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Review Article

"Death may suck, but it's better than the emergency room", Lived experiences of healthcare avoidance and systemic harm among people experiencing homelessness: A meta-synthesis

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Abstract

Background: People experiencing homelessness face persistent structural and interpersonal barriers to healthcare that contribute to delayed care, avoidance, and preventable harm. While disparities are well documented, less is known about how repeated healthcare encounters shape engagement over time.

Purpose: This qualitative interpretive meta-synthesis examined healthcare access and avoidance among people experiencing homelessness and service providers to identify shared barriers influencing system navigation and care delivery.

Methods: An adapted qualitative interpretive meta-synthesis design was employed. Systematic searches were conducted across eight academic databases between January and April 2025. Peer-reviewed qualitative studies focused on adult homelessness and healthcare access were included. Verbatim participant quotations were extracted and analyzed using line-by-line coding, constant comparative analysis, and team-based synthesis.

Results: Fifteen qualitative studies met inclusion criteria, representing 334 unhoused individuals and 72 service providers. Six interconnected themes emerged: systemic stigma in healthcare settings; financial inaccessibility and cost-related avoidance; fear-based avoidance of healthcare systems; barriers due to bureaucracy and lack of information; dehumanization and the emotional toll of healthcare encounters; and marginalized mental health needs within fragmented healthcare systems. Findings suggest healthcare avoidance often reflects rational responses to cumulative systemic harm rather than disengagement.

Conclusions: Healthcare exclusion among people experiencing homelessness is driven by intersecting structural, clinical, and relational failures identified by both service users and providers. Trauma-informed, equity-oriented, and person-centered approaches are essential to improving access, trust, and continuity of care in community nursing and primary care settings.

Keyword: Homelessness; Healthcare Access; Stigma; Qualitative Interpretive Meta-Synthesis; Primary Care

Research Highlights

What is the current knowledge?

- Unhoused individuals often struggle to access healthcare due to stigma, discrimination, and systemic obstacles within medical institutions.

What is new here?

- This qualitative interpretive meta-synthesis draws on multiple studies to show how stigma: spanning individual interactions, clinical settings, and broader institutions, shapes healthcare experiences among unhoused people and often leads them to avoid seeking care

Background

People experiencing homelessness (PEH) represent one of the most medically vulnerable populations globally, facing persistent barriers to essential healthcare. In the United States, over 653,000 people experienced homelessness in 2023 (Garcia et al., 2024), with global lifetime prevalence estimates ranging from 4.2% to 4.9% across the United States and Europe (Fornaro et al., 2022). Homelessness disproportionately affects racially and ethnically marginalized populations and is closely tied to structural inequities such as poverty, discrimination, and social exclusion. Beyond its social dimensions, homelessness critically shapes health, influencing exposure to illness, access to care, and overall well-being.

PEH experience disproportionately high rates of acute and chronic illness, mental health disorders, infectious diseases, and substance use compared to housed populations (Fornaro et al., 2022; Garcia et al., 2024; Richards & Kuhn, 2022). Unsheltered individuals face compounded risks due to environmental exposure, poor sanitation, and fragmented care systems (Richards & Kuhn, 2022). Yet despite severe health needs, PEH often lack consistent access to preventive and primary care services. Many do not have insurance or a regular provider and struggle to navigate complex healthcare systems, leading to delayed diagnoses and disease progression (Baggett et al., 2010; Kushel & Moore, 2023). As a result, emergency departments frequently become default care sites thus reflecting both limited primary care access and prior negative healthcare experiences (Miller et al., 2024).

Barriers to healthcare for PEH extend far beyond finances and logistics; they are embedded in how healthcare systems are structured and delivered. Financial obstacles such as treatment costs, medications, insurance gaps, and transportation force individuals to choose between survival needs and medical care (Henderson et al., 2021; Wise & Phillips, 2013). Even when coverage exists, finding providers who accept specific plans or who are equipped to manage complex needs can be difficult (Gunner et al., 2019; Meehan et al., 2023). Bureaucratic requirements such as proof of identification, stable addresses, scheduled appointments, and administrative documentation, often clash with the instability inherent in homelessness and function as exclusionary mechanisms (Carmichael et al., 2023). Limited health literacy, cognitive challenges, mental illness, and the ongoing stress of housing instability further compound these barriers (Wille et al., 2017).

Interpersonal and institutional harms also profoundly shape healthcare experiences. Qualitative research consistently documents stigma, stereotyping, and moral judgment in healthcare settings, with PEH frequently described as undeserving, noncompliant, or drug-seeking (Bruguera et al., 2023; Gunner et al., 2019; Purkey & Greenle, 2019). These perceptions undermine clinical interactions, compromise communication, and contribute to inequitable treatment decisions (Miller et al., 2023). Repeated experiences of dismissal and disrespect erode trust and reinforce feelings of dehumanization. Many individuals leave care prematurely or avoid seeking care altogether (Forchuk et al., 2024; Sturman & Matheson, 2020). Although provider education initiatives may improve attitudes, compassionate and equitable care for PEH remains inconsistent (Qian & Hauser, 2022).

