangaramoorthy& Guevara, 2017). This situation is attributed to the concerns that inclusive health services may increase the probability of deportation of undocumented immigrants and potentially jeopardize their future legalization proceedings (Joseph, 2017a). The immigrants' failure to use inclusive provision can also be attributed to the anti-immigrant sentiment and legislation, a current national hoovering rhetoric (Gurrola& Ayón, 2018). The concern of documentation status is worse for undocumented persons experiencing homelessness living in America. Additionally, it is valid to assert that restrictive federal policies accompanied by a national-level anti-immigrant sentiment in the United States undermine even the inclusive subnational policies in the socially progressive states (Sangaramoorthy & Guevara, 2017). It is clear that a homeless person’s documentation status is a potential barrier to access to healthcare and insurance coverage in America.

The mistrust, negative attitudes, and skepticism about health care by the population experiencing homelessness can deter them from seeking medical insurance and health care. Baggett and Kertesz (2020) investigated common health issues affecting homeless Americans and as well as recommendations for improving access to care for this vulnerable group. The authors noted that Americans experiencing homelessness have a heavy burden of mental and physical illnesses. The authors further discussed the high utilization of acute health care services among this population group. The authors, however, never addressed the homeless’ attitudes, mistrust, and skepticism about health insurance and the health care system.

The results of the reviewed research offer crucial information on the health condition of the population experiencing homelessness. In a similar study, Carroll et al. (2017) also assessed the correlation between health insurance gaps in children and housing instability. Recent qualitative researchers have focused on promoting primary care services for insured individuals and families experiencing homelessness (e.g., Karnick et al., 2019). Karnick et al. identified five enablers or facilitators of primary care use among the homeless: financial assurance, sense of community, integrated health services, mutual patient-provider respect, and patient care teams. Karnick et al. demonstrated the establishing and maintaining regular use of primary care services. The homeless desire respect from providers and need to feel a sense of community, affordable within their means (Karnick et al., 2019). The mistrust and skepticism about care providers, both insurance and health professionals, prospectively affect the consistent use of primary care by persons experiencing homelessness.

Housing assistance, such as HUD, is associated with obtaining health insurance coverage. Using the National Health Interview survey approach, Simon et al. (2017) sought to determine this association. The authors established a lower insurance rate among current recipients than future recipients. The results demonstrated that gaining housing insurance increases the chance of obtaining health insurance. The study's relevance is connected to the insurance rate among the population experiencing homelessness; however, it is fundamental to establish the role of attitudes, mistrust, and skepticism of this population group regarding health insurance (Bouyer, 2020). The contribution of local economic conditions such as unemployment, the housing market, and poverty to homelessness is profound (Hanratty, 2017). Hanratty confirmed that economic factors, particularly the cost of rent and poverty, are driving forces of homelessness. Understanding drivers of homelessness can be a pointer to knowing the attitudes, skepticism, and mistrust about health insurance and the health system. Researchers have also studied the social and healthcare providers' views on access to healthcare by young people experiencing homelessness (Gallardo et al., 2020). The results are consistent with earlier studies on health care access, as youths with homelessness experience reported reduced access to health care and health insurance.

Similar studies have also been undertaken to determine the impacts exerted on the population experiencing homelessness by health insurance parameters. For instance, Lee et al. (2020) focused on the implications of health insurance on the homeless and elderly population because as these groups represent highly vulnerable populations, the provision of health insurance is critical in increasing their access to health care. The authors revealed that having insurance is positively correlated with age and mental health conditions, gender, and physical disabilities. Ideally, these factors increase the chance of enrolling in state and federally funded programs such as Medicaid and Medicare. Further, the results supported the significance of obtaining health insurance in the transition period to the community from state homelessness. Lee et al. did not examine the health system's adverse perceptions, attitudes, and mistrust as possible challenges to healthcare access. Freitas et al. (2019) used a cross-sectional study and found considerable oral and dental problems in the target population. The factors contributing to dental and oral problems include age, as well as drug, alcohol, and tobacco use. Most of the ailing people reported their inability to obtain required dental care. In a narrative review, Rosenthal et al. (2019) investigated the factors deterring access to optimal health by children experiencing homelessness aged below 5 years. The authors acknowledged that most children experiencing homelessness fail to attain full cognitive development. Further, the authors identified barriers at family and individual levels, such as the absence of care plan, lack of access to needed medication, and lack of health insurance and community barriers, including poor housing and unreliable transportation. The barriers to health care are similar across the elderly, middle-aged, and child populations.

Stigma Associated with Homelessness

The stigma associated with homelessness is detrimental to the homeless persons' willingness and ability to access health care and medical insurance in the United States. Mejia-Lancheros et al. (2020) indicated that homeless persons are often mischaracterized as dangerous, violent, mentally ill, substance-dependent, or perceived to engage in criminal activities. The mischaracterization is often accompanied by denial of services. Whether intentional or not, the actions are punitory and nurture the pervasive cycle of poor health and socioeconomic disadvantage apparent among homeless populations (Lapinski, 2019). Moreover, the stigmatization is purported to translate to an aura of hopelessness, low self-esteem, and lack of empowerment among persons experiencing homelessness, consequently discouraging them from seeking essential health services. Pendyal (2020) echoed this stigmatization sentiment in a study in which they revealed that out of the research's 19 participants, 11 were homeless and had previously experienced stigmatization by healthcare providers. This discussion affirmed that the stigma associated with homelessness is a contemporary issue that continues to hinder the ability and willingness of persons experiencing homelessness to access essential primary care and healthcare insurance in the United States.

Health Insurance Inequality

Multiple studies have examined the connection between poverty levels and acquisition and payment for health insurance among the homeless community. Numerous studies (e.g., Hanratty, 2017), assessed the contribution of local economic conditions such as poverty level, unemployment, and the housing market area on the rate of homeless. The results indicated local labor market conditions and housing significantly contribute to the speed of homelessness. The median rent for rental housing and poverty level is significantly correlated with homelessness. Hanratty failed, however, to address the connection between these factors on insurance inequality in the homeless community. Studies on insurance inequality have assessed the insurance coverage inequality across races (e.g., Bhaskar & O'Hara, 2017). Bhaskar and O’Hara revealed high inequality and worse health outcomes among the Alaska Natives and A.I. than in other American ethnic groups. These results provide essential information on the distribution of health insurance and health inequality. Other similar studies on racial-ethnic inequality disparity in mental health care have been conducted. For example, Cook et al. (2017) found no reductions in disparities in accessing mental health care over the 2004-2014 periods. Instead, disparities were exacerbated for Blacks and Hispanics over the same period, signaling the ineffectiveness of the interventions such as health insurance expansion, early detection of mental health disorders, and other measures for removing financial barriers to health access. Cook et al. collected the results, which offered critical information on the significant role of health insurance in bridging health inequality.

Various studies have been undertaken to determine the social-economic barriers to healthcare. For example, Hoshide et al. (2011) examined sheltered homeless residents in Honolulu to assess risk factors related to healthcare barriers amongst homeless residents. Hoshide et al. took note of the main domains of healthcare barriers and found that a lack of health insurance was a significant financial barrier to health care access among homeless residents. Annor and Oudshoorn (2019) focused on the health challenges facing this population's families. The authors considered differences in experiences of populations experiencing homelessness, focusing on families as the fastest growing segment in this group(Annor&Oudshoorn, 2019). The results indicated a clear distinction between the health challenges of children and parents in families experiencing homelessness. The study provides a crucial foundation for addressing health and insurance inequality for various components of a family experiencing homelessness. In a narrative review of the literature, Rosenthal et al. (2019) exposed the barriers to accessing optimal health for children below 5years. Consistent with previous literature, the authors identified race/ethnicity, fear, and immigration as barriers at the family and individual level, whereas poor access to health care, lack of health insurance, and care plans were identified as system-level barriers. Poor housing and transport limitations were noted as community-level barriers to optimal health among children aged below 5years.

Health and Health Insurance Inequality

The disparity in access to healthcare among homeless and immigrant groups is primarily attributed to a lack of insurance coverage. Researchers have examined health inequality among families and individuals experiencing homelessness (e.g., Koh & O'Connell, 2016; White & Newman, 2015). Using equity of access to the medical care framework, White and Newman examined access to primary care among this population through a quasi-systematic literature review. The authors found several barriers to primary care access for individuals and families experiencing homelessness. The lack of insurance coverage and competing priorities, such as the need for food and education, were critical barriers to primary care access. Considering the health equity challenge of the present time, Koh and O’Connell focused on addressing health care access issues among individuals and families experiencing homelessness. Given the composition of groups experiencing homelessness, special needs are required through patient-centered care via integrated care services. This has proved effective in meeting the needs of marginalized people disconnected from the health system. The authors further identified the need for broader policy interventions, such as the housing first policy, to address the problem of homelessness. These studies provide relevant data on health inequality among the homeless, an issue closely linked to insurance inequality.

Despite efforts to reduce health care inequalities, Gusmano et al. (2017) found persistent racial/ethnic health and health care access inequality in avoidable hospital conditions among New York residents. The researchers concluded that inequalities are primarily attributable to the widening economic disparities among residents based on the study’s results. Accordingly, these authors called for significant policy changes to address rising income and wealth inequality in mitigating racial-ethnic health inequalities. The state and federal level policy framework also includes insurance coverage for the low-income population to improve healthcare access (Alderwick et al., 2019; Annor & Oudshoorn, 2019). Such policy frameworks can prove reasonable, given that some health issues have been mainly linked to the population experiencing homelessness.

Certain health problems are more specific to the population experiencing homelessness. There are many potential health problems for the homeless resulting from the COVID-19 pandemic (Tsai & Wilson, 2020). Tsai and Wilson noted that people experiencing homelessness reside in a contagious environment for a pandemic, making them the most vulnerable group to COVID-19. Besides, the researchers noted that most of this population has chronic diseases and engage in substance abuse, which exposes them to the disease. The authors further observed that people experiencing homelessness are more geographically mobile and transient than the general population, making it challenging to trace contact and prevent the spread of disease. The health and insurance inequality could further render the homeless population vulnerable to health pandemics. There is a need to address health inequality using the social determinants of health (Daniel et al., 2018). These are nonmedical factors influencing one's health condition or outcomes. In acknowledging the role of social determinants of health, scholars have explored the associated complexities better to integrate the social programs into the health care system (Chang, 2019; Daniel et al., 2018). Researchers have found, however, that this system would never succeed without addressing the issue of insurance inequality. Similar research has investigated the prescription challenges of vulnerable unsheltered people with mental diseases (Balasuriya et al., 2020). Balasuriva et al. noted that financial and other difficulties, such as unreliable transportation, poor nutrition, secure storage, and lack of access to electricity, are worth consideration when prescribing medication. Consistent with Daniel et al. (2018), there is a call to consider social determinants in prescription decision-making for the homeless (Balasuriya et al., 2020).

Health Care and Health Insurance Barriers

As the most vulnerable group to health and insurance inequality, scholars have extensively examined immigrants. Disparities in access to health insurance and health care can result from education level and even language barriers. Researchers have studied the social aspects of immigrants to determine the link between social factors in health care and health insurance disparities (Chang, 2019). Estimates indicate that 44.5 million U.S populations are foreign-born, and 12.1 million are undocumented immigrants (Baggett &Kertesz, 2020). Chang (2019) noted that these groups are highly vulnerable to social problems, including lack of educational achievement, linguistic issues, housing insecurity, and poor access to health care. Further, these groups are also stigmatized, marginalized, and have a fear of deportation and acculturation issues.

Consequently, immigrants and foreign-born populations have little or no access to health insurance and health care, thus contributing to insurance inequality. Similarly, in a participatory cross-sectional study, Müllerschön et al. (2019) focused on how health insurance influences access to health care and HIV testing among African immigrants in Germany. Like the United States, and due to many challenges, the researchers found that migrants in Germany without insurance coverage face numerous barriers to accessing health care. These studies revealed a high inequality in insurance coverage among migrants and the foreign-born populations. Still, researchers exploring obstacles to health care access, attitudinal barriers, and facilitators to health insurance coverage amongst homeless residents in urban areas found that a majority of homeless residents in urban areas prefer facilitator guidance during the insurance enrolment process (Brown, 2017). In contrast, 43.8% were aware of enrolment assistance, while the other 43.7% were not aware of the assistance. Although a significant proportion of this population is uncovered, they all acknowledged the importance of health insurance.

Researchers have also highlighted the relevance of transportation challenges related to the homeless population's ability to acquire appropriate medical services. For instance, a lack of reasonable transportation delays access to medical care (Wolfe et al., 2020). Wolfe et al. found that lack of transportation delayed medical care for more than 5.8 million people in 2017 alone. The researchers also revealed a significant increase in transportation barriers in health care access over the years. Specifically, Hispanics, Medicaid recipients, people living below the poverty threshold, and those with functional limitations are most vulnerable to transportation barriers. The transportation barrier is disproportionately against persons of low income and those with chronic conditions.

Ganuza and Davis (2017) found considerable challenges with NEMT services, including customer service concerns, fraud and abuse, structural inefficiencies, and inadequate responsiveness. These challenges have contributed to health inequality against Medicaid patients due to missed or delayed appointments. In another study, Canham et al. (2019) affirmed the vital role of health support in homeless patients' transition from the hospital into unfavorable locations for recovery and follow-up care. Such information reinforces the unsheltered population's inability to obtain the necessary echelons of medical care to the sustained financial and transport issues (Mongelli et al., 2020). On the other hand, it is imperative to note that lack of healthcare access is associated with both transport problems and housing challenges.

Recently, researchers have explored the issue of housing assistance from different perspectives. Simon et al. (2017) found that HDU housing assistance is linked to health insurance and access to care. The researchers used a health interview survey of adults aged 18-64 years and found that HDU assistance was strongly associated with high insurance rates. Access to care due to cost was also higher among the recent recipients than future recipients (Joseph, 2017b). This study's evidence is critical as it supports the relevance of housing assistance in improving access to care and insurance. Joseph found within healthcare stratification following the passage of the 2010 ACA that undocumented immigrants were still excluded from the benefits of healthcare reforms (Joseph, 2017b).

Although the act was meant to increase Americans' access to affordable and quality health care, noncitizens are left out due to geographic stratification in the implementation of the ACA. The results gathered by the researchers demonstrated that such stratification could prospectively worsen current disparities in health insurance coverage and access to health care by vulnerable Americans. Joseph (2017b) sought to unfold cracks in ACA coverage on the same issue of documentation and coverage. Using interviews to collect data, the author observed that immigrants' documentation status reduces access to health care. The findings revealed that various stakeholders perceived document status as a barrier to immigrants' access to health, even for those with health coverage. Further, Van Natta et al. (2019) focused on Latinx legal status in the healthcare safety net of the United States. Researchers' focus on the correlation between homeless people's acquisition of healthcare and housing suggests that comprehensive insight into the issue can also be obtained by considering possible facilitating factors that would impact their ability to obtain health insurance for better medical services.

Facilitators of Health Insurance

The disproportionate health burden against the homeless population is well documented in the literature. Bhathena et al. (2020) uncovered many healthcare barriers among uninsured and patients experiencing homelessness at a free clinic run by students. According to the authors, the high cost of healthcare, unreliable transport, and lack of health insurance are the main barriers to accessing health care service among Americans experiencing homelessness. The Medicaid program was rated the most trusted and valuable insurance plan, followed by caseworkers and medical assistance programs.