Structural and interpersonal barriers often produce psychological consequences that reinforce healthcare avoidance. Many PEH delay care until conditions escalate into crises, treating healthcare as a last resort rather than a preventive resource (Gunner et al., 2019; Thorndike et al., 2022). Collective narratives of mistreatment circulate within unhoused communities, deepening mistrust and discouraging engagement. Mental health needs are particularly vulnerable within fragmented systems, where psychological distress may be dismissed as secondary or "too complex" when co-occurring with substance use, physical illness, or housing instability (Bennett-Daly et al., 2021). Rigid eligibility requirements and disconnected services further leave many without care during acute crises (Priebe et al., 2012; Siersbaek et al., 2023).

Although prior research has documented barriers to healthcare access among PEH, much of this literature relies on small, localized samples and often overrepresents individuals already engaged with healthcare services (Gunner et al., 2019; Henderson et al., 2021). Less attention has been given to synthesizing lived experiences across diverse qualitative studies or examining how systemic, interpersonal, and psychological barriers interact to

shape patterns of healthcare avoidance. Accordingly, the purpose of this qualitative interpretive meta-synthesis was to synthesize participant narratives across multiple qualitative studies to better understand how structural, interpersonal, psychological, and clinical mechanisms shape healthcare access, avoidance, and trust among people experiencing homelessness.

Methods

Study Design

Qualitative Interpretive Meta-Synthesis (QIMS) is a method that brings together findings from multiple qualitative studies to develop a richer, more nuanced understanding of a shared phenomenon (Aguirre & Bolton, 2013). Meta-synthesis approaches are commonly used across nursing, public health, and social work. Aguirre and Bolton (2013) specifically refined the QIMS framework for social work contexts by emphasizing participant voice, interpretive meaning-making, and analytic rigor. An additional strength of QIMS is its ability to address the sample size constraints typical of individual qualitative studies. By pooling participant accounts across multiple investigations, QIMS creates an aggregate sample comparable in scope to those found in quantitative research.

This study used a modified QIMS approach designed for a graduate-level social work research methods project with faculty supervision. While QIMS is typically conducted by experienced research teams, we structured this project as a team-based interpretive synthesis to maintain QIMS's core principles: meaning-making, participant voice, and interpretive rigor within an educational setting. Faculty provided methodological guidance and quality oversight rather than direct involvement in coding or interpretation. This structure kept analytic decisions student-led while maintaining established qualitative standards.

We made several methodological adaptations to fit our context. First, rather than presenting individual reflexivity statements for each researcher, which is the standard practice for smaller QIMS teams, we developed a collective credibility statement. Given our team size and course-based structure, this approach allowed us to transparently represent our shared academic training, professional backgrounds, lived experiences, and social positions while keeping the methodology clear and manageable. Second, we focused our extraction and analysis exclusively on verbatim participant quotations from the Results sections of included studies, rather than coding full manuscripts or author interpretations. We coded these quotations line-by-line using concise descriptive codes (2–5 words), then iteratively compared and clustered them through a structured multi-week process. This process emphasized independent initial coding, peer comparison, consensus-building discussion, and faculty-guided refinement of themes. These modifications preserved the interpretive depth of QIMS while enhancing transparency and feasibility within our educational research setting.

In qualitative research, researchers are the primary instruments of interpretation, making it essential to address positionality, potential bias, and methodological rigor. A team of 12 Master of Social Work (MSW) students conducted this synthesis under the direction of the lead author, who served as both course instructor and project director. Community experts and institutional collaborators provided additional guidance throughout the project. We completed the research within a 15-week semester, which required careful adaptation of the QIMS process for this timeframe. The lead author coordinated the project, adapted QIMS for collaborative implementation, and provided consistent supervision across all phases.

Because this study used secondary data from publicly available qualitative research articles, we did not recruit new participants and did not require Institutional Review Board approval. This synthesis report was developed in accordance with the Enhancing Transparency in Reporting the Synthesis of Qualitative Research (ENTREQ) guideline to strengthen reporting transparency and methodological rigor.

Research Question

This synthesis was guided by the following research question: How do people experiencing homelessness encounter and navigate healthcare systems, and how do structural, interpersonal, psychological, and clinical mechanisms shape healthcare access, avoidance, and exclusion?

Inclusion and Exclusion Criteria

We included studies if they used qualitative or mixed-methods designs with a substantial qualitative component; focused on adults or teens experiencing homelessness or recent housing instability; examined healthcare access, utilization, or encounters; were published in peer-reviewed journals or credible scholarly outlets; and were available in English. We excluded studies that were exclusively quantitative; did not include participant voice or verbatim participant accounts; focused solely on provider perspectives without patient narratives; were conference abstracts, dissertations, or non-peer-reviewed publications; or did not explicitly address healthcare access or experiences.