Notably, access to the emergence of care is hampered by a lack of reliable means of transportation. These results have shown that people experiencing homelessness trust and have positive attitudes toward state and federal-funded programs. A similar systematic review further examined the key barriers and facilitators of health care access and use among persons experiencing homelessness with mental illnesses (Lapinski, 2019). Given an elevated rate of substance abuse, mental health diseases, and suicidal rates among youths experiencing homelessness, this population requires special medical attention to meet diverse health needs. The study results suggested a range of barriers from financial, communication with care providers, stigmatization, administrative requirements, and lack of awareness as critical to accessing care.

The attitudes, mistrust, and skepticism about health insurance and the health system were not identified as facilitators or walls in this study. In a broad review, Sanders et al. (2020) sought to identify personal barriers and drivers of social determinants of health. Personal identification is a fundamental factor in gaining access to social determinants of health for marginalized groups in North America. The authors focused on the critical themes of acquiring and retaining personal identification, accessing health and social services, and facilitation of identification programs. The study revealed a significant understanding of current PID service models among rural residents. From such a perspective, it is critical to explore barriers to accessing and maintaining PID by marginalized groups, such as persons experiencing homelessness.

Researchers are seemingly inclined to the perspective that documentation plays a fundamental and irreplaceable role in determining the ability of the unsheltered population to access appropriate healthcare services. As such, documentation status is a critical barrier to healthcare access for immigrants and foreign workers. Mexican immigrants are among the population groups facing limited access to healthcare due to their documentation status (Martinez-Donate et al., 2017). Martinez-Donate et al. revealed that Mexican immigrants experience several difficulties in receiving healthcare, particularly in the postmigration phase. The authors advocated for increased efforts to provide affordable insurance coverage and reduce transportation challenges and incarceration to improve access to care among these immigrants. In a study in Madrid, Spain, Vázquez et al. (2020) evaluated that barriers that homeless women immigrants experience. The authors compared access to care between homeless women born in Spain and women immigrants and found significant similarities between these groups.

Nonetheless, additional research may prove helpful in ascertaining the existence and impacts of the documentation component in light of immigrant and homeless minority factions. Sangaramoorthyand Guevara (2017) assessed the health of immigrants and minority groups in rural Maryland. The research is significant due to the growing size of the rural immigrant population and the eastern show of Maryland amidst declining health system resources. The in-depth interviews revealed that limited health care resources, high cost of health care, lack of health insurance, language barriers, and noncitizen status are fundamental barriers hindering immigrants from accessing health care. Overall, the study's relevance is connected to identifying significant barriers and facilitators among vulnerable groups such as immigrants, undocumented, and persons experiencing homelessness in accessing health care.

Stigma is a common problem among people experiencing homelessness due to the nature of their condition. Researchers have examined the role of stigmatization, providers, cost, and partners as prospective barriers to the uptake of Preps among American women (Goparaju et al., 2017). Goparaju et al. were motivated by low rates of Preps use in women and significantly high service in American men. Besides their lack of awareness, social and structural challenges hinder their access to and utilization of Preps. Using focus group discussion, the women also expressed concern that the stigma associated with using HIV medicines deters them from using Preps. The hostile reactions, mistrust, and accusation from male partners after suspecting their use of HIV drugs prevent them from seeking medical services.

Overall, there is a need for efforts to reduce HIV stigma, make Preps affordable, and improve patient-provider relationships to facilitate healthcare access. The study conducted by Goparaju et al. was essential as it revealed women's mistrust of care providers as a hindrance to accessing medication. Researchers have also assessed health care experiences of prerelease and post release women in the prison system as one of the vulnerable groups (Abbott et al., 2017). The analysis was critical in providing better support for women transitioning from prison to the community. The results demonstrated that for women transitioning from prison to community, accessing care is experienced as medical homelessness due to long exclusion from community-based care and prison cycles. These women's healthcare experience is characterized by transient patient-provider relationships, unsuccessful efforts to access care, poor medical management, and stigma preventing their candidacy to health care during serious illness events. Omerov et al. (2020) also assessed homeless persons' health and social needs and experience. The authors revealed that homeless individuals prioritize essential human need provision, including food and shelter, over social and health needs. Furthermore, discrimination, bureaucracy, strict business hours of care facilities, and stigma bars them from accessing social and health services.

Several researchers have employed a qualitative descriptive approach to justify their use for this research. A qualitative descriptive method is used to look closely at who, what, and where of a poorly understood phenomenon, mainly in healthcare-related research (Kim et al., 2017). This healthcare-related research seeks to examine the perspectives of homeless people concerning issues in accessing healthcare services.

Bowen and Irish (2018) employed a qualitative descriptive approach to explore the experiences of adults 18-24 dealing with homelessness as they negotiate access to food to uncover their experiences related to acquiring food. This approach was highly effective at uncovering their experiences associated with obtaining food. The authors found that although 70% of their participants were recipients of the Supplemental Nutrition Assistance Program, they faced access barriers, including initial denial of eligibility as a result of being listed on a parent's application despite not living in that residence and a stigma associated with using food pantries and meal programs. The participants also expressed a preference for organizations, such as Food Not Bombs. The authors concluded that policy and interventions need to be developed to improve food access for adults 18-24.

Ramsay et al. (2019) utilized a qualitative descriptive approach to explore issues that homeless people face when trying to access healthcare in a Canadian regional municipality. These barriers included affordability, challenges finding primary care, the inadequacy of the psychiatric model, inappropriate management, lack of trust in health care providers, poor therapeutic relationships, systemic issues, and transportation and accessibility. They identified eight factors that can facilitate healthcare access, including accessibility to services, community health care outreach, positive relationships, and shelters coordinating health care. Knowledge of the direct experiences of marginalized individuals can help create new health policies and enhance the provision of clinical care. Dickins et al. (2020) uncovered what strategies are most useful for improving care access and promoting consistent primary care use and what factors influence primary care patterns.

Qualitative descriptive research has helped researchers examine issues that medical providers and homeless adults have as they negotiate care. Hudson et al. (2017) utilized this approach to explore how palliative care is experienced among homeless people. The authors found minimal conversations between the homeless participants and medical staff regarding future care preferences and identified challenges to these conversations (e.g., attitudes toward death, a recovery-focused nature of services for those experiencing homelessness, uncertainty regarding prognosis and place of care, and fear of negative impact). The authors called for a new approach to supporting homeless people experiencing severe illnesses.

In Chapter 3, I provide more detail to justify this research methodology for investigating the phenomenon of healthcare access by homeless adults. As qualitative description focuses on obtaining a broad and deep understanding of a phenomenon, it was selected as the optimal methodology for this research. I sought to focus specifically on health insurance inequalities that affect access.

Methodology

I implemented a descriptive qualitative approach for this research. I chose a descriptive design because researchers have suggested that this design is appropriate for exploring the descriptions of individuals concerning the phenomenon of interest (Atumanya et al., 2020; Borglin et al., 2020). The descriptive design is used to describe a phenomenon in-depth instead of studying causal relationships and testing theories (Mwaguni et al., 2020). I chose the descriptive approach because it best depicts the phenomena and illustrates its presence based on the descriptions of those who experience the phenomenon first-hand. Other research designs (e.g., case study, phenomenology, grounded theory, and narrative research) were also considered (Clandinin, 2016; Moustakas, 1994; Yin, 2017). Addressing this study’s purpose and research questions is not aligned with the distinct characteristic of using one of the other design options. Therefore, I deemed a general descriptive qualitative design to be appropriate for this study.

Chapter Summary

This review of literature has demonstrated significant efforts by scholars to identify factors related to health insurance inequalities among the population experiencing homelessness. In unraveling these factors, the review covered the prevalence of health inequality and health insurance inequality among different population groups both in the United States and globally. Studies on health and health inequality have focused on vulnerable groups such as the homeless, immigrants, and those living in poverty and populations with mental and physical illnesses. Health access and health insurance inequality barriers are a critical area of interest for researchers to be addressed by various stakeholders in the health sector to attain health equity. The presented evidence suggests multiple factors and barriers to insurance inequality, including immigration, high level of poverty, homelessness, immigration status, unreliable educational achievement, language barriers, and health insurance literacy. Most important, the authors in the reviewed studies acknowledged the importance of health insurance in reducing health disparity for various population groups.

The literature review indicated the prevalence of homelessness and, consequently, a lack of health coverage. A uniform reason for lack of health insurance is the need to prioritize other basic needs, such as housing and food, over health access. Also, the work requirements for eligibility criteria indicate that most people experiencing homelessness are unemployed and, therefore, unable to pay for coverage. Over the years, cases of homelessness were on the rise in the United States and across the world. Therefore, to reduce the gap of uninsured people among the homeless population, the policymakers should look into providing affordable housing units so that people can have financial resources to pay for health insurance. It is evident from these reviews that mistrust and negative attitudes have not been extensively studied by scholars, highlighting the empirical gap. The barriers and facilitators vary depending on the nature of the study population, such as immigrants, vulnerable women, low-income groups, and individuals experiencing homelessness. There is a need for a study to fill this empirical gap by examining how these factors play out as facilitators and barriers to access to health care. In Chapter 3, I focus on the research design in close reference to the method that was adopted to collect data for answering the research questions. I will also address the ethical issues surrounding the research.

Chapter 3: Research Method

The problem I addressed in my study was that it was not known how homeless people perceive social barriers and their access to health insurance. The purpose of this qualitative study was to explore the perspectives of people experiencing homelessness toward possible social barriers to obtaining health insurance. I utilized a qualitative methodology for this study in order to address the problem and fulfill the purpose of this study

In this chapter, I provide details of the descriptive qualitative methodology that was used for this study. The sections included in this chapter are as follows: (a) research design and rationale, (b) role of the researcher, (c) methodology, (d) instrumentation, (e) procedures for data collection, (f) data analysis plan, and (g) ethical procedures. The chapter ends with a summary.

Research Design and Rationale

I used a descriptive qualitative approach to complete this research. A descriptive design was used because researchers have suggested that this design is appropriate for exploring the descriptions of individuals in relation to the phenomenon of interest (see Atumanya et al., 2020; Borglin et al., 2020). A descriptive design is used to describe a phenomenon in depth in lieu of studying causal relationships and testing theories (Mwaguni et al., 2020). I chose the descriptive approach because it best depicted the phenomena and illustrated its presence based on the descriptions of those who experience it firsthand. I considered other research designs (e.g., case study, phenomenology, grounded theory, and narrative research) for this study. In addressing the purpose and research questions of this study, however, these designs were not aligned with the distinct characteristic of using just one of the other design options. Therefore, I deemed a general descriptive qualitative design to be appropriate for this study.

Role of the Researcher

As the researcher, I served as the central research instrument for data gathering and analysis (see Dietz & Baker, 2019). As an instrument of data gathering, I recruited the participants for the study. I also served as the interviewer to collect data from individuals experiencing homelessness about their perceptions on access to health insurance. Further, I was responsible for generating interpretations and analysis of the perceptions of these participants based on data gathered from the interviews.

In the recruitment phase, the researcher is responsible for ensuring that site permission is obtained before contacting potential participants (LeCroix et al., 2017). As such, I was responsible for initiating contact with participants by inviting participants to participate through email. It was important to note that I did not have personal or professional relationships with the participants of the study. Because I selected the participants, the main consideration was minimizing conflict of interest (see LeCroix et al., 2017). To do this, I refrained from recruiting any family member, friend, relative, colleague, or subordinate at work. I also provided participants copies of the informed consent to ensure that the participants who were interested in participating in this study were provided with knowledge about their rights and roles before signing as a respondent of the study.

Researchers are vulnerable to potential personal biases which may influence the findings of a research study (FitzPatrick, 2019). To avoid any potential bias, I used the interview protocol for guidance during each interview. The interview protocol contained the questions to be asked to the participants during the interviews. Furthermore, with the interview protocol, I conducted the semistructured interviews in a guided manner that aligned with the problem and purpose while allowing for flexibility to gain more relevant information for the study. Moreover, before collecting any data for the study, I identified and enumerated the personal expectations, point of view, and possible biases in relation to possible findings of the study so that I was aware and cautious of these data while performing data gathering and analysis.

Another means of minimizing influences of researcher biases during the course of data gathering and analysis is bracketing and maintaining intellectual honesty (Janak, 2018). Bracketing was necessary to help maintain the focus of the research and not interject personal opinions into the research process, specifically during the data collection and analysis phases (Janak, 2018). In the bracketing process, I acknowledged and set aside any relevant past experiences, attitudes, and beliefs for the entire duration of the study to maintain the objective of the study (see Janak, 2018).

Ensuring intellectual honesty, which requires that the researcher avoid allowing personal beliefs to interfere with data collection and analysis all throughout the study duration, is an important role of the researcher (Lincoln & Guba, 1985). To ensure intellectual honesty, I made sure that no information was purposefully omitted or altered, which was certified through member checking (see Lincoln & Guba, 1985).Member checking was completed by sharing the interview transcripts and my initial interpretations with participants to ask for their feedback regarding accuracy of transcription and interpretation. I used member checking to ensure that the transcripts matched the memory and intentions of the participants.

Methodology

In this section, I discuss the details of the participant selection logic, which includes the target population, sampling strategy, selection criteria, and sample size. I also discuss the instrumentation and procedures for recruitment, participation, and data collection. I also present details of the data analysis plan.

Participant Selection Logic

The population for this research was homeless persons with different backgrounds (e.g., race and ethnicity, education level, social status, and gender). I chose this specific population for this study because these individuals had the experience, background, and knowledge necessary to provide relevant information about the phenomenon of interest. Moreover, the experiences and perceptions of the chosen population aligned with addressing the questions and purpose of the study.

I used purposeful sampling to recruit participants for this research. Purposeful sampling is commonly used in qualitative research studies because the aim of such research is to understand how or why a phenomenon occurs based on the perspectives of the most relevant participants (Kalu, 2019; Morse & Clark, 2019). Purposeful sampling was a strategy grounded on the selection of participants based on preselected criteria (Kalu, 2019). Purposeful sampling was, therefore, appropriate for this descriptive study, as it allowed me to obtain relevant data for answering the research question and addressing the study’s purpose.

When recruiting participants through purposeful sampling, I used a set of criteria to assess prospective participants’ eligibility. The following are the inclusion criteria that I used to determine who could participate in this study: (a) meet the U.S. Department of Housing and Urban Development’s (2013) definition of homeless, (b) are aged 18-60, and (c) tried to access health care insurance within the last 12 months. The exclusion criteria were at least one of the following: (a) younger than 18 years old, (b) older than 60 years old, (c) pregnant females, (d) individuals with substance abuse problems within the past 12 months, and (e) individuals with physical and learning disabilities. These individuals were excluded from the study because they were not considered part of the population of concern for this study. I utilized a set of screening questions based on the inclusion criteria to determine eligibility during the recruitment phase.

Researchers have shown that the sample size for qualitative studies range from six to 25 participants as being sufficient to achieve data saturation (Beck, 2009; Mason, 2010). I interviewed 10 participants during the data collection phase. In qualitative research, sample size sufficiency is based on the data saturation point, which is the point during data collection and analysis where no new data, no new code, and no new themes emerge from the information gathered from one participant (Braun & Clarke, 2019). Although I interviewed the 10selected participants, I noted no new themes were presenting after the eighth participant interview; therefore, I finished two more interviews to assure saturation was met.

Instrumentation

I conducted semistructured interviews with open-ended questions to collect data from participants. Semistructured interviews are commonly used in qualitative studies (Brown& Danaher, 2019). Using a semistructured interview facilitated flexibility in the manner of interviewing, which meant that I was able to ask follow-up questions, provided they were aligned with and relevant to the questions in the interview guide (see Brown& Danaher, 2019).

I developed an interview guide to aid in the process of data collection. I asked a panel of experts in the field of qualitative research to review the questions in the interview guide. These experts were part of my dissertation committee. The panel members were composed of experts in one of each of the following fields: (a) qualitative research, (b) health care insurance, and (c) homeless care services. The experts reviewed the validity of the interview guide in terms of the content of the questions included in the protocol. During the review, the experts also assessed the validity of the questions based on how the interview questions were written, worded, and framed. Moreover, the experts reviewed the correctness of the structure or wording of the questions. The committee further reviewed the appropriateness of the questions to address the research questions of the study. Based on the expert review, the interview questions did not require any modifications.

Procedures for Recruitment, Participation, and Data Collection

To have an initial set of participants, I asked social service centers for a list of potential participants for the study. I visited social service centers and asked for referrals to homeless individuals that they had helped in relation to accessing health care insurance. I also posted recruitment flyers (see Appendix A) at multiple social service locations to invite participants for the study.

All potential participants who expressed interest in the study were asked to contact me to determine whether they satisfy the inclusion criteria without possessing any characteristics for exclusion. All those who met the criteria for participation and were willing to participate in the study were required to sign consent forms. Those who signed the consent forms were also asked to provide their email addresses and other contact information to schedule their interview.

At the scheduled date of the interview, I met with the participant in an open area in a local social service facility. I observed all health protocols, including wearing masks and social distancing of at least 2 meters. I audio recorded each interview. Each interview lasted no more than 60 minutes. To begin each interview, I greeted the participants and gave a brief description of what would occur during the interview process as well as a brief overview of the topic. I also briefly reviewed the contents of the informed consent to ensure that each participant recalled its major contents. I used an interview guide during each interview. I asked questions based on the contents of the individual and topic-based questions to address the research questions of the study. Using this flexible framework enabled me to explore the topic at hand by asking questions in whatever order seemed appropriate for each participant.

Data Analysis Plan

I utilized Braun and Clarke's (2006) six step thematic steps to process the data collected from the interviews. Thematic analysis involves the breaking down of data into smaller units so that patterns and themes can be used to interpret the data (Braun & Clarke, 2021). Data collected during this research were coded and analyzed by quantifying the frequency of a particular theme to explain a phenomenon (Braun & Clarke, 2021).I began data analysis through data familiarization, which entailed reading the data several times. After this familiarization, I highlighted the relevant terms, phrases, and sentencesthat addressed topics associated with the research questions.

Once the data were organized and relevant descriptive texts were identified, I began coding. Using key descriptive phrases, I coded the data set by assigning a unique phrase to describe each relevant word or phrase. I did this for every unique data set encountered; however, if a text was identified or classified under an already defined code, I used the existing code for the data.

It was during this step that the point of data saturation was actually determined. Because there were no more new codes found with the addition of new interview data from the ninth to tenth participant, data saturation was achieved. I grouped all similar codes into one theme and provided a label for each code group as a single theme. The label was relevant to at least one research question of this study. In this step, I developed the initial list of themes.

I made the appropriate changes to the themes developed for this study. Changing theme composition was limited to combining two themes or decomposing one theme into two smaller but more concise themes. I made these changes in order to achieve more direct and complete answers to the research questions of the study.

I identified the final list of themes that addressed the research questions. Themes that were common for four or five participants of each group were identified as a major theme. The themes that werepresent from the data of three or fewer participants for each group were deemed minor themes. Each theme was defined in relation to the research questions of the study. The final step was to develop a discussion of the results. The information about the results is presented in Chapter 4. The overall conclusion of the study is provided in Chapter 5.

Issues of Trustworthiness

To ensure credibility of the data collected, I performed member checking for verification of the accuracy of transcripts, as reviewed by the participants themselves (Lincoln & Guba, 1985). Ensuring that the transcripts are accurate, based on review of participants, is especially important. The findings of this study were validated with the respondents. Moreover, I kept all of the collected data in their original form to prevent distortion. For transferability, the focus is to ensure that the study may be applicable to other chronically homeless transgendered women in different parts of the country from the group used by the researcher of the original study (Lincoln & Guba, 1985). Hence, I achieved transferability by providing in-depth and detailed descriptions of the phenomena under investigation to provide readers with a full understanding of the topic. Finally, to ensure dependability, the research methods, context, and participant information was given in detail. This may assist future researchers with repeating the work and assessing the extent to which appropriate research practices were followed.

Ethical Procedures

Ensuring all ethical issues are addressed is an important aspect of any research or academic exercise that involves human subjects (Arifin, 2018). For this study,I identified ethical issues and provided steps or techniques accordingly. It must be noted that the research involved a vulnerable population of homeless individuals who have tried accessing health care insurance within the past 12 months. To ensure that this vulnerable population was protected, I minimized the risk of re-traumatization by avoiding asking questions that were not related to the topic of the study or triggered past traumas not related to accessing health care insurance. Also, I asked a social worker or psychologist to have a debriefing session with the participants after the interviews to assess any stresses or psychological discomforts that the study may have caused the participants. I also performed and completed the following procedures to address ethical issues: (a) institutional review board (IRB) permission, (b) informed consent, (d) confidentiality of participants, (e) security of data, and (f) voluntary participation. To acquire approval for conducting the qualitative data gathering for this study, I submitted an ethics application to the university. To gain approval from the University’s IRB, I provided an explanation of the research objective, question and process, and participants’ consent. Upon obtaining the required approval, I then began recruitment.

Confidentiality is an important issue that must be addressed when human participants are used in research. I assured the participants that their identity would be kept confidential by deleting all identifying information. I also replaced participants' names with pseudonyms. The information on how to keep identity confidential was relayed to the participants through the informed consent.

All data that were used for the study were kept inside a locked cabinet in my home office. All documents, such as consent forms, flyers, recorded interviews, and the interview transcripts, were kept inside a private office inside a locked, waterproof, and fireproof safe. All electronic files were password-protected in my personal computer inside the private office. I was the only one who could access these data and records. I will keep all the files in a locked cabinet for 5 years upon the conclusion of the study, and after this time, I will destroy them through burning, breaking, or shredding for all physical documentation, and through permanent deletion for any data existing on any computer devices.

All participants were volunteers. I did not force anyone to be part of the study, nor did I provide any added benefits to the study's participants. This information was also included in the informed consent. Participants were provided the option to quit their role as participant at any time without repercussion. Even in the event that participants had already consented to participate, they could still discontinue their participation without any consequences. All the files containing the data or information collected from those who quit would be returned to them and would not be included in the study; however, no participants quit the interview or withdrew from the study.

Summary

In Chapter 3, I provided the details of the methodology that was implemented for this study. In summary, I utilized a qualitative descriptive approach for this study. I recruited 10 participants from the target population of homeless individuals who tried accessing health care insurance within the past 12 months. I recruited participants through purposive sampling. I gathered data through semi-structured interviews, and data were analyzed using thematic analysis. The results of the analysis are presented and discussed in Chapter 4.

Chapter 4: Results

This chapter contains the presentation of the results of this qualitative descriptive study. The purpose of this study was to explore the perspectives of homeless people toward possible social barriers to obtaining health insurance. The following research questions guided this study:

RQ1: What are the perspectives of homeless people toward social factors that hinder access to health care insurance?

RQ2: What are the perspectives of homeless people toward social factors that enable access to health care insurance?

The sample of this study consisted of 10 homeless individuals selected using a purposeful sampling technique. The inclusion criteria were as follows: (a) meet the U.S. Department of Housing and Urban Development's (2013) definition of homeless, (b) are aged 18-60, and (c) have tried to access health care insurance within the last 12 months. The exclusion criteria were at least one of the following: (a) younger than 18 years old, (b) older than 60 years old, (c) pregnant females, (d) individuals with substance abuse problems within the past 12 months, and (e) individuals with physical and learning disabilities. I interviewed the participants individually using a semistructured format. I thematically analyzed the interview data which involved searching for patterns within the collected data (see Braun & Clarke, 2021). I completed the data analysis with the use of NVivo 12 qualitative data analysis software.

The study participants' demographic characteristics are detailed in Table 1. There were no discernible patterns in the interview responses based on ethnicity or gender identity. No patterns based on age cohort were possible because it was constant, not variable.

Table 1

Demographic Characteristics of Study Participants

Participant	Ethnicity	Gender identity	Age cohort
1	White non-Hispanic	Female	45-60
2	White non-Hispanic	Male	45-60
3	African American	Male	45-60
4	African American	Female	45-60
5	White non-Hispanic	Male	45-60
6	African American	Male	45-60
7	White non-Hispanic	Male	45-60
8	African American	Female	45-60
9	African American	Male	45-60
10	African American	Male	45-60

The analysis resulted in 34 codes that described the essence of interview data. The codes were combined into 14 initial themes, which were then integrated into six themes. The development of codes into initial and final themes was based on the research questions and the constructs of Ryvicker's (2018) behavioral-ecological framework.

I further detail the thematic analysis process in the following section. The description includes sample quotes and definitions to support the codes, initial themes, and final themes. Following the section on data analysis procedures is the presentation of the results per research question. The presentation includes a synthesis of the data that represents the study participants' enablers and barriers to obtaining health insurance. A summary of the results is provided to conclude this chapter.

Data Analysis Procedures

Familiarization entailed immersion in the data. Immersion involved reading and rereading the interview transcripts while taking note of general patterns about the enablers and barriers to obtaining health insurance as perceived by the study participants. The general patterns pertained to the individual influences, environmental influences, as well as health insurance access and coverage as social enablers and barriers to homeless people obtaining health insurance. The general patterns were in line with the concepts of the behavioral-ecological framework. Using NVivo, I assigned a color for each of the three general patterns to differentiate the codes during the coding process.

Next, I reread transcripts line-by-line with the general patterns and the research questions in mind to begin the coding process. Coding involved breaking the whole dataset into small units of meaning or codes (Ryvicker's, 2018). The codes were determined through closely reading each line of the transcript in search for texts that were meaningful to the research questions. The initial coding process yielded 34 codes. The codes with sample quotes, number of supporting participants, and number of occurrences in the data are presented in Table 2.

Table 2

Initial Codes

Code	Example quote	No. of ssupportingpparticipants	No. of ooccurrencesin the data
No clean clothing	“No clean clothing and not feeling clean enough to be in a doctors’ office…”	1	1
No transportation	“I do not have transportation to go anywhere, I had to walk to the ER last week.”	9	18
No computer or internet access	“I was told it can be applied for online and you know I do not have a computer.”	8	10
No permanent address or contact number	“I could not give them a permanent address for myself…”	5	10
Digital illiteracy	“I would not even know how to fill out the application online.”	2	2
No health insurance	“I have been to the doctor’s office but they would not see me because I did not have insurance…”	6	7
No money for medicine	“I went to the pharmacy I could not get them filled because they were very expensive and I could not afford them…”	3	3
Not an immediate need	“Everybody should get healthcare regardless of age, should be free healthcare but before that I need a place to stay, shower and live normal life.”	7	11
Unhealthy eating	“I do my best to eat	10	12

patterns	healthier but my resources are limited, I eat whatever my hands get on to satisfy my hunger.”		
Unhealthy sleeping patterns	“How can I be physically healthy when I sleep on floors, streets, parking lots?”	9	12
Unhealthy behaviors	“Being on drugs or alcohol…”	3	3
Unhealthy beliefs about oneself	“I feel ashamed and shy to be around people and in my mind, people are just looking at me.”	3	3
Looked down upon	“A lot of people look down at you because of [being homeless].”	4	5
Rushed out of ER	“When they called me to the back I felt as the nurse and the doctor were disgusted by me. I think they just rushed to get me out of there.”	3	3
Stigmatized	“Being stigmatized and the feel of being judged…”	7	13
COVID-19 barriers	“I caught covid and that was a bad experience…”	10	13
Lack of information	“I do not know where to start, I do not know of any resources available to me.”	5	8
No assistance	“I struggle to find assistance in any place or even find direction for assistance.”	2	3
Addressing health needs	“I am going down mentally and I am going to need to see a psychologist soon…”	6	19
Avoiding negative	“To not be in debt and have medical aid in my	1	2

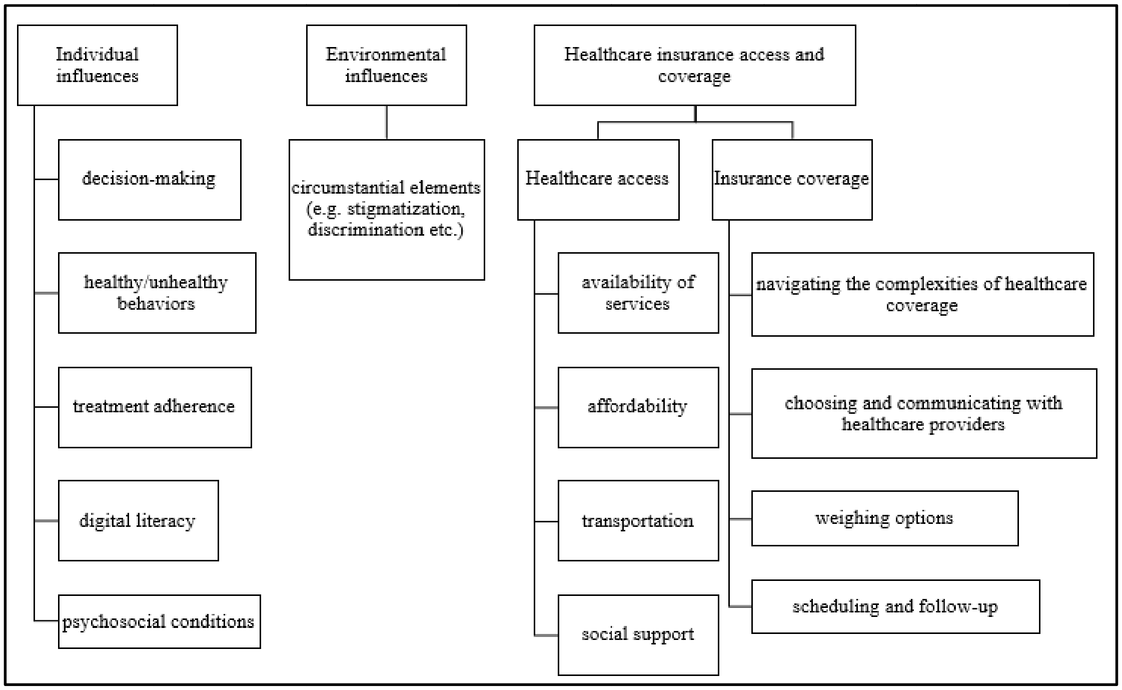
circumstances	life for when I need it.”		
Help-seeking behaviors	“I kinda stayed on top of it as well to make sure I have insurance.”	2	4
Desire to be healthy	“I think having health insurance and a primary care to go to who would follow my health and see me when I need seen is important and can help me survive through the situation.”	6	10
Hope for change	“I always hope for a better day.”	2	2
Luck	“I am lucky to have that lady helped me.”	2	3
Assist with using technology	“I think people may need a mentor as well, there is guys out here that do not know how to use a computer or navigate the internet.”	1	1
Resource persons	“You need to get help from a social worker.”	10	24
Simplified process	“A more simplified process will help.”	1	1
Straight to the point	“[Homeless people] like to get straight to what they need, and everything else is considered waste of time.”	1	1
Communication and transportation resources	“Offering us transportation computers, internet can also be good.”	6	6
Community resources	“Free clinics can be resources too…”	6	13
Addressing needs	“I would say make housing available is the first step as every application asks for an address.”	2	3
Making	“Make a system that can	5	6

resources accessible	easily accessible to homeless people.”		
Avoiding inaccessible resources	“We need a program to reach us not through the form of internet, computers, [and] TV.”	2	2
Using accessible resources	“Maybe posters on the streets where homeless people be or in the shelter.”	4	8

I combined codes with similar meanings to develop initial themes. To combine codes to initial themes, a theme must be composed of at least two codes. Similarities in meanings among codes were determined through the concepts under the individual influences, environmental influences, and healthcare insurance access and coverage based on the behavioral-ecological framework (see Ryvicker, 2018). The thematic map that guided the identification of initial themes is shown in Figure 1.