Search Strategy

We conducted a systematic literature search to identify peer-reviewed qualitative studies examining healthcare access and barriers among people experiencing homelessness. Our searches across eight academic databases yielded approximately 3,200 potentially relevant records. We organized search terms into five conceptual categories to ensure comprehensive coverage while allowing flexibility across disciplinary databases. Within each category, we used multiple synonyms and related terms to account for terminology variations across social work, public health, and healthcare research.

The first category, healthcare access, included terms such as healthcare access, medical care access, health services utilization, healthcare disparities, and public health services. The second category, systemic and structural barriers, captured institutional and policy-level obstacles using terms such as systemic barriers, structural barriers, policy barriers, administrative challenges, and healthcare inequity. The third category, unhoused populations, included population descriptors such as people experiencing homelessness, homeless individuals, unhoused populations, and housing-insecure populations. The fourth category, health experiences, incorporated terms such as lived experiences, patient narratives, qualitative interviews, healthcare challenges, and personal experiences to ensure we captured participant-centered qualitative research. The fifth category, healthcare systems and settings, included terms such as healthcare systems, public health systems, Medicaid access, community health centers, and free clinics.

We used Boolean operators to combine categories and refine search results. An example search string applied across databases was: ("healthcare access" OR "medical care access" OR "health services utilization") AND ("people experiencing homelessness" OR "homeless individuals" OR "housing-insecure populations") AND ("lived experiences" OR "patient narratives" OR "qualitative interviews") AND ("systemic barriers" OR "structural barriers" OR "healthcare inequity"). Additional searches incorporated healthcare system-specific terms combined with qualitative methodology indicators. We adapted search strings as needed to align with the indexing terms and search functionalities of individual databases.

Study Selection Process

Our searches across eight academic databases yielded approximately 3,200 potentially relevant records. After removing duplicates, 2,150 records remained for title screening. We excluded 1,650 records during title screening that were clearly outside our scope, most commonly due to quantitative-only designs, lack of focus on healthcare access or encounters, or absence of lived experience perspectives.

The remaining 500 records advanced to abstract screening, where we excluded 350 studies for failing to meet inclusion criteria. Common reasons included insufficient qualitative data, exclusive focus on service delivery models without participant narratives, or lack of relevance to healthcare experiences among people experiencing homelessness.

We conducted full-text review for 150 articles and excluded 135 studies due to limited qualitative rigor, absence of verbatim participant quotations, or insufficient alignment with our analytic focus. Our final synthesis included 15 peer-reviewed qualitative studies, representing the voices of 334 individuals with lived experience of homelessness. An additional 72 service providers were included across these studies for contextual understanding. Figure 1 summarizes the study selection process.

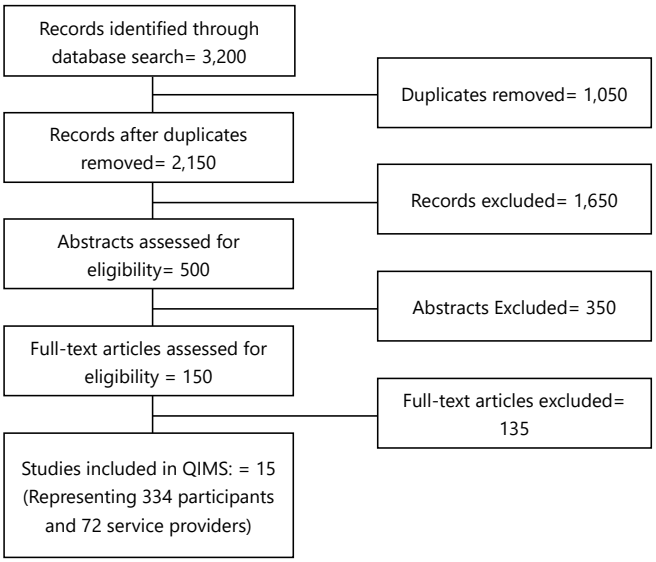

Figure 1. PRISMA Flow Diagram of Study Selection

Quality Appraisal

During full-text review, we assessed methodological rigor and transparency of included studies. We examined clarity of qualitative design, presence of verbatim participant quotations, transparency in sampling and data collection procedures, and coherence between findings and supporting evidence. Studies lacking sufficient qualitative rigor or participant voice were excluded during full-text screening. We also embedded safeguards within our own analytic process, including independent coding, peer comparison, consensus-building discussion, faculty-guided refinement of themes, structured team meetings, and reflexive record-keeping to strengthen transparency and credibility.

Data Extraction and Synthesis

Our data consisted exclusively of verbatim participant quotations extracted from the Results sections of each included study. We compiled original author-reported themes and citation information in Table 2. Using this matrix, we conducted line-by-line coding of all quotations to generate concise descriptive codes (2–5 words) that captured the core meaning of participant experiences. We systematically compared codes across studies and iteratively grouped them through a recursive analytic process that emphasized convergence, divergence, and contextual nuance. Through team-based discussion, constant comparison, and consensus-driven refinement, we synthesized these groupings into six overarching themes, with three analytically distinct subthemes nested within the first theme.