Figure 1

Thematic Map for Initial Coding

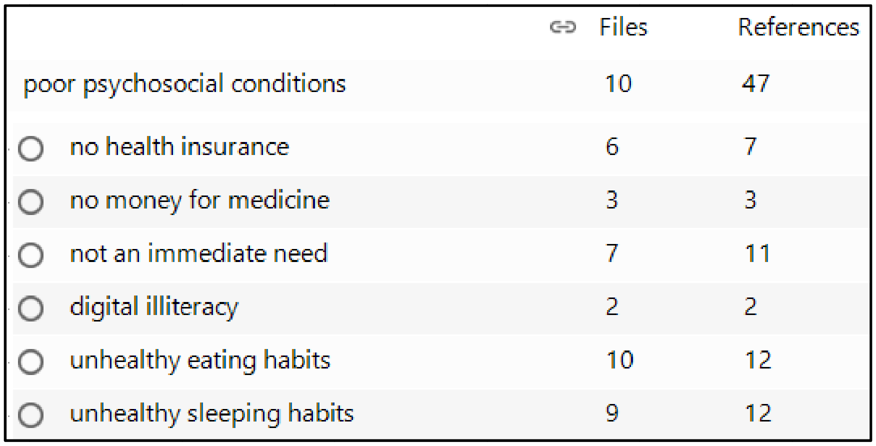


Note. Adapted from Ryvicker (2018)

For instance, the codes *digital illiteracy*, *unhealthy sleeping patterns*, and *no moneyfor medicine*were among the codes that are linked with the psychosocial conditions that hinder homeless individuals from healthcare insurance access. Therefore, with the use of the hierarchy feature in NVivo 12, the codes were clustered together to form the initial theme *poor psychosocial conditions*. The full hierarchy of codes under the initial theme is shown in Figure 2. Files refer to the number of supporting participants, while references refer to the number of occurrences of the codes and initial theme.

Figure 2

Poor Psychosocial Conditions Hierarchy



	Files	References
poor psychosocial conditions	10	47
○ no health insurance	6	7
○ no money for medicine	3	3
○ not an immediate need	7	11
○ digital illiteracy	2	2
○ unhealthy eating habits	10	12
○ unhealthy sleeping habits	9	12

I followed the same specifications and thematic map to identify all of the initial themes. This step of the analysis resulted in 14 initial themes. The initial themes with the corresponding codes and definitions are presented in Table 3.

Table 3

Initial Themes

Initial theme	Codes from Table 1	Definition	No. Of supporting participants	No. Of occurrences in the data
Difficulties in accessing the health insurance office	No clean clothing	Showing up to the doctor's office with dirty clothing	9	19
	No transportation	Walking as the only option to reach their desired destination		
Difficulties in following through application	No computer or internet access	Inability to apply and follow-up in insurance application through online means	9	20
	No permanent address or contact number	Absence of a permanent means to reach the homeless individuals with regard to their insurance application		
Poor psychosocial conditions	Digital illiteracy	Ignorance in using the internet and electronic devices	10	47
	No health insurance	Unavailability of insurance to cover medical expenses		
	No money for medicine	Insufficiency of money to afford prescribed medicine		
	Not an immediate need	Having other priority for the sake of survival		
	Unhealthy eating patterns	Consuming whatever food available		
	Unhealthy sleeping patterns	Sleeping anywhere		
Unhealthy decisionmaking	Unhealthy behaviors	Drug or alcohol abuse	8	14

	Unhealthy beliefs about oneself	Having low self-esteem		
Discrimination from other people	Looked down upon	Being perceived as inferior	9	21
	Rushed out of ER	Treated hastily in the ER		
	Stigmatized	Treated with prejudice		
Navigating healthcare	COVID-19 barriers	Concerns about exposure to the virus and the extensive protocols resulting from the pandemic	10	24
	Lack of information	Having no idea about navigating the healthcare insurance process		
	No assistance	Having no person to aid in healthcare insurance access and navigation		
Healthy behaviors	Addressing health needs	Caring for one's physical and mental health		
	Avoiding negative circumstances	Wanting to avoid stress and debt upon availing medical services		
	Help-seeking behaviors	Actively pursuing health insurance access	7	25
Positive attitudes	Desire to be healthy	Inclination to have good health condition	10	15
	Hope for change	Belief in potentially moving away from homelessness		
	Luck	Belief that good fortune was upon them		
Assistance	Assist with using technology	Having aid in using the internet and a computer	10	25
	Resource persons	Having assistance from social workers, hospital staff, and the government		
Process	Simplified	Making healthcare	1	2

	process	insurance access and navigation easy		
	Straight to the point	Making healthcare insurance access and navigation straightforward		
Resources	Communication and transportation resources	Making internet access, phones, computers, fare, and vehicles accessible for homeless individuals	7	19
	Community resources	Using shelters, libraries, and free clinics to reach homeless individuals		
Accommodate the needs of homeless people	Addressing needs	Providing for the individual, housing, and employment needs of homeless individuals	6	8
	Making resources accessible	Considering the convenience of access to benefit homeless individuals		
Deliver information more effectively	Avoiding inaccessible resources	Averting the use of internet and electronic devices to reach homeless individuals	5	8
	Using accessible resources	Utilizing public community spaces to reach homeless individuals		

I then reviewed the initial themes in comparison with the research questions and with each other. The purpose of the theme review was to validate whether the themes made sense in forming the narrative of the study participants' perceptions and experiences of enablers and barriers to obtaining health insurance. The narrative that emerged from this step of the analysis was that the individual influences of poor psychosocial conditions and unhealthy decision making hindered individuals experiencing homelessness from obtaining health insurance while healthy behaviors and positive attitudes enabled individuals experiencing homelessness from obtaining health insurance. Among the environmental influences, difficulties in navigating the healthcare insurance system and discrimination from other people were barriers, while the availability of resources and assistance, as well as a simplified process, were enablers to obtaining health insurance. Furthermore, difficulties in accessing the health insurance office and in following through with the application hindered individuals experiencing homelessness from obtaining health insurance, while accommodating the needs of homeless people and effective delivery of information enabled homeless individuals to obtain health insurance.

In the theme naming and definition procedures, however, all of the initial themes appeared to have some overlap. For instance, the initial themes *navigating healthcare* and *discrimination from people* both pertained to the difficulties of interacting with healthcare service providers while being a homeless individual. Therefore, the initial themes were combined to generate the final theme *interacting with healthcare providers as a homeless* *person*. Six final themes emerged from the theme naming and definition, as presented in Table 4. The report of the results is provided in the next section.

Table 4

Final Themes

Theme	Initial themes from Table 2	Definition	No. of supporting participants	No. of occurrences in the data
Inability to prioritize health-related decisions	Poor psychosocial conditions	Homeless individuals' conditions render them unable to make decisions regarding healthcare insurance	10	61
	Unhealthy decision-making			
Interacting with healthcare providers as a homeless person	Navigating healthcare	Homeless individuals experience difficulties and discrimination when dealing with the navigation of the healthcare insurance system	10	45
	Discrimination from other people			
Difficulties in follow-up and scheduling	Difficulties in following through application	Homeless individuals experience difficulties in filing and follow-up on their application to healthcare insurance services	10	39
	Difficulties in accessing the health insurance office			
Providing accessible assistance and	Assistance	Homeless individuals' perceptions of the advantages of assistance,	10	46

resources		resources, and easy processes to obtaining healthcare insurance		
	Resources		10	40
	Process			
Individual attitudes and behaviors about health	Healthy behaviors	Homeless individuals' perceptions of their own attitudes and behaviors to enable access to healthcare insurance		
	Positive attitudes			
Reaching out to homeless people	Accommodate the needs of homeless people	Homeless individuals' perceptions of making information and resources on healthcare insurance accessible	8	16
	Deliver information more effectively			

Inability to Prioritize Health-Related Decisions

All 10 participants experienced unfavorable psychosocial conditions which resulted to their inability to prioritize decisions about obtaining health insurance. All participants reported having unhealthy eating and sleeping patterns since becoming homeless due to the lack of resources for healthy choices. Despite understanding the adverse effects of their eating and sleeping patterns to their health, the participants generally believed that they were left with no choice but to survive each day. Participant 7 expressed,

> I am not getting enough sleep. I am always drowsy and cannot even sleep well. My stomach hurts at times due to eating junk food all the time. I know I am not getting enough nutrition into my system but again what can I do at this point? I am just living my life day by day.

The participants shared that obtaining health insurance was not an immediate need compared to food, housing, and employment. Participant 3 stated, "Everybody should get healthcare regardless of age, should be free healthcare but before that I need a place to stay, shower and live normal life." Furthermore, six participants shared that they had been refused by primary care doctors due to not having insurance. Participant 5 stated, "I have been to the doctor's office, but they would not see me because I did not have insurance, so I ended up going to the ER." Participant 9 went to the ER for stomach pains and was referred to primary care. Without health insurance, Participant 9 experienced difficulties finding a doctor. As a result, Participant 9 "gave up" on seeking treatment. Apart from being unable to access proper healthcare services due to having no insurance, three participants reported that they could not afford the prescribed medicine. Participant 4 shared the following:

> Last week, I was not feeling well I went to the ER, they saw me and everything was good until they gave me prescriptions, when I went to the pharmacy, I could not get them filled because they were very expensive and I could not afford them.

When asked about applying for health insurance, Participants 1 and 5 shared that the application process would be completed online using either a computer or a smart phone. Both participants stated that they had access to the internet and an electronic device, but they reported being digitally illiterate. Participant 1 disclosed, “When my phone is on, I have internet but I honestly do not know how to access an application.” According to eight participants, being homeless also resulted in having low self-esteem. Participants 1 and 7 cited “low self-esteem” as part of their experiences of being homeless. With low self-esteem, Participant 4 perceived, “I am not even sure if I qualify for insurance.” With regard to applying for health insurance, a permanent address was one of the requirements. Participant 4, as well as Participants 6 and 8, shared that they felt ashamed about using the homeless shelter’s address. Participant 8 stated, “I try not to use the shelter’s address because of embarrassment.” Lastly, Participants 1, 7, and 10 reported drug and alcohol abuse as a common problem among homeless individuals due not having better choices to cope with their circumstances. Participant 7 stated, “They see [drugs] as the only ticket to get better.”

Interacting With Healthcare Providers as a Homeless Person

Ten participants described their experiences of interacting with healthcare providers, such as navigating the healthcare system and being discriminated as part of the barriers to obtaining health insurance. Nine participants shared that they experienced being stigmatized, looked down upon, and treated hastily when they went to the ER or the doctor’s office. Seven participants described being stigmatized as being disregarded and treated differently than individuals who were not homeless. Participants 1, 6, 8, 9, and 10shared that people stared, looked at them “differently,” and with judgment. In attempting to apply for insurance using public library resources, Participant 1 narrated,

> One time I went to the library to try to apply for health insurance online, of course I was stigmatized, and I [sought] assistance from library personnel they said they are not trained to do that and they are not responsible to help anybody apply for insurance.

Four participants perceived that other people looked down on homeless individuals. Participant 2 revealed that other people think of homeless individuals as “drug addicts, alcoholics, [or] handicapped.” Participant 2 added that homeless individuals are not respected. In the healthcare setting, three participants shared that doctors and other hospital personnel “rushed” to get them to leave. Participant 6 shared, “When they called me to the back I felt as the nurse and the doctor were disgusted by me. I think they just rushed to get me out of there.” Participant 7 shared,

> I felt as the front desk lady was very disturbed by my presence in the waiting area there and could not wait for me to leave. It is the stigma that I am used to by now. I get it, I do not look very clean, I wear dirty clothes.

Five participants also shared that they generally lacked information about navigating the healthcare insurance system, and two participants reported that they did not receive any assistance to move their application forward. Participant 7 stated, “I find it very difficult to obtain that or have any type of assistance in order to obtain that.” Participant 10 expressed that they did not know who to contact regarding health insurance and that they did “not even know where the [insurance] office is.”

The challenges in the process involved in obtaining health insurance were exacerbated by the COVID-19 pandemic. Nine participants expressed that they feared exposure to the virus due to poor hygiene and shared living in homeless shelters. Participant 10 caught the COVID-19 disease and was hospitalized. The government covered the hospital expenses. Participants 2 and 8 stated that they attempted to obtain health insurance during the pandemic, but both participants were unsuccessful, as they needed to book an appointment through calling the office. Participant 2 shared, "due to pandemic you can't go into office you have to wait on the phone, and nobody answers."

Difficulties in Follow-Up and Scheduling

Ten participants perceived that homeless individuals experience difficulties in applying for health insurance due to challenges in scheduling and follow-up. Scheduling and follow-up may involve the need to be physically present in the insurance provider's office, which requires transportation and clean clothing. Some insurance providers had online application processes; however, homeless individuals generally did not have access to the internet and electronic devices. Furthermore, when following-up, homeless individuals did not have a permanent home address or a permanent contact number. Nine participants shared that they relied on walking to go to the places they needed to go to. While the hospital may be a short walk within the community, the participants generally believed that health insurance offices could not be reached without a vehicle. The participants perceived that they needed to be physically present at the insurance provider's office when applying for health insurance because of the required signatures. Participant 6 also added that they did not have clean clothing if they go to the healthcare insurance office. Participant 6 expanded,

> Getting there is going to be an issue…she said I might need to go there in order to collect some signatures from me, I will figure out how to get there when she calls me, I might walk or get help obtaining a bus ticket to get there.

Eight participants reported that the application for health insurance may be completed online, but that they did not have access to internet or an electronic device. Participant 5 shared, “I was told it can be applied for online and you know I do not have a computer.” Lastly, five participants shared that in their attempt to obtain health insurance, they were faced with the hindrance of not having a permanent address and contact number by which insurance providers may reach them. Participant 9 stated, “I could not give them a permanent address for myself or even a phone number.” According to Participants 1 and 8, not having a permanent contact number may have caused them to be unable to follow up on their application. Participant 1 shared, “My phone is disconnected and I do not know if she called me or not.”

Providing Accessible Assistance and Resources

Ten participants perceived that assistance and resources enable homeless individuals to obtain health insurance. The participants generally perceived that assistance from social workers, hospital staff, and the government would be beneficial for homeless individuals. Participant 5 believed that social workers were easily approachable to homeless individuals, as they often stayed in homeless shelters. Participant 8 experienced the assistance of a social worker from the homeless shelter to begin their health insurance application. Participant 2 similarly experienced the assistance of a social worker, but revealed that they had to actively follow-up to obtain insurance. Participants

3 and 4 perceived that hospital staff, particularly ER staff, may help homeless people obtain health insurance, as the ER was also conveniently accessible to individuals experiencing homelessness. Participant 1 received assistance from an ER staff to apply for insurance coverage. Participants 2, 3, and 4 perceived that the government had control over laws and the healthcare system such that they could change policies to modify the system and make the process of obtaining insurance easier for individuals experiencing homelessness. Participant 4 compared the U.S. policy to the policy in Canada where health insurance was free for all citizens. Participant 2 perceived that the government may send staff to aid individuals experiencing homelessness with the application process. Participant 3 stated, “Law makers can help too by making laws to get health insurance for persons experiencing homelessness.” Participant 8 was the only participant to share the need to assist individuals experiencing homelessness with navigating the online application process. Participant 8 stated, “I think people may need a mentor as well, there is guys out here that do not know how to use a computer or navigate the internet.”

To make finding assistance easier for individuals experiencing homelessness, seven participants shared that health insurance providers may utilize community resources such as the homeless shelter, the public library, and free clinics. Participant 2 shared, “I feel the shelter can be more involved into helping people get insurance, more resource can be made available throughout the guys here at the shelter, such as phone services, internet, computers.” According to Participant 5, the public library may also provide access to the internet and computers. Participants 1 and 3 perceived that free clinics may provide assistance with the insurance application process.

Participant 7 added that insurance providers could make the process of obtaining insurance coverage “more simplified” to accommodate individuals experiencing homelessness. For context, Participant 7 believed that individuals experiencing homelessness prioritize obtaining basic needs such as food and a place to stay over health insurance. The current process requires application online or in the office, both of which are believed to be complicated for people experiencing homelessness. Therefore, Participant 7 elucidated,

> Some homeless people oddly enough even though they have all the time in the world they do not like staying at one place for long, they do not like listening for an hour-long conversation, they like to get straight to what they need, and everything else is considered waste of time…A more simplified process will help.

Individual Attitudes and Behaviors About Health

All 10 participants perceived individual attitudes and behaviors enable individuals experiencing homelessness access to healthcare insurance. Individual attitudes include the desire to maintain their health, as well as holding on to the hope of no longer being homeless. Individual behaviors involved actively addressing health problems, avoiding unwanted circumstances, and seeking help.

Six participants stated that they were aware of the possible adverse effects of homelessness on their physical and mental health. The participants shared that they decided to obtain health insurance to be healthy. Participant 1 elucidated,

> I would obtain health insurance. I do not eat healthy, I am ill mentally and physically, I think having health insurance and a primary care to go to who would

> follow my health and see me when I need seen is important and can help me survive through the situation.

Participants 6 and 9 shared their attitudes about hoping for “a better tomorrow,” and perceived that they needed to maintain their physical health while being homeless in order to be able to work and eventually no longer be homelessness. Participant 9 stated, “I need to treat my mental illness and health issues that I have…to try to find a job and maybe being able to put a roof on top of me.” Participant 8 reasoned that they obtained health insurance after becoming homeless to take care of their mental health. Participant 8 stated, “I obtained health insurance when I became homeless, as I knew that my health will worsen as homeless and I might need mental help down the road as well.” Participants 7 and 8 attributed their success in obtaining health insurance to luck; however, both participants also shared that they actively pursued their application. Participant 8 described their help-seeking behavior as, “I kinda stayed on top of it as well to make sure I have insurance.” Participant 7 sought to obtain health insurance to avoid the stress of paying for medical services and to avoid being in debt. Participant 7 shared, “In case anything happens to me health-wise I am covered and I would not have to worry. I would just go to the hospital and get treated.”

Reaching Out to Homeless People

Eight participants perceived outreach as a factor that enables access to healthcare insurance for homeless people. The participants generally described outreach as making the resources and information to obtain health insurance accessible for individuals. Participants 1 and 10 perceived that peopleexperiencing homelessness first needed resources for housing and employment before considering resources for health insurance. Participant 1 stated, “I would say make housing available is the first step as every application asks for an address.”

Participant 9 perceived that healthcare insurance providers needed to consider that the needs of homeless individuals may not be the same as the needs of individuals who were not homeless. Therefore, providers needed to reach out and “be more flexible” to homeless people. Participants 4 and 6 referenced the need for the government to assist in reaching out to homeless individuals to make the resources and information accessible. Participant 6 stated, “There should be medical services and health services available through the shelter and I think the government can be responsible for making such thing.”

Making information and resources accessible to homeless individuals entails the use of resources that are available to them, as well as avoiding the use of unavailable resources. Accessible resources include social workers, laws, and public spaces, while inaccessible resources include the internet and electronic devices. Participants 5 and 7 shared that individuals experiencing homelessness are often in the streets or in homeless shelters; therefore, posters should be displayed where individuals experiencing homelessness can see them. Additionally, healthcare insurance resources should be made available in ERs to reach people experiencing homelessness. Participant 5 explained, “Maybe posters on the streets where homeless people be or in the shelter, or at the ER since we all mostly go to the ER.” Participant 4 perceived that “the law needs to change to help people.” Participant 4 believed that the law did not mandate healthcare insurance providers to reach homeless individuals and added that providers must avoid the use of the internet and electronic devices to target people experiencing homelessness. Participant 7 shared a similar sentiment as Participant 4, stating, “[We need] a more visible process that reach homeless people…like I said before, we need a program to reach us not through the form of internet, computers, [and] TV…currently, the primary beneficiaries have no clue of such program existence.”

Summary

This chapter contained the presentation of the results of this qualitative descriptive study. The results were derived from the thematic analysis of individual interview data collected from 10 individuals experiencing homelessness. The interview data were broken down into 35 units of meaning that pertained to the study participants’ perceptions and experiences of enablers and barriers to obtaining health insurance. The meaning units or codes were clustered together using similarities based on the concepts of individual influences, environmental influences, as well as health insurance access and coverage derived from the propositions of the behavioral-ecological framework (Ryvicker, 2018). A total of 14 initial themes emerged to describe the narrative that homeless individuals’ access to health insurance was hindered by poor psychosocial conditions, unhealthy decision-making, difficulties in navigating the healthcare system, discrimination from other people, difficulties in following through with the insurance application, and difficulties in accessing the health insurance officer. Additionally, homeless individuals’ access to health insurance was enabled by the availability of assistance, resources, as well as a simplified process, healthy behaviors, positive attitudes, accommodations afforded to people experiencing homelessness, and effective delivery of information about health insurance. The initial themes were narrowed down into six final themes to answer the two research questions. The final themes were (a) inability to prioritize health-related decisions, (b) interacting with healthcare providers as a homeless person, (c) difficulties in follow-up and scheduling, (d) providing accessible assistance and resources, (e) individual attitudes and behaviors about health, and (f) reaching out to people experiencing homelessness.

Individuals experiencing homelessness are unable to make health-related decisions due to their poor conditions, behaviors, and beliefs about themselves. The study participants shared that they were generally unhealthy, digitally illiterate, had low self-esteem, and prioritized basic needs over health needs; therefore, their decisions were generally focused on survival. During instances in which they needed to see a doctor, the participants proceeded to the ER as a result of having no health insurance. In the ER, the participants experienced being treated hastily and with prejudice. Some participants did not attempt to apply for health insurance due to difficulties in accessing the health insurance office, while some participants who applied for health insurance experienced difficulties in following through the application process.

To enable homeless individuals' access to health insurance, individuals experiencing homelessness needed to have the desire and the corresponding behaviors to get out of homelessness and to be healthy to obtain health insurance. The participants generally perceived that the government, healthcare providers, and social workers needed to make the information and resources for health insurance accessible for homeless individuals. The participants of this study generally perceived the need for assistance, especially with using the internet and an electronic device, to start the application process. Individuals experiencing homelessness also require access to communication and transportation resources through public community spaces that they frequently visit, such as homeless shelters, the ER, the library, and free clinics to obtain health insurance. In Chapter 5, I explain these findings, the interpretations of these findings, and their implications. I also share recommendations for future research, the limitations noted, and the conclusions.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this qualitative descriptive study was to explore the perspectives of homeless people toward possible social barriers to obtaining health insurance. The problem addressed was that it was not known how homeless people perceive social barriers and access to health insurance. I collected and analyzed interview responses from a sample ($N = 10$) of homeless persons to discern how homeless individuals perceive these social barriers to accessing health insurance. These responses were used to answer two specific research questions:

RQ1:What are the perspectives of homeless people toward social factors that hinder access to health care insurance?

RQ2:What are the perspectives of homeless people toward social factors that enable access to health care insurance?

I analyzed the data using Braun and Clarke's (2006) six-step thematic data analysis process with general patterns established in line with the concepts of the behavioral-ecological framework that guided the current study. Further, I employed NVivo software to ensure the data were analyzed accurately. In Chapter 5, I present a discussion associating the key findings with a response to each posed research question and relate these responses to the reviewed literature. The answers to the research questions may provide future information to the government and relevant stakeholders responsible for the health insurance needs of the homeless population.

The key findings from this analysis included extracting six specific themes that were established through overall comments formed into nine initial themes. From these nine initial themes, the six themes included (a) the inability to prioritize health-related decisions, (b) interacting with healthcare providers as a homeless person, (c) difficulties in follow-up and scheduling, (d) providing accessible assistance and resources, (e) individual attitudes and behaviors about health, and (f) reaching out to homeless people. In this chapter, I explain the interpretations of the findings, the limitations of the study, recommendations for future research and future practice, and the positive social implications.

Interpretation of the Findings

The findings were extracted from the interviews, which showed that those who identified as homeless understood the necessity for health insurance while also recognizing the barriers and challenges associated with accessing such. These results supported the current literature related to the known prevalence of acquiring health insurance, the inequity found within health insurance coverage, and how individuals who were homeless were significantly more vulnerable to severe physical and mental health issues (see Lee et al., 2020).

Theme 1. Inability to Prioritize Health-Related Decisions

The findings suggested that individuals experiencing homelessness were unable to prioritize health-related decisions due to their environmental conditions. This inability was found from the sample’s explanation that a homeless individual’s psychosocial conditions impacted their decision-making abilities due to their homelessness. I found that the participants were distinctly unable to make health-related decisions and recognized that this was because of their homeless situation. During the interviews, theparticipants agreed that having health insurance was not part of their daily survival plans even though they all had health issues. The findings showed that other needs, such as shelter and food, took priority over the need for health insurance.

Furthermore, the participants agreed that using the emergency room for health issues was the most accessible means of receiving health care. Therefore, the homeless felt no urgency in acquiring health insurance. The literature mirrored this result with studies showing homeless individuals were reliant on emergency rooms for their healthcare needs (Bhathena et al., 2020; Morel, 2019; Salhi et al., 2018). The homeless were known for emergency room visits for healthcare, shelter, and safety needs (Joseph, 2017a;Luo & Escalante, 2018). Such a high use of emergency services by the homeless indicated the prevalence of non-insurance among the homeless population was of low importance in this population (Gallardo et al., 2020; Lee et al., 2020).Overall, the participants agreed that they were unable to prioritize health-related decisions due to the environmental conditions in which they lived.

Theme 2. Interacting with Healthcare Providers as a Homeless Person

The participants agreed that interaction with healthcare was mainly a negative experience. Most experiences with health care professionals were noted as unpleasant, with the homeless individual feeling that they were treated with extreme prejudice. The sample shared their feelings of being stigmatized and disregarded when they approached health care services. The participants' perceptions of interactions with healthcare providers were challenging, with some claiming that obtaining health insurance was exacerbated by the negative feelings from healthcare providers.

Researchers have shown that specific demographics are associated with homeless individuals acquiring health insurance (see Morel, 2019; Seo et al., 2019). One primary consideration found in the literature regarding why homeless individuals felt unable to secure health insurance was the treatment of homeless persons by healthcare professionals (Cleveland, 2020; Morel, 2019; Sangaramoorthy& Guevara, 2017). Furthermore, researchers have discussed stigma as a common problem among homeless people, suggesting that such stereotyping was predominant in failing to improve interactions with healthcare providers (Goparaju et al., 2017; Sangaramoorthy& Guevara, 2017; Vázquez et al., 2020). My study confirmed and built upon this past research. I found that homeless individuals did report that interaction with healthcare was typically a negative experience.

Theme 3. Difficulties in Follow-Up and Scheduling

Findings from the data analysis suggested that the prevalence of homeless individuals' difficulties in following up or scheduling healthcare services was due to the problems associated with applying for and acquiring health insurance. Participants claimed that the need for such acquisition of health insurance required their physical presence in an insurance provider's office. Even with Medicaid, homeless individuals needed to visit the government office and, more importantly, were required to have a permanent home address or permanent contact number. The participants also claimed that the difficulties in gaining health insurance were based on physical inabilities. These physical abilities included needing to apply online but having no computer, having no transportation to the health insurance office, and even being ignored based on their appearance once arriving at the health insurance office.

Comparatively, the literature related to this theme focused more on the perceptions of individual homeless who revealed that the need for health insurance was not as critical when they were continually searching for shelter and food. Researchers have shown that homeless individuals are the most notable population lacking health insurance (Osei Asibeyet al., 2020; Wille et al., 2017). Many researchers have posited that the prevalence of homeless not having insurance was the norm even though there were numerous health insurance programs available to the homeless, including Medicare, Medicaid, and other public programs (Edward et al., 2018; Fryling et al., 2015; Gallardo, 2020). Researchers have shown that the ability to pay for health insurance implied that one could access significant levels of health care use, and the homeless were shown to overuse emergency departments for their unmet health care needs. The rationale stems from the high prevalence of uninsured health among the homeless population (Edward et al., 2018; Wille et al., 2017).

Theme 4. Providing Accessible Assistance and Resources

The findings that led to this fourth theme were extracted from the participants' perceptions, including discussions on the lack of assistance from social workers, hospital staff, and government agencies, which the participants considered beneficial for homeless individuals. The participants suggested that accessibility of aid and resources to health insurance should be made easier with the assistance of workers within the homeless shelters providing help with health insurance applications. The findings showed that homeless individuals considered employees of homeless shelters, emergency rooms, public libraries, and free clinics as easily approachable to the entirety of the homeless population and, therefore, these employees should be skilled in assisting this population with insurance applications. Participants also commented that health insurance providers should use community resources such as homeless shelters, emergency rooms, public libraries, and free clinics to make obtaining insurance assistance reachable for homeless individuals. The perception of providing accessible assistance and resources was overshadowed, however, by the participants noting that active follow-up was required to obtain insurance. Often, the homeless do not return to the same location where they began the application.

Researchers have identified the factors for inaccessibility to assistance and resources for health insurance, with most researchers noting that, first and foremost, poor health among the homeless population is correlated to relatively high medical needs and an inability to access preventive or primary healthcare services (Carroll et al., 2017; Sritharan & Koola, 2019). Researchers argued that although individuals experiencing homelessness have relatively higher healthcare needs, they can seldom afford health care or the insurance needed for their care (Bhatena, 2017; Mongelli et al., 2020). This strongly suggests that the poor health of individuals experiencing homelessness is aggravated by an inability to meet costs associated with obtaining medical care or insurance. Researchers have shown the population experiencing homelessness has worsened medical conditions that drastically reduce life expectancy because of their inability to obtain health insurance (Bhatena, 2017; Mongelli et al., 2020).