We used constant comparative analysis to identify convergence and variation in participant accounts across studies. We embedded multiple forms of triangulation in our analytic process: (a) data triangulation through synthesis of multiple qualitative studies; (b) investigator triangulation through independent coding, peer comparison, and team-based theme development; and (c) methodological triangulation by incorporating findings across the diverse qualitative traditions represented in the included studies. We maintained reflexive record-keeping, structured team meetings, and consensus-based theme refinement throughout the project to strengthen transparency and credibility.

Results

Study Selection

A total of 3,200 records were identified across eight academic databases. After removal of 1,050 duplicate records, 2,150 titles were screened. Of these, 1,650 records were excluded during title screening for being outside the study scope, most commonly due to quantitative-only designs, lack of focus on healthcare access or encounters, or absence of lived experience perspectives. The remaining 500 records underwent abstract screening, resulting in the exclusion of 350 studies that did not meet inclusion criteria.

Common reasons for exclusion at this stage included insufficient qualitative data, exclusive focus on service delivery models without participant narratives, or lack of relevance to healthcare experiences among people experiencing homelessness. Full-text review was conducted for 150 articles. Of these, 135 studies were excluded due to limited qualitative rigor, absence of verbatim participant quotations, insufficient focus on healthcare access, or misalignment with the analytic focus of the synthesis. A final sample of 15 peer-reviewed qualitative studies met all inclusion criteria and were included in the meta-synthesis. Table 1 presents key characteristics of the included studies.

Table 1. Demographics of studies included in the qualitative interpretive meta-synthesis

Author and publication year	Qualitative Data Collection Method	(N)	Age range, race, gender, unhoused, staff, policy maker etc	Recruitment City, State, Year
Bennett-Daly et al (2021)	Interviews	15 (10 unhoused and 5 service providers)	Over the age of 18, 5 staff, 10 unhoused individuals, male and female	Launceston Tasmania, Australia, March–May 2021.
Gunner et al (2019)	Interviews	22	24 to 70 years old, White, Asian, Black, Mixed, and one preferred not to answer, male and female, unhoused individuals	West Midlands, England, year NR
Henderson, McCurry, Deatrick, and Lipman (2022)	Focus Groups	16	Age range 18-70, Black/African American, Caucasian, and undisclosed, men, homeless, English speaking	Philadelphia, Pennsylvania July 2017
Meehan et al (2023)	Interviews and Focus Groups	68 (focus groups n=43, interviews n=25)	18-65+, exact age range NR (Source: pg. 4, pg. 5) men, women, transgender men, non-binary, and other, American Indian or Alaska Native, Black or African American, Native Hawaiian or other Pacific Islander, White, Multiracial, Prefer not to say, unhoused	Seattle, Washington, July–October 2021
Moore-Nadler, Clanton, and Roussel (2020)	Interviews	13	Over age 18, male and female, Caucasian and African American, speak English, homeless	Mobile, Alabama, year NR
Moore, Manias, and Gerdtz (2011)	Interviews	47 (20 unhoused and 27 service providers)	28-68 years, race NR, male and female, unhoused, service providers.	Melbourne, Australia, year NR
Nicholas et al (2016)	Grounded Theory and community based approach. Interviews and focus groups	42 (focus group participants n=39, individual interviews n=3)	Age range of 15 to 26, race NR (Source- pg. 3, pg. 4), male and female, homeless and/or involved in street life, currently or previously accessed ED in the last four months.	City NR (Source- pg. 2-5), large city in western Canada, year NR (Source- pg. 2-5)
Paradis-Gagné, Jacques, Pariseau-Legault, Ahmed, and Stroe (2023)	Critical ethnography. Interviews and observations	N =12 (70 hours of observation).	Ages 30-70, male and female, White and Indigenous, unhoused	Montréal, Canada, Year NR (Source: pg. 1-12)
Purkey and MacKenzie (2019)	Interviews, focus groups, and surveys	Unhoused individuals interviews/focus groups n=31, service providers interviews n=10, service provider survey n=136	Age range NR (Source: pg. 1-6), race NR (Source: pg. 1-6), gender NR (Source: pg. 1-6), unhoused, service providers	Kingston, Ontario. Canada, year NR (Source: pg. 1-7)
Saharan, Balachander and Sparke, (2021)	Narrative based approach. Interviews	N=5	Over the age of 18, race NR (Source: pg. 1-6), women, unhoused or marginally housed, able to speak English	Santa Cruz, California, December 2019 to February 2020
Strange, Fisher, Ping-Delfos, Arnold-Reed, and Brett (2018)	Interviews	Unhoused individuals interviews n=27. Service providers interviews n=5	Age range 23-84, Aboriginal and Torres Strait Islander, Non Indigenous, male and female, unstable housing or unhoused, service providers	Australia, April to September 2016.