Theme 5. Individual Attitudes and Behaviors about Health

The participants regarded behaviors and attitudes related to health, health services, and health insurance similarly, emphasizing an understanding that healthcare was necessary for maintaining good health. The individuals experiencing homelessness also agreed that they strove to maintain their physical health while being homeless, so that they can work and eventually no longer be homelessness, but that this was challenging to achieve due to their homelessness status. The recognition that physical and mental health worsened since becoming homeless, however, was apparent. Obtaining health insurance after becoming homeless to take care of their psychological and physical health problems was understood, but continued to be inaccessible for most. Several participants noted that the success in obtaining health insurance was based on luck and actively pursuing the health insurance application process relentlessly.

Studies presenting individual attitudes and behaviors related to health revealed mixed opinions. Most agreed that the life expectancy of individuals experiencing homelessness continues to persist with a continued decline due to such factors as drug and alcohol abuse, being exposed to all types of climates, poor nutritional habits, and ignoring health conditions requiring healthcare attention (Kenning et al., 2017; Pendyal, 2020). Individuals experiencing homelessness recognize the need to pay for health insurance which allows for access to significant levels of health care use(Joseph, 2017a; Wille et al., 2017). Researchers have emphasized the overutilization of emergency departments and unmet health care needs among the homeless (Wille et al., 2017). Researchers do not disagree that there isa positive correlation between homelessness and the lack of medical care insurance; however, these scholars do disagree that the lack of insurance is a key barrier to receiving primary health care (see Karnick et al., 2019; Martinez-Donate et al., 2017;Omerov et al., 2020).

Theme 6. Reaching Out to Homeless People

The final theme extracted from the participants' responses is the perception that to enable access for individuals experiencing homelessness to health insurance, communities, the government, and especially health insurance organizations should provide easier access to resources, information, and acquisitions of this insurance. Based on the findings, outreach was revealed as a perceived factor critical to the participants as a means to enable better access to healthcare insurance for people experiencing homelessness. The use of outreach such as homeless shelters, emergency rooms, and government agencies was thought to help this population acquire health insurance. The findings showed that in reaching out to the population experiencing homelessness, healthcare insurance providers should consider that the needs of individuals experiencing homelessness may not be the same as the needs of individuals who were not homeless; therefore, providers need to find the flexible means for such assistance.

Researchers have recommended a distinct need to develop working approaches to reducing health insurance inequity, particularly among the homeless (Cleveland, 2020; Duque, 2020; Simon et al., 2017). Researchers have also shown that homelessness is a significant challenge in acquiring health insurance. Housing instability creates further issues, as money is necessary for rent or mortgage before paying for health insurance. Furthermore, such instability in housing is considered a significant factor associated with insurance gaps and the overall lack thereof (Carroll et al., 2017). This problem can be mitigated by streamlining insurance enrollment and renewal processes, such as delinking insurance renewal from mailing addresses (Dror et al., 2016). The prevalence of health care insurance among the homeless was noted as significantly limited, with homelessness playing a pivotal role in barring the homeless from health care insurance availability as well as access.

Based on the results of this study, it is clear that individuals experiencing homelessness consider such social factors as the inability to prioritize health-related decisions, difficulties in follow-up and scheduling for insurance acquisition, and a lack of outreach to the homeless population as factors hindering access to health care insurance among this population. The findings further answered research question two, showing that such social factors as social workers being easily accessible to assist individuals experiencing homelessness with acquiring health insurance would enable this population to obtain health insurance. Also, factors were established, such as understanding the need for health insurance due to possible effects of homelessness based on physical and mental health issues and a desire to maintain their health, as enabling access to health care insurance. Overall, the study's findings indicated that individuals experiencing homelessness perceived access to health insurance as complicated and fraught with barriers. These barriers create inexcusable challenges that were suggested as problematic because individuals experiencing homelessness are often ignored, stereotyped, or treated in an undignified manor. The homeless are usually not provided with adequate healthcare due to their failure to have health insurance. It is challenging for the homeless to acquire health insurance for multiple reasons, including not having a permanent address and a lack of finances to afford such care insurance. Furthermore, individuals experiencing homelessness find the availability in accessing health care, with such government programs as Medicaid or Medicare, proves difficult due to issues with transportation, difficulty in following through with the insurance application, and even the inability to make a significant decision regarding their health and healthcare. The participants considered healthcare providers as typically unhelpful when attempting to access health insurance.

Limitations of the Study

The current study's limitations were inherent to conducting qualitative descriptive research. Recognizing the limitation of personal biases and opinions was noted and mitigated by acknowledging the expectations and personal opinions related to the study's outcomes. I, therefore, recognized that individuals experiencing homelessness do not have immediate access to health insurance due to their situational environment of being characterized as homeless. By acknowledging the participants' homelessness, bias was negated during the data collection and analysis process as I recognized the participants' position related to the acquisition of health insurance. Furthermore, I used bracketing to minimize any influences of researcher bias during data gathering and analysis. Bracketing helped maintain the focus of the research and mitigated the incorporation of any personal opinions into the research process.

Another limitation was to ensure that all data were accurate and trustworthy. I did not purposefully omit or alter any data collected to provide intellectual honesty. To maintain all transparency and ensure the validity and reliability of the data, I used member checking with all participants to review the transcribed interview data and their interpretations.

The next limitation was considered based on an inability to generalize the findings outside the population of interest. With a small sample size, qualitative studies are commonly non-generalizable. Nevertheless, I discussed the chosen methodology in detail so that replication of the study to another group of individuals may be possible for future researchers in related fields. Moreover, the study's findings directly address the research questions of the study. I confirmed that the sample size was large enough to attain data.

Recommendations

The recommendations for further research are grounded in the strengths and limitations of the current study. These recommendations include expanding this study to include a larger population of individuals experiencing homelessness. Future researchers should explore and incorporate the perspectives of social workers, homeless shelter workers, emergency department workers (non-medical), and health insurance providers. As I recruited a sample of 10 individuals experiencing homelessness from a single and distinct locale, expanding this research to integrate a larger population would allow for a broader range of perspectives and may perhaps help to determine information beneficial to the homeless acquiring insurance problems. Future researchers could also examine the perspectives of healthcare leaders to explore their ideas of changes and methods of increased assistance in helping individuals experiencing homelessness receive health insurance.

Another recommendation is to examine the different health insurance providers' methods for helping individuals experiencing homelessness access health insurance. Conducting a comparative study may allow researchers to expand the study to a larger population using a quantitative methodology, thereby allowing the research to be generalized. Furthermore, the use of quantitative research may help avoid the bias limiting the current study, as quantitative methods are less likely to encourage bias in the analysis as the data would be numerically statistical.

Implications

The potential impact for positive social change at the organizational level involves reorganizing several organizations to make information and resources more readily available and accessible to individuals experiencing homelessness. Accessible resources should include social workers, laws, public spaces, and providing such resources as the internet and electronic devices to help establish a new health insurance application. Among the environmental influences, difficulties in navigating the healthcare insurance system and discrimination from healthcare providers and others should be recognized and removed. At the same time, the availability of resources and assistance and a simplified process is encouraged for persons experiencing homelessness attempting to obtain health insurance.

Furthermore, organizations should recognize the difficulties in accessing the health insurance offices and following through with applications. Participants identified these challenges as hindering individuals experiencing homelessness from obtaining health insurance. The social change at an organizational level should provide the necessary accommodations for people experiencing homelessness through the effective delivery of information to enable individuals experiencing homelessness to obtain health insurance.

The potential impact for positive social change at the individual level prompts individuals experiencing homelessness to understand the resources available when considering health insurance. Most prominent in this social change would be to revise housing and assist the homeless in finding affordable living areas. Access to a home address would significantly provide stability for those in need and allow for insurance benefits to be gained. This social change, however, would necessitate changes to policies such as those found in the government housing authority.

Conclusion

The results from the current study affirm the inequality in health insurance coverage for the population experiencing homelessness and depict a need for changes in terms of ways to secure health insurance for those individuals who identify as homeless. The sample of this study generally perceived that the government, healthcare providers, and social workers must make the information and resources for health insurance accessible for individuals experiencing homelessness. The study underscored the need to eliminate insurance inequality among the population to increase access to healthcare (Alderwick et al., 2019; Mongelli et al., 2020; Morel, 2019).

The findings further exhibited how the participants of this study generally perceived the need for assistance, especially with using the internet and an electronic device to start the application process. To obtain health insurance, individuals experiencing homelessness also require access to communication and transportation resources through public community spaces that they frequently visit, such as homeless shelters, the ER, the library, and free clinics. The findings also reflected the literature, which revealed a prevalence of poor health and life expectancy among the homeless (Bhatena, 2017; Klop et al., 2018; Pendyal, 2020; Sritharan & Koola, 2019; Wille et al., 2017). Previous researchers also presented this prevalence regarding a lack of healthcare insurance among the homeless (Bhathena et al., 2020; Cleveland, 2020; Osei Asibeyet al., 2020).

Consequently, without significant changes to the health insurance system, it will remain difficult for people experiencing homelessness to access health insurance. The disparity in access to health care exists between the uninsured and the insured. Just as for any individual, access to healthcare is essential, including for the population experiencing homelessness (Dickins et al., 2020; Lapinski, 2019). The vulnerable populations of individuals experiencing homelessness experience significant social barriers to health insurance access which must be corrected to enable equity for all within the healthcare and health insurance industries.

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Appendix A: Recruitment Flyer

There is a new study called Perspectives of Social Barriers to Accessing

Health Care Insurance among the Homeless Population that could help social service providers assist homeless people access healthcare insurance. For this study, you are invited to describe your experiences and perspectives toward possible factors that prevent homeless people from obtaining health insurance.

This survey is part of the doctoral study for Abedalhakeem Abukhalil a Ph.D. student at Walden University.

About the study:

This study involves the following 2 steps:

- First meeting, participants will be asked to participate in an audio recorded

interview session which will take approximately 60 minutes. The interviews will take place in an area in a local social service facility.

- Second meeting, an in person meeting where participants will be asked to read and validate the transcribed interview responses (30 minutes).

Volunteers must meet these requirements:

- 18 to 60 years old
- homeless
- has tried to access health care insurance within the last 12 months

To confidentially volunteer,
contact the researcher:
[000-000-0000]

Appendix B: Interview Guide

Date/time

My name is Abedalhakeem Abukhalil, and I will be facilitating this interview. Thank you so much for participating in this interview. The purpose of this study is to explore the perspectives of homeless people toward possible social barriers to obtaining health insurance. Understanding the perspectives of homeless people surrounding social barriers to health insurance may provide information to the government and the relevant stakeholders in the health sector on the measures to put in place to meet health insurance access needs for the homeless population.

Your participation is voluntary, and you may discontinue the interview at any time. This interview will be audio recorded. If you feel uncomfortable at any time, please do let me know and I will stop the recording.

If you are ready, let’s get started.

Appendix C: Interview Questions

1. When did you become homeless?
2. What are your experiences as a homeless individual?
3. As a homeless individual, do you perceive yourself as physically healthy?
4. Did you have past experiences when you needed to access healthcare services for yourself? Please describe that event or experience.
5. Did you try obtaining medical insurance for yourself?
    a. If yes,
    b. When was this?
    c. Why did you try to obtain medical insurance?
    d. How did you do it?
    e. Were you successful?
    f. What challenges have you faced in trying to obtain health insurance?
6. Do you think homeless individuals must be given health insurance?
    a. Why?
    b. How do you think this is supposed to be accomplished?
7. What do you think are the factors that may hinder homeless individuals from getting health insurance?
8. What do you think should be done so that homeless individuals could obtain health insurance?
9. If given the chance, and the process is accessible to you, would you obtain medical insurance? Why?

Appendix D. Transcripts

P1

1. When did you become homeless? 6 months ago
2. What are your experiences as a homeless individual? Very frustrating, it gets hard at times it is also enlightening, as homeless person I encountered a lot of health issues, cough and cold, skin issues, nutrition issues. At times I feel so down, depressed, and mentally unstable, and at times I feel that I should be stronger to fight my situation. Most times I feel low self esteem though
3. As a homeless individual, do you perceive yourself as physically healthy? not very healthy, I do not eat well so I know I am not getting all the nutrition I should be receiving, my immune system is weak I always catch colds, flu. I do not sleep good at night, a lot of times I have stomach issues.
4. Did you have past experiences when you needed to access healthcare services for yourself? Please describe that event or experience. Yes I had many struggles accessing healthcare services multiple times when I got sick I had no transportation to the er I had to walk to get to the emergency room, since I did not have insurance I could not get any of the prescriptions given to me filled. Besides the fact that I felt everybody at the er was staring at me, when they asked for my address I was shy to say homeless, even though they could tell by looking at me I was homeless,
5. Did you try obtaining medical insurance for yourself? yes

   If yes,

    a. When was this? when I went to the er, this nice lady there said she was going to apply for insurance coverage for me, however, I never went back and I have no idea what she did, she said she will be following up with me but my phone is disconnected,
    b. Why did you try to obtain medical insurance? Because I am sick I need to get checked and be able to get medications when I need them
    c. How did you do it? The hospital helped me apply but again I do not know if I was able to get it
    d. Were you successful? I still do not know
    e. What challenges have you faced in trying to obtain health insurance? My phone is disconnected and I do not know if she called me or not, she gave me her card so I called from the shelter and left her a message to call me back at the shelter, I have not heard back from her yet, I am thinking about walking to the hospital or possibly get try to get a bus pass to get there.

   If no,

    f. Why haven't you tried obtaining medical insurance?

6. Do you think homeless individuals must be given health insurance? yes
    a. Why? No doubt about it physically and mentally emotionally all the aspects of human being should be covered medically for homeless people. I feel as homeless person we need health insurance more than stable people, we are more vulnerable and susceptible to disease, viruses, and other disease states.

  b. How do you think this is supposed to be accomplished? Different people require different assistance, me personally I can take care of myself but there is others in the shelter that need assistance, the first thing homeless persons needs is an address, I would say make housing available is the first step as every applications asks for an address, using the shelters address causes stigma and it is not guaranteed how long to be at this shelter. I feel the shelter can do more and help us get insurance. One time I went to the library to try to apply for health insurance online, of course I was stigmatized, and I seeked assistance from library personnel they said they are not trained to do that and they are not responsible to help anybody apply for insurance.

7. What do you think are the factors that may hinder homeless individuals from getting health insurance? Ignorance, lack of accessibility, dependence on drugs and alcohol, mental illness, a lot of applications now are available online and I do not have access to internet or a computer, when my phone is on I have internet but I honestly do not know how to access an application through my phone and even if I did I cannot print it and I do not have an email.
8. What do you think should be done so that homeless individuals could obtain health insurance? Once again everything is individual some people real tentative care and some need little accessibility, when chronic homeless they needs hand on assistance, little tender loving care if you will. I feel that many things can be offered through shelters, having social workers at the shelter who can handle

obtaining health insurance for the uninsured from a thru z would be helpful, I also feel that another social worker who can handle healthcare needs for persons in need would also be helpful. Free clinics come here from time to time but that is not enough, it is only momentum, we need to be seen regularly rather than once whenever the free clinic has trainees to train. I also think libraries should offer help applying for insurance.

9. If given the chance, and the process is accessible to you, would you obtain medical insurance? Why? I need more, the more knowledgeable I become I am going to try to acquire more and try harder to obtain more. Yes I would obtain health insurance. I do not eat healthy, I am ill mentally and physically, I think having health insurance and a primary care to go to who would follow my health and see me when I need seen is important and can help me survive through the situation.