Author and publication year	Qualitative Data Collection Method	(N)	Age range, race, gender, unhoused, staff, policy maker etc	Recruitment City, State, Year
Ungpakorn and Rae (2019)	Interviews	10	Ages 26-56, White British, White Latvian, White Polish, Black Ghanaian, White Bulgarian, Mixed Caribbean Cuban, male and female, unhoused	London, United Kingdom, between June 4, 2018-June 28, 2018
Varley et al (2020)	Interviews	Unhoused individuals interviews n=36. Healthcare professionals interviews n=25	Mean age of 48, White, African American, Asian/Pacific Islander or Native American, other, male and female, unhoused, healthcare professionals.	Birmingham, Alabama, and Boston, Massachusetts, 2009
Warren, Gilmore, and Wright (2021)	Phenomenological case study. Interviews	N=6	Age range 32-69, race NR (Source: pg. 2, pg. 3), male and female, unhoused	Recruitment city NR (Source: pg. 1-3), England, United Kingdom, 2017
Wise and Phillips (2013)	Phenomenological approach. Interviews	N=11	Age range 21-54, Black, White, Middle Eastern, German, male and female, homeless	Knoxville, Tennessee, year NR (Source: pg. 1-5)

Theme 1: Systemic Stigma in Healthcare Settings

Across the included studies, participants consistently described experiences of stigma within healthcare settings that extended beyond isolated interpersonal bias. In this synthesis, systemic stigma refers to patterned and institutionalized forms of moral judgment, stereotyping, and differential treatment that are embedded within healthcare environments and activated once homelessness becomes known or perceived. Rather than representing individual provider attitudes alone, systemic stigma reflects structural assumptions that frame people experiencing homelessness (PEH) as irresponsible, drug-seeking, noncompliant, or undeserving of care. Across diverse geographic contexts and clinical settings, participants reported that their housing status shaped how providers interpreted symptoms, determined treatment decisions, and engaged in clinical communication.

This theme captures how stigma operates simultaneously at interpersonal, clinical, and institutional levels. Participants described shifts in provider demeanor, reduced thoroughness in examinations, premature diagnostic conclusions, and assumptions about motives for seeking care. The recurrence of these accounts across all 15 included studies suggests that stigma functions as a systemic feature of healthcare delivery rather than an isolated behavioral issue. To further explain how systemic stigma operates within healthcare encounters, three interrelated subthemes emerged: (1) moral judgment and stereotyping by healthcare providers, (2) clinical dismissal and differential treatment, and (3) internalized stigma, shame, and care avoidance.

Subtheme 1: Moral Judgment and Stereotyping by Healthcare Providers

Participants frequently described experiencing moral judgment and stereotyping from healthcare providers once their homelessness was known or perceived. One participant succinctly stated how pervasive this stigma feels: *"People will judge me everywhere, doctors, nurses, chemists and that's the truth. (W 32)"* (Warren et al., 2021). This quote reflects how PEH experience judgment as an unavoidable reality, shaping how they anticipate and engage with healthcare systems. Such judgment contributes to feelings of shame and reinforces expectations of negative treatment.

Several participants described being stereotyped as drug users, regardless of their presenting health concerns. As one participant explained, *"Not everyone who's homeless is on drugs. They assume things about us"* (Henderson et al., 2022). This excerpt illustrates how healthcare providers may equate homelessness with substance use, resulting in assumptions that influence clinical interactions and patient care.

Others described more overt forms of devaluation and social exclusion. One participant stated, *"Being homeless- I mean people look at you as though you're*

a low life, piece of crap. I mean, you're a drug addict and everything else. You're not worth the shit that you sleep in [..]. You're restricted because of the way you look. You're on the street. You don't have a place. Doors are shut. People just shun you and everything else (FG9B)" (Purkey et al., 2019). This quote demonstrates the dehumanization PEH experience, as well as feelings of isolation, worthlessness, and lack of support, all of which shape their interactions with healthcare providers.

Participants also noted how stigma became immediately visible in provider behavior. One participant remarked, *"As soon as they know you're on the streets you can see their face change like I stink of something. They just talk to you badly and don't bother with you no more. (F, 54)"* (Warren et al., 2021). This quote highlights perceived shifts in provider demeanor and a lack of empathy once homelessness is disclosed.

Appearance-based judgments further reinforced stigma. One participant reflected, *"Homelessness just in itself has sort of a stigma or even looking homeless or not having average clothing, just being bulky or having a coat. It's big and it's kind of old. Just gives that stigma and they're like, 'Oh, he's homeless, we can make him wait. He didn't really have anything to get back to, he doesn't pay taxes, he doesn't do this, he doesn't do that'"* (Nicholas et al., 2016). This quote underscores how visible markers of homelessness contribute to assumptions about worth and entitlement to care, reinforcing differential treatment.

Subtheme 2: Clinical Dismissal and Differential Treatment

Beyond moral judgment, participants described how stigma translated into clinical dismissal and unequal treatment within healthcare settings. One participant expressed this bluntly: *"They treat us like shit because we're scum"* (Nicholas et al., 2016). This statement reflects both the emotional harm experienced by unhoused individuals and their perception of how they are viewed by healthcare providers.