P2

1. When did you become homeless? August 22, 2019, 2 years
2. What are your experiences as a homeless individual? Living condition, housing, healthcare, come and respect most people review as certain stigma even though we are trying to get our lives together , it is frustrating trying to get a job, but I do not feel fit to be interviewed I need to shower wear clean clothes to interviews, these are things that I face when thinking about a job. The one time I got a job I was paid minimum wages which was not enough to live off of. Being homeless is difficult. People think only drug addicts alcoholics, or handicapped be homeless,

anyone can become homeless. It is ver hard to feel rootless and alone and no one cares about you, when you know you have family that lives under a roof and they know you are homeless and yet they do not try to help you, this is the hardest part

3. As a homeless individual, do you perceive yourself as physically healthy? Not healthy at all, dealing with many health issues and medications are hard to obtain, I have glaucoma, stage 2 colon cancer. How can I be physically healthy when I do not have my basic life needs, shelter, food, water, clothing, if you are not getting enough of those you cannot be physically or mentally healthy. You will get by that is about it though. I do my best to eat healthier but my resources are limited, I eat whatever my hands get on to satisfy my hunger, but as homeless for a few years now, it is not getting any better with the kind of food we eat.
4. Did you have past experiences when you needed to access healthcare services for yourself? Please describe that event or experience. It has been a while since I got eye drops and these little clinics do not provide it, I have to get a referral and go from one hospital to another, unfortunately I wear reading glasses as opposed to getting prescription glasses. I need to be seeing an eye doctor but I can not see one because I do not have insurance and when I tried to make an appointment they told me first available in 4 months then when they found I do not have insurance they asked for proof of funds to make sure I can pay them before I go see the eye doctor. But of course I do not have money and I can not see the doctor, the one time I had to go to the ER, when the receptionist asked for my

address I said I was homeless, they were rushing to just see me and get me out of there, I felt like I was a bug that they trying to get rid of.

5. Did you try obtaining medical insurance for yourself? yes

    If yes,

    a. When was this? last year, there is a long waiting list, due to pandemic you can't go into office you have to wait on the phone and nobody answers and it keeps spinning from one person to another.
    b. Why did you try to obtain medical insurance? I have been continuously coughing and my body feels weak, I feel I should have health insurance for when I need to see the doctor to be able to go to the doctor. I feel I should be able to get my medicine filled, I should live healthier, yes I do not have a roof on top of my head but it does not mean I need to stay living unhealthy.
    c. How did you do it? Someone here at the shelter helped me apply, she gave a me a phone number to call anc check if I qualified for Medicaid, I keep calling and phone call kepr going in circles from one person to another
    d. Were you successful? No
    e. What challenges have you faced in trying to obtain health insurance? Like I said phone call kept going from one person to another, I do not have car to drive and try to speak to someone on site, they were not even accepting walking in due to pandemic, I do not have access to computer where I can

do online as the answering machine was mentioning applying online when I called.

If no,

f. Why haven't you tried obtaining medical insurance?

6. Do you think homeless individuals must be given health insurance?
    a. Why? Yes it is important to stay healthy and should be top priority especially for homeless people as they tend to be unhealthier than others who have normal lifestyle and live under a roof. The think of it is when you become homeless, if you are healthy, you will get sick and if you are sick, you will get worse, and therefore, as homeless person I feel I am entitled to health insurance to stay healthy bad enough my rood is gone I do not want to lose my health also. I do not feel safe you know.
    b. How do you think this is supposed to be accomplished? i feel the shelter can be more involved into helping people get insurance, more resource can be made available throughout the guys here at the shelter, such as phone services, internet computers, may be the government can send agents from the county to check if we qualify for Medicaid and help us apply.
7. What do you think are the factors that may hinder homeless individuals from getting health insurance? Availability, transportation, someone who can take an intake as opposed to someone assuming that everybody homeless is on drugs and alcoholic makes it hard to be stigmatized, someone comes in and do not want to get near you because they think you stink or contagious is an awful feeling . We

need people who have more heart and can see us through their heart, do not be judgmental, feeling down all the time makes me less energetic and not wanting to do anything.

8. What do you think should be done so that homeless individuals could obtain health insurance? Funding, staffing, facility, we should have a clinic that come in to the shelter I am a cancer patient and there is nothing here for me, the clinic is far away that I can't even make it to. They should be able to cover more than just basic eyes, ears, and throat. If you need a medical care it should not matter whether you took a shower or your hair is combed or not. How people perceive you, half of them will not even allow you come into the clinic
9. If given the chance, and the process is accessible to you, would you obtain medical insurance? Why? I definitely will because of the health issues I have, I need it in certain neighborhoods healthcare services is little or nothing, and here it is nothing. When they come here to do a service, they do not come to service or care for us, they bring students to train on us. If I do not get medical care, I might lose my sight due to lack of treatment. I am going to a clinic now to beg for medications because I need them. All I want is the proper care and access to it.

P3

1. When did you become homeless? 2 years ago
2. What are your experiences as a homeless individual? It is hard, it is real hard especially getting money, I go to minute man to try to make some money from

time to time but what I make is not enough, when homeless, you always feel down and looked at differently, I do not eat health I donot live healthy, life is hard. Nothing is easy specially that I do not have an address, I do not always plan on staying at one place for a long time, I always feel I need to change the shelter where I stay I even sleep on the streets often.

3. As a homeless individual, do you perceive yourself as physically healthy? Not really, I go to therapy because of brain infection. Being homeless caused me mental issues, depression, stress, and physical issues as well, I do not eat healthy I do not sleep healthy I do not sleep enough, my hygiene is bad, no showers, brushing teeth, the feel of being clean does not even exist on my mind. I do not know when the last time I had a shower and that is why I am hesitant to even see a doctor.
4. Did you have past experiences when you needed to access healthcare services for yourself? Please describe that event or experience. I never took the time to apply for coverage, even if I wanted I do not know where to start, I do not know of any resources available to me
5. Did you try obtaining medical insurance for yourself? No

   If yes,

   a. When was this?
   b. Why did you try to obtain medical insurance?
   c. How did you do it?
   d. Were you successful?

   e. What challenges have you faced in trying to obtain health insurance?

   If no,

   f. Why haven't you tried obtaining medical insurance? I do not know where to go, a lot of people say I can get care source or get buckeye, I was never offered resources and I do not know where to start. Even if I have insurance I do not know if a doctor would be seeing me looking like this or smelling most of the time, so when I get sick I just suck it up and live through it until I feel better, and sometimes I go to the er and get treated there. God is good.

6. Do you think homeless individuals must be given health insurance?
   a. Why? Everybody should get healthcare regardless of age, should be free healthcare but before that I need a place to stay, shower and live normal life where I can give an address when I go to doctors.
   b. How do you think this is supposed to be accomplished? I feel the emergency room can offer help to homeless people by directing them where to apply for insurance or may be help them apply or connect them with doctors to see regularly. Libraries can have programs to help, shelters can also be part of this. Free clinics can be resources too, I hear other homeless individuals I know go to the free clinic sometimes; why not help the, get insurance. Law makers can help too by making laws to get health insurance for homeless persons.

7. What do you think are the factors that may hinder homeless individuals from getting health insurance? Time, everybody is busy or putting it off. Even though I got nothing to do I feel I am always busy thinking, mentally I am not stable I do not have transportation to go places, my phone is not on all times, I know there is a lot of things to be done online, but I have no computer and I do not know how to use internet that good, I am not sure I am fit to fill an application
8. What do you think should be done so that homeless individuals could obtain health insurance? You cannot get them get healthcare, but it is needed, like I said before make computers available and internet may be in the shelter and have people to guide homeless how to apply, may be a social worker in charge of helping homeless persons apply and find out if they qualify.
9. If given the chance, and the process is accessible to you, would you obtain medical insurance? Why? Yes because I am really in a bad place and I need to go to the doctor, everybody should get healthcare and we need to take time to get healthcare and insurance, because no telling when it is needed . it is a lot of homeless people here that need help bad, this shelter is helping a little bit but you still need to fight yourself nothing is coming to you, you need to go get it.

P4

1. When did you become homeless? 1 month ago
2. What are your experiences as a homeless individual? Not a blessed one and it is scarce, no counselors and I am still moving around not knowing where I am going to sleep tonight or where I am going to be tomorrow. It has been rough out here, I

do not know what to eat and if I am going to eat healthy. I have not showered for over a month now, it does not feel good at all, it has been bad, I feel ashamed and shy to be around people and in my mind people are just looking at me.

3. As a homeless individual, do you perceive yourself as physically healthy? Yes I do, I have not been homeless for that long and I still feel physically healthy I just do not know how long this is going to last. Having a roof on top of my head feels different and better. I see others, homeless, out there that are in a really bad shape, recently I have not been practicing my normal hygiene, I feel disgusted at times, not brushing teeth, not showering, not washing clothes, do not even have much clothes to change.
4. Did you have past experiences when you needed to access healthcare services for yourself? Please describe that event or experience. I had a healthcare though the va, however no longer have insurance because I went to prison. Last week I was not feeling well I went to the ER, they saw me and everything was good until they gave me prescriptions, when I went to the pharmacy I could not get them filled because they were very expensive and I could not afford them, so I did not get the prescriptions filled. It is sad that I serve this country and I lose my benefit because I went to prison and now I am homeless, I feel that I was let down.
5. Did you try obtaining medical insurance for yourself? No I have not

   If yes,

   a. When was this?
   b. Why did you try to obtain medical insurance?

c. How did you do it?

d. Were you successful?

e. What challenges have you faced in trying to obtain health insurance?

If no,

f. Why haven't you tried obtaining medical insurance? Because I was in good shape and I was in prison I did not need any, I only been homeless for a month and I did not need it until last week, but now that I think about it I do not know where to start and what is out there for me. I am not even sure if I qualify for insurance. Even if I knew where to start, I do not have transportation to go anywhere, I had to walk to the ER last week. Luckily it was a short walk.

6. Do you think homeless individuals must be given health insurance? Yes I do
   a. Why? Because it is needed when you are out here on the street, you are not eating healthy and susceptible to all diseases especially covid now. I feel as I am going down mentally and I am going to need to see a psychologist soon, if I do not have insurance I do not think I will be able to see any doctors. If I get worst mentally, I know things will get worst for me.
   b. How do you think this is supposed to be accomplished? If you have a job and seeing people, you need to get information and get it done it should be free like in Canada. May be if hospitals offer assistance to obtaining health insurance for homeless that might be helpful I am able to walk to the

hospital around here and get assistance and like I said before transportation will be an issue for me of I have to travel somewhere to apply. Or may be offer computers at the shelter to apply online that will not be a bad idea.

7. What do you think are the factors that may hinder homeless individuals from getting health insurance? It is a hard question, mainly availability of resources, how one feels about himself also block someone from approaching people or agencies to seek help getting health coverage. Feeling stigmatized, and feeling shameful can damage someone mentally and physically, therefore not be able to seek the help needed when needed. Again transportation, access to computers, internet or even a phone line can be very helpful.
8. What do you think should be done so that homeless individuals could obtain health insurance? Places set up where they can go and get it, welfare system should be automatically implemented and when they first either get sick or go to a hospital and see a doctor, homeless should automatically be covered under a government plan to protect their health and well being,. The law needs to change to help homeless people more, I do not know of any resources out there, who knows they might exist but where would I hear about them I do not watch tv I do not listen to radio, I do not get on the internet. Government need to make resources available and make sure they reach to homeless. Being homeless means being disconnected from everything.

9. If given the chance, and the process is accessible to you, would you obtain medical insurance? Why? Yes because I am getting older I am turning 62 and I will need to see doctors more as I am older and I need to get my physicals done, I need to live healthy and be healthy to be able to get by. Medicare and healthcare services should be made accessible to everybody

P5

1. When did you become homeless? 3 months
2. What are your experiences as a homeless individual? It has been bad and I am trying to get out more, I had a house before and I lost my money and my house, I sit outside, run out side, it is an awful feeling when you do not have a home, somewhere to go to sleep, eat, relax and live a normal life,. My body aches from sleeping on floors, parking lots, even the shelter does not offer good mattresses but it is better than being outside at least specially in the cold. I am not getting enough food because my brain is going out, my brain stopped and I can’t get my ssi any more
3. As a homeless individual, do you perceive yourself as physically healthy? I have not been eating healthy and sleeping good, I would say somewhat healthy, I ve seen others who have been homeless for longer and they are in rough shape I am afraid that I am going to end up like them.
4. Did you have past experiences when you needed to access healthcare services for yourself? Please describe that event or experience. Yes I have been drunk before I have been down before I got do what I can do and get back on my feet. I have

been to the doctor's office but they could not see me because I did not have insurance so I ended up going to the ER, they saw me and gave me an IV line while I was there, I left the next day but I did not know if I can get medications since I di not have insurance so I did not even try to go to a pharmacy, I figured it would be a waste of time to walk there, it is a long walk to the pharmacy and as you know I am homeless I would need someone to take me and I have no one to ask.

5. Did you try obtaining medical insurance for yourself? no

   If yes,

   a. When was this?
   b. Why did you try to obtain medical insurance?
   c. How did you do it?
   d. Were you successful?
   e. What challenges have you faced in trying to obtain health insurance?

   If no,

   f. Why haven't you tried obtaining medical insurance? I do not know where to start, I asked at the shelter and they did not have much to offer, I was told it can be applied for online and you know I do not have a computer or a phone to call. I think someone told me to go the library and use the computer and internet there to apply online, I would not even know how to fill out the application online. The library is too far I tried to take the bus there but I did not have a bus ticket.

6. Do you think homeless individuals must be given health insurance? yes
    a. Why? Because we deserve to live healthy like everybody else, I am out here in the street catching all type of viruses and diseases my body is going to eventually get weaker and not be able to tolerate being sick any more. I should be able to get vaccines when I need them.
    b. How do you think this is supposed to be accomplished? The man upstairs told me he was going to help me. I think the shelter can offer us help may be provide us transportation to go apply where we need to apply or even to library. Having a social worker the shelter might be a good idea too, who knows if there is resources out there that I do not even know off. May be making these resources available and let homeless persons know of it somehow. May be posters on the streets where homeless people be or in the shelter. Or at the ER since we all mostly go to the ER
7. What do you think are the factors that may hinder homeless individuals from getting health insurance? Being able to go places besides walking, transportation is a big issue, not having a television, a phone or computer we are disconnected from the world.
8. What do you think should be done so that homeless individuals could obtain health insurance? Someone can let us know of what is available to us, I do not know how but I am sure the government can find a way of letting us know of resources out there. Assign us case workers through the shelter and having them

come to shelter to help that can also be resourceful. Offering us transportation computers, internet can also be good.

9. If given the chance, and the process is accessible to you, would you obtain medical insurance? Why? No doubt, I need to live healthy and be healthy I deserve to have health insurance like others do who knows when I need it.

P6

1. When did you become homeless? 2 years ago
2. What are your experiences as a homeless individual? It has been very difficult at times I feel it is better not be around sometimes, but I always hope for a better day. Not knowing where I am going to sleep eat or shower for the day is not a good feeling. Being looked ta different, treated different, feeling ashamed, shy to say homeless when asked what is your address, it is difficult, I never thought I would live like this. looking dirty all the times takes away my chances of finding a job or even getting on the bus or seeing a doctor.
3. As a homeless individual, do you perceive yourself as physically healthy? no how can I be physically healthy when I sleep on floors, streets, parking lots, eat junk food, leftovers from people, or sometimes go days without food to eat. I am physically and mentally destroyed.
4. Did you have past experiences when you needed to access healthcare services for yourself? Please describe that event or experience. Yes I was not feeling well and I had to go to the ER, it was a terrible experience as I walk in I can feel everybody in the ER just staring at me. It was an awful feeling I almost walked out. When I

checked in I did not know what to write for address so I wrote homeless. When they called me to the back I felt as the nurse and the doctor were disgusted by me. I think they just rushed to get me out of there. They wrote me prescriptions that I could not get filled.

5. Did you try obtaining medical insurance for yourself? yes

   If yes,

   a. When was this? recently Why did you try to obtain medical insurance? Because I need to get physicals done and blood work, I know to make sure I get healthier and get better to be able to get a job and work to get out of being homeless.
   b. How did you do it? I called the welfare office, the lady took my information and said she was going to call me back and help me file for insurance benefits, I have been waiting on her to call me back, she said I might need to go there in order to collect some signatures from me, I will figure out how to get there when she calls me, I might walk or get help obtaining a bus ticket to get there.
   c. Were you successful? Still waiting
   d. What challenges have you faced in trying to obtain health insurance? Getting there is going to be an issue and also I do not know if my phone is going to be on when she calls me back

   If no,

   e. Why haven't you tried obtaining medical insurance?

6. Do you think homeless individuals must be given health insurance?
    a. Why? Yes so you can go to the hospital and get proper care, yes homeless people like I said before are physically and mentally destroyed they need health insurance to be able to get better physically and mentally, they deserve to live healthy like everybody else.
    b. How do you think this is supposed to be accomplished? Not being aware of where to apply and the opportunities that are available is a big issue. May be the city can help people become aware of what is out there specially for us homeless people, I am very sure there are things that we are not aware of, how can we know without having access to computers, tv, internet.
7. What do you think are the factors that may hinder homeless individuals from getting health insurance? Feeling down all the time, feeling stigmatized and not having proper transportation , clothing and not feeling clean enough to be in a doctors office are things that always cross my mind when I think of going to the doctor
8. What do you think should be done so that homeless individuals could obtain health insurance? Getting more help from the city and the state, even the shelter can be part of this. why not making offices to help homeless people obtain health insurance just like there is a shelter for people to sleep, there should be medical services and health services available through the shelter and I think the government can be responsible for making such thing.

9. If given the chance, and the process is accessible to you, would you obtain medical insurance? Why? Yes because it is needed to stay healthy and live better, if I stay unhealthy not feeling clean and mentally destroyed I will always stay homeless, coming out of homelessness requires repairing us physically and \mentally and to do that health insurance will be essential and very important. It is just as important as having a roof on top my head.

P7

1. What are your experiences as a homeless individual? Struggle to find assistance in any place or even find direction for assistance as well as finding shelter on top of your head, and medicine whenever needed. It has been difficult, stressful and depressing every day goes by very slow. I do not know how long this is going to last for. I am always say it will get better, but it is not getting any better and covid made it worse.
2. As a homeless individual, do you perceive yourself as physically healthy? Currently yes, but I am starting to feel it, sleeping on the streets, and parking lots, and the shelter is not even that comfortable either. My back hurts at times but what can I do I just tolerate the pain and suck it up. I am not getting enough sleep, I am always drowsy and cannot even sleep well. My stomach hurts at times due to eating junk food all the time. I know I am not getting enough nutrition into my system but again what can I do it is what it is at this point, I am just living my life day by day.

3. Did you have past experiences when you needed to access healthcare services for yourself? Please describe that event or experience. There were moments when I needed to access healthcare service however I was never taught how to properly go about that. I find it very difficult to obtain that or have any type of assistance in order to obtain that. There was many time when I had to see the doctor, one time went to a doctor that I used to see back in the day, however they told me I could not be seen due to not having insurance, I felt as the front desk lady was very disturbed by my presence in the waiting area there and could not wait for me to leave. It is the stigma that I am used to by now. I get it, I do not look very clean, I wear dirty clothes, I am not who I used to be any more so I have to deal with the consequences of the new life I have.
4. Did you try obtaining medical insurance for yourself? yes

   If yes,

   a. When was this? a month ago
   b. Why did you try to obtain medical insurance? To have myself covered and not be in debt and have medical aid in my life for when I need it, I think my mental health needs to be checked by a psychiatrist, there is no way I cannot remain mentally stable living like this, I am getting by now but I am afraid that my mental stability will not last for much longer, I can feel the depression more, I am more moody now

   c. How did you do it? Applied through the homeless shelter assistance, the lady was very helpful and did a lot for me to get the application sent to the right people.
   d. Were you successful? Not yet, I have been waiting
   e. What challenges have you faced in trying to obtain health insurance? Time and patience trying to find the right people, people who actually care and want to help. So far the process of actually obtaining, that is the most difficult part, I am lucky to have that lady helped me.

   If no,

   f. Why haven't you tried obtaining medical insurance?

5. Do you think homeless individuals must be given health insurance? yes
   a. Why? Because no one want to see dead bodies on the street or people with sickness or withdraws and pain they need help as much as anyone else. Because once homeless, you will eventually have physical and mental issues that you will need a doctor for and to see a doctor you need health insurance
   b. How do you think this is supposed to be accomplished? I guess making a program easier, being able to advertise, become known out there and get familiar to the community, going up to certain individuals as some people need help and do not know how to ask or too stubborn to ask and do not know where to start. Putting people on the right path is the first step and for that the government need to implement programs within communities

and shelters to make sure they reach to homeless people. There is not point of programs that homeless people are not aware of. We do not just need programs for help, we need to make sure that the programs and information reach us to be able to utilize it and benefit from it.

6. What do you think are the factors that may hinder homeless individuals from getting health insurance? Pride, lack of direction as well as whatever drug that they may have been on that destroyed their life and they see that as the only ticket to get better but it is not. Low self esteem, being stigmatized, and having no resources or transportation all play a factor into hindering homeless people from obtaining the health care they need.
7. What do you think should be done so that homeless individuals could obtain health insurance? Making programs a bit easier because some homeless people oddly enough even though they have all the time in the world they do not like staying at one place for long, they do not like listening for an hour long conversation, they like to get straight to what they need, and everything else is considered waste of time. A more simplified process will help, a more visible process that reachs to homeless people is very helpful like I said before we need a program to reach us not be knows form the people who has internet, computers, tv, and yet the primary beneficiaries have no clue of such program existence.
8. If given the chance, and the process is accessible to you, would you obtain medical insurance? Why? Of course yes, like I said it is tricky. I would want that

in my life in case anything happens to me health wise I am covered and I would not have to worry, I would just go to the hospital and get treated.

P8

1. When did you become homeless? 9 months ago
2. What are your experiences as a homeless individual? It is not easy finding housing there is a lot of obstacles against you, a lot of people look down at you because of that, it is hard to find a job, I try not to use the shelters' address because of embarrassment. But again when I go to an interview for a job, people can tell I am homeless, I try to be as clean as I can be but it is difficult to maintain. Life is rough though.
3. As a homeless individual, do you perceive yourself as physically healthy? yes for now, I am very sure it will get ugly at some point, nothing I do is healthy, I am confident it will affect my health physically and mentally at some point, no good food, no good hygiene, not sleeping well. It will add up and eventfully get me
4. Did you have past experiences when you needed to access healthcare services for yourself? Please describe that event or experience. I did I went through welfare and got Medicaid for medical and dental. After I had insurance I tried to have my own doctor and do physicals and follow up, but it was hard scheduling the appointment, I left a message one day I am not sure if they called me back as I used the shelters telephone line. So I walked in to see if they would see me or schedule me an appointment, they told me due to covid they were only seeing

patients who are sick and has to be seen; otherwise the offered to see me virtually, but I do not have a computer or internet access.

5. Did you try obtaining medical insurance for yourself? yes

   If yes,

   a. When was this? 8 months ago
   b. Why did you try to obtain medical insurance? I have couple of health issues and I needed to be seen so I made sure I obtained health insurance when I became homeless as I knew that my health will worsen as homeless and I might need mental help down the road as well.
   c. How did you do it? A social worker through the shelter, she helped me get started and I kinda stayed on top of it as well to make sure I have insurance
   d. Were you successful? yes
   e. What challenges have you faced in trying to obtain health insurance? Being stigmatized and the feel of being judged, and not being able to contact services as everything is digitalized now. Between the library and the shelter I worked my way and luckily I got it

   If no,

   f. Why haven't you tried obtaining medical insurance?

6. Do you think homeless individuals must be given health insurance? yes
   a. Why? Everyone must have insurance; it should be given at all times. there is a lot of people that have mental health issues that need help and do not

how to get it. If they do not get treated, they are just getting worst and it will not get any better for them.

   b. How do you think this is supposed to be accomplished? Having a case worker will help, there is several services available. However not everybody is able to follow up and utilize resources like I did, I think people may need a mentor as well, there is guys out here that do not know how to use a computer or navigate the internet.

7. What do you think are the factors that may hinder homeless individuals from getting health insurance? Being lazy and following up on drug and alcohol addiction programs, next you know they are in the hospital because they did not get the proper medical treatment they deserve. Lack of transportation, not knowing of available resources out there, homeless people are disconnected from the virtual world. And everything is digitalized and virtual now a day.
8. What do you think should be done so that homeless individuals could obtain health insurance? I really feel like once they do the intake they need to find away to provide it to them automatically, some of these people at the shelter have no coverage what so ever. They need more social workers at the shelter, may be posters on the streets of available services and resources that homeless people can benefit from.
9. If given the chance, and the process is accessible to you, would you obtain medical insurance? Why? I do have insurance now and if I did not, I would seek

it because I am getting older and the issues that I have now I will need treatment for the rest of my life.

P9

1. When did you become homeless? 4 months
2. What are your experiences as a homeless individual? Negative energy all around because the people stuck in the situation, and cannot get their selves out of the situation. It is not easy, it is rough and very difficult to get by, being looked at different, I do not eat healthy I do not sleep enough, my life flipped 360 degrees nothing is the same any more. Life sucks
3. As a homeless individual, do you perceive yourself as physically healthy? No because I am not doing the right routine I am not eating well and not sleeping well, I am not physically healthy. I am always feeling sick and week. I hope it does not get worst, I know this is the beginning; all I can do at this point is hope for a better tomorrow.
4. Did you have past experiences when you needed to access healthcare services for yourself? Please describe that event or experience. Yes, when I went to the ER for an upset stomach, they treated me and I was advised to see a primary care however, I had a hard time finding one therefore I gave up. Doctors would not want to see me looking like this, smelling like I do.
5. Did you try obtaining medical insurance for yourself? yes

   If yes,

   a. When was this? 2012

   b. Why did you try to obtain medical insurance? Because I had a mental illness due to being shot when I was 17
   c. How did you do it? Homeless shelter
   d. Were you successful? No
   e. What challenges have you faced in trying to obtain health insurance? Being looked at different and stigmatized as homeless all the time, had a hard time communicating with the different offices I had to contact to obtain coverage, I could not go from one place to another, I could not give them a permanent address for myself or even a phone number.

   If no,

   f. Why haven't you tried obtaining medical insurance?

6. Do you think homeless individuals must be given health insurance? Yes
   a. Why? Because they go, homeless people, through a lot of situation with their health and nobody helps them. I think homeless people suffer mentally and physically all therefore they need health insurance
   b. How do you think this is supposed to be accomplished? People, homeless people, supposed to get on the phone and call the right people and let them know they need health insurance. May be if we had more social workers, or even social workers who care to do the work, I have seen all of them, I think they just care to get paid at the end of the week, they do not care whether we obtain insurance or not. Do not get me wrong I have seen a few of them who really cared, but again that was not enough there is a lot

of people here at the shelter and that requires having more social workers. May be libraries can help to. Or even a social worker s the ER can help. A lot of us here go to the ER when medical help is needed.

7. What do you think are the factors that may hinder homeless individuals from getting health insurance? They think their body al alright and they do not know that they have issues due to lack of proper eating and drinking people think they are healthy already and nothing wrong with them but they have no doctor, to do physicals and routine visits. But again we have no internet access no cars to get to places no computers or television
8. What do you think should be done so that homeless individuals could obtain health insurance? Homeless people should love themselves and try to seek health insurance, and the system should be more flexible to accommodate health needs of homeless people, the system can be better on delivering information and available resources to homeless people.
9. If given the chance, and the process is accessible to you, would you obtain medical insurance? Why? Yes because I need to treat my mental illness and health issues that I have I also need to improve physically to try to find a job and may be being able to put a rood on top of me

P10

1. When did you become homeless? 1 year and a half ago

2. What are your experiences as a homeless individual? I try to do the best I can to keep my head to the sky, but life is tough and being homeless does not help at all it is not fun.
3. As a homeless individual, do you perceive yourself as physically healthy? Somewhat, I think my body is still holding not sure for how long though. As you probably know sleeping on the streets, parking lots, under bridges, on the grass, and shelters are not very comfortable or healthy. My body aches once in a while. I do not eat healthy either; it is all junk or leftover foods.
4. Did you have past experiences when you needed to access healthcare services for yourself? Please describe that event or experience. Yes I caught covid and that was a bad experience, I got very sick and I had to stay at the hospital, I was told the covid treatment was covered from the government so I did not have to worry about charges, which was good. But now I have to see a primary care doctor to follow up with and I do not have one
5. Did you try obtaining medical insurance for yourself? yes

   If yes,

   a. When was this? a year ago
   b. Why did you try to obtain medical insurance? I felt I need it to be able to visit a primary care doctor, and I had just became homeless at that time and I had a feeling that my physical and mental health will get bad
   c. How did you do it? When I left prison they helped me apply, I tried to follow up but I did not get anywhere.

   d. Were you successful? No
   e. What challenges have you faced in trying to obtain health insurance? Being looked at different, not knowing who to contact, having no resources to access or even transportation to go their office. I do not even know where that office is

   If no,

   f. Why haven't you tried obtaining medical insurance?
6. Do you think homeless individuals must be given health insurance? yes
   a. Why? Because when you are sick you need to be able to see the doctor and being able to establish care with a doctor is important. Homeless people probably get sick more than others and should have insurance
   b. How do you think this is supposed to be accomplished? You need to get help from a social worker or a person at the shelter should be designated to help people in getting health insurance and direct them in the right direction when they need help. May be the system can make resources visible and reachable to homeless community
7. What do you think are the factors that may hinder homeless individuals from getting health insurance? Being looked at different, feeling ashamed, being on drugs or alcohol, lack of transportation, lack of resources, and being disconnected from the digital world.
8. What do you think should be done so that homeless individuals could obtain health insurance? Help homeless get jobs and make a system that can easily

accessible to homeless people. Make resources available to homeless people. Supply the shelters with more social workers, computers, internet,

9. If given the chance, and the process is accessible to you, would you obtain medical insurance? Why? Yes, because am getting older I need some type of insurance there is no telling when I fall again, I need to be able to stay on my feet.

Appendix E: CITI

CITI PROGRAM

Completion Date 31-Jul-2021
Expiration Date N/A
Record ID 43853732

This is to certify that:

ABEDALHAKEEM ABUKHALIL

Has completed the following CITI Program course:

Not valid for renewal of certification through CME.

Student's
(Curriculum Group)
Doctoral Student Researchers
(Course Learner Group)
1 - Basic Course
(Stage)

Under requirements set by:

Walden University

CITI
Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?w0e2b54af-76a0-4475-a3aa-522f9d5fe030-43853732