Participants frequently described being dismissed as seeking shelter rather than medical care. One participant explained, *"They (the staff) were just, like, 'You're homeless. You're just looking for a bed, so we're going to make you wait all night and then treat you like shit in the morning,' pretty much"* (Nicholas et al., 2016). In this account, healthcare providers assumed the participant's motive for seeking care rather than conducting appropriate medical assessments, limiting the quality and timeliness of care.

Similarly, another participant described being categorized and not taken seriously once their housing status was known: *"If you go into their emergency room, and they know you're homeless, you get kind of like, categorized, and not really taken seriously and [staff don't] want to go into real detail or depth with you. [They seem to], give you an antibiotic and send you on your way"* (Saharan et al., 2021). This quote illustrates how stigma influences clinical decision-making, resulting in superficial treatment and reduced provider engagement.

Subtheme 3: Internalized Stigma, Shame, and Care Avoidance

Participants also described how repeated stigmatizing encounters led to internalized shame and avoidance of healthcare services. A service provider noted, *"Overwhelmingly, with most [FSD patients] ... there's an underlying sense of shame about their life circumstances and they feel that they've failed or they don't fit into society. So, people in that situation ... in my experience ... they underuse medical services relative to their needs (Service provider)"* (Strange et al., 2018). This observation highlights how stigma contributes to reduced healthcare utilization among PEH.

Participants echoed this experience directly. One stated, *"If you are homeless you are like not well taken care of, so people may be ashamed to go to a clinic. CM34"* (Ungpakorn et al., 2019). This quote demonstrates how anticipated judgment discourages PEH from seeking care. Another participant emphasized how differential treatment reinforces expectations of poor care: *"They (hospital staff) treat us differently because we're on the street"* (Nicholas et al., 2016). Such experiences reinforce internalized stigma and further discourage engagement with healthcare services.

Table 2. Themes extracted from original studies

Author and Year	Extracted Themes/Study Findings
Bennett-Daly et al (2021)	Personal vulnerability (client level theme), hardship and adversity (subtheme), homelessness (subtheme), lived experiences and wellbeing (subtheme), lack of empowerment (subtheme), disconnectedness (system level), gaps in or between services (subtheme), social stigma and social expectations (subtheme), expense of services (subtheme), acceptability of the MHNC (Mission Health Nurse-led Clinic) (service level), rapport and trust (subtheme), continuity of care (subtheme), drop-in and fee-free service (subtheme), client advocacy (subtheme), and health promotion (subtheme).
Gunner et al (2019)	Organization and delivery of services, patient registration at general practices (subtheme), integration of services (subtheme), continuity of care (subtheme), waiting times and appointment lengths (subtheme), patient-related factors, patient's knowledge and awareness of primary healthcare services (subtheme), patient's resources (subtheme), patient's feelings and emotions (subtheme), social exclusion and stigma, and GP awareness of the complex healthcare needs of people who are homeless.
Henderson, McCurry, Deatrick, and Lipman (2022)	Men who are homeless experience bias throughout their health care and interpersonal relationships, the best care is person-centered and considers patients' priorities, and care coordination resources are inadequate.
Meehan et al (2023)	Health care settings, elements shaping health care experiences, ability to access health care (subtheme), level of clear communication from health care facilities and staff (subtheme), ease of securing timely follow-up care (subtheme), respect vs stigma or discrimination (subtheme), current perceptions of health care, positive perceptions (subtheme), neutral perceptions (subtheme), and negative perceptions (subtheme).
Moore-Nadler, Clanton, and Roussel (2020)	Social determinants of health with subthemes of lack of housing and employment opportunities, inadequate psychosocial support, and barriers to health care, compromised system with subthemes of former institutionalization, insurance status, community infrastructure, and interagency competition for resources, professionalism with subthemes of ethics, communication, advocacy, social responsibility, and social identity, dehumanization with subthemes of stereotyping, objectification, groupthink, and bias, engagement with subthemes of health care providers' lack of cultural competency regarding the culture of homelessness, the resilience of those experiencing homelessness, empowerment, and having a voice, and downward trajectory with subthemes of hopelessness, learned helplessness, survival mode, and opting out
Moore, Manias, and Gerdtz (2011)	Complexity of care needs, respect for homeless people and co-workers, engagement as a key strategy in continued care, lack of after-hour services, lack of appropriate accommodation, and complexity of services.
Nicholas et al (2016)	Difficult youth/staff interactions, youth (minor) status downplayed in ways that disadvantaged SI youth, negative impact of street involvement on ED care, youth response in the form of abbreviated care and ED avoidance, broader system gaps, and recommendations for improved services.
Paradis-Gagné, Jacques, Pariseau-Legault, Ahmed, and Stroe (2023)	Worrisome health and social needs, non-use of healthcare services, and what connects us to health services.
Purkey and MacKenzie (2019)	Experiences and consequences of stigma and shame when accessing healthcare, inflexibility of the healthcare system, lack of accountability of the healthcare system towards equity-seeking populations, and positive experiences that warrant discussion for what they teach us about potential improvements.
Saharan, Balachander and Sparke, (2021)	Interactions with healthcare personnel, interactions with health services, navigation of health and food systems, and resilience.
Strange et al(2018)	Doctor–patient empathy, better understanding of patient circumstances, fostering of social capital, facilitating referral pathways, and supporting the transition to mainstream general practice.
Ungpakorn and Rae (2019)	A human connection, street outreach as a bridge, and the right approach.
Varley et al (2020)	Accessibility, continuous healing relationships or continuity of relationships, shared knowledge and free flow of information, patient as a source of control, coordination of care, accountability, cooperation, evidence-based decision-making, homeless-specific needs, substance use and mental health, and trust and respect.
Warren, Gilmore, and Wright (2021)	Impact of previous healthcare experiences, benefits of embedding healthcare within the shelter, and future service development.
Wise and Phillips (2013)	Same/different, fair/unfair, freedom/barriers, and choice/no choice.

Feelings of rejection and social exclusion were also prominent. One participant explained, *"... that feeling too when you are homeless... it's very hard ... you feel isolated and you feel ... that you are not part of the community anymore. So going to a normal GP ... it's a very difficult thing to do. Because it's [homelessness] not something that you can just get out of straight away. It takes time to get housing ... and the FSD sympathetic to that ... and safe and there's understanding ... because you do ... you feel rejected ... rejected by society ... by the community.* (Female, aged 32 years, living in a refuge)" (Strange et al., 2018).

Across these accounts, recurring patterns of moral judgment, stereotyping, and clinical minimization reveal how stigma operates as a structural mechanism within healthcare systems. While related to dehumanization and emotional harm (addressed in later themes), systemic stigma specifically captures the institutional logic that frames homelessness as moral failure rather than structural vulnerability. This distinction is critical because it shifts responsibility away from individual patient behavior and toward healthcare environments that normalize suspicion and diminished care for unhoused individuals. By synthesizing narratives across multiple studies, this analysis demonstrates that stigma not only harms patients interpersonally but also shapes diagnostic decision-making, limits care quality, and contributes to anticipatory avoidance of healthcare services. Recognizing stigma as systemic reframes healthcare avoidance not as noncompliance, but as a rational response to repeated experiences of institutional harm. This has direct implications for trauma-informed practice, provider education, and structural reforms aimed at promoting equitable healthcare access.

Theme 2: Financial Inaccessibility and Cost-Related Avoidance

This theme captures how financial constraints directly prevent people from accessing healthcare, often forcing them to delay care, self-manage serious health conditions, or avoid treatment altogether. Participants repeatedly described cost, not only of treatment, but also prescriptions, insurance gaps, and transportation as a defining factor in decisions about whether to seek care. Across the studies, participants described weighing health needs against the risk of financial harm, by frequently choosing to endure worsening symptoms rather than incur additional debt. These accounts illustrate how healthcare is experienced as a commodity rather than a guaranteed right.

One participant described how past medical debt shaped ongoing health decisions:

"I have not gone to a doctor because I've already filed bankruptcy once. I really don't want to have to file it again. There's been times that it's like, 'Okay, let's play the game panic attack or heart attack'" (Meehan et al., 2023). This quote highlights how the long term consequences of medical debt create lasting barriers to care. Even when faced with serious or potentially life threatening symptoms, fear of additional financial burden discouraged help seeking, demonstrating how financial precarity becomes internalized as a reason to avoid care.

Providers working with vulnerable populations similarly acknowledged that cost frequently excluded individuals from care options entirely: *"Most of our clients [don't] have the money to pay the gap . . . there wasn't really places we could send because most of the clients who come to us have no money (MHNC staff, 11)"* (Bennett-Daly et al., 2021). This account illustrates how structural cost barriers limit even well intentioned care networks. The financial "gap" between coverage and out-of-pocket expenses remained insurmountable for many, leaving both patients and providers without viable pathways to care.

Financial inaccessibility was particularly evident during moments of medical crisis. One participant described being discharged from the hospital without the means to complete prescribed treatment: *"Morrie: I got this huge infection in my gut, you know. So I'm there for like 11, 12 days, like that. So then they say, 'Okay, you're all better,' you know, 'And here—here's your prescription for antibiotics. Make sure you take 'em all.' And I said, 'I don't have any money. I don't have any insurance'"* (Wise & Phillips, 2013). This account illustrates the disconnect between medical recommendations and financial feasibility. Despite receiving inpatient care for a serious infection, the inability to pay for prescribed medication created a barrier to recovery and continuity of care.

In some cases, limited access to funded treatment options led individuals to take extreme measures to obtain support. One participant explained: *"I wanted to come off alcohol that bad they said it was killing me,*

but they couldn't have no funding until April... I got self-sent to prison for 3 weeks so they could help detox me (M, aged 34 years, SA)" (Gunner et al., 2019). This quote reveals the lengths to which individuals may go when timely treatment is unavailable. Access to care was determined not by urgency or medical need, but by funding availability, thus underscoring the structural failures embedded within healthcare systems.

Financial barriers were further compounded by dismissive responses from healthcare providers. One study reported the following interaction: *"As an example, following a request from a youth for assistance relating to an unfeasible fee for a needed prescription, an HCP's response reportedly was, 'Get some money!'"* (Nicholas et al., 2016). Rather than addressing the financial obstacle, this response reinforced exclusion and discouraged future help seeking. Such encounters undermined trust in healthcare systems and intensified perceptions that care was inaccessible to those without financial means.

A consistent pattern emerged across these accounts: financial barriers weren't just about lacking money, but about being systematically excluded from healthcare systems. Participants described an impossible choice between paying for treatment and meeting their basic survival needs, which led to delayed care, avoidance, or desperate alternatives. Our findings show how inadequate funding, insurance gaps, and provider responses work together to restrict care access, deepening inequities and worsening health risks for people experiencing homelessness. Over time, these repeated experiences of financial exclusion and unmet healthcare needs created a broader pattern of care avoidance. Healthcare systems became associated not just with economic barriers but with psychological distress, leading to fear-driven decisions to delay or completely abandon seeking care.

Theme 3: Fear-Based Avoidance of Healthcare Systems

This theme captures how people experiencing homelessness develop fear-driven avoidance of healthcare systems rooted in mistrust, prior negative experiences, and the belief that seeking care may cause further harm. Participants described deliberately avoiding medical services because they expected judgment, mistreatment, or emotional distress. For many, hospitals and clinics were not seen as places of healing but as institutions tied to stigma, dehumanization, and retraumatization. Healthcare avoidance functioned as a coping strategy shaped by trauma, systemic exclusion, and survival priorities, not simply by inconvenience or lack of awareness.

One participant articulated a long-standing avoidance rooted in fear and collective narratives: *"I've tried to avoid them, my whole life. I just… I've heard too many bad stories"* (Nicholas et al., 2016). This account reflects internalized fear reinforced by shared community experiences, thus showing how avoidance can develop even without direct personal harm. Once established, fear overrides the perceived benefits of medical care and contributes to delayed treatment and deteriorating health. Another participant described healthcare as a last resort, only accessed in moments of extreme crisis:

"The people in the street are not going to go there . . . Why don't they go? It's often personal. They don't want to. Do you understand what I mean? Unless, like I told you, they're bleeding. Or if they have a physical injury. When it's a physical injury, when it's permanent, when it becomes chronic . . . But, apart from that, the homeless people I know, they don't really use the hospitals. They try to get through their injuries . . . They don't give a damn about their health (P7)" (Paradis-Gagné et al., 2023).

This narrative demonstrates how healthcare is perceived as emotionally draining and inaccessible, leading people to endure illness or injury until care becomes unavoidable. Avoidance reflects fear of being judged, dismissed, or mistreated within healthcare settings.

Participants also described engaging in self-management strategies to prevent illness and avoid medical encounters altogether. One individual explained, *"When it's cold season I try and do extra vitamin C like juices and stuff just to try and prevent getting sick because once you get sick and you're homeless it's like the worst," adding that "something has to be really seriously bad usually for me to go to the doctor"* (Saharan et al., 2021). This reliance on preventive self-care highlights both limited access and intentional avoidance. Medical care was framed as a last resort, delayed until conditions became severe due to previous discrimination or negative experiences within healthcare systems.

Fear-based avoidance was often reinforced by direct experiences of stigma and dehumanization. One participant stated, "*They treat us like shit because we're scum*" (Nicholas et al., 2016). Another echoed this sentiment more starkly: *"Death, death may suck, but it's better than the emergency room"* (Nicholas et al., 2016). These statements reveal the profound emotional harm associated with healthcare encounters. For some, the anticipation of mistreatment was so severe that it outweighed concerns about serious illness or injury. Additional participants described feeling objectified and diminished within healthcare settings. One recalled, *"the last time I went to the doctor I felt like cattle…I'm somewhat disillusioned (MHNC client, 10)"* (Bennett-Daly et al., 2021). This comparison underscores perceptions of being treated as less than human, reinforcing mistrust and disengagement from care.

Experiences of differential and discriminatory treatment further intensified fear. One participant described, *"When we go GP or like er healthcare, no matter dentist or anything, it's different. Some it's very good at treat[ing] like same (equally) but some we feel like racist. We got problem[s], ill[ness], but you treat us like this. We're humans, we are human[s] (F, aged 35 years, SB)"* (Gunner et al., 2019). This quote highlights how inconsistent and discriminatory treatment undermines trust, reinforcing avoidance even when respectful care is occasionally encountered. Fear-based avoidance appeared consistently throughout these accounts as a common response to the stigma, emotional harm, and retraumatization participants anticipated in healthcare settings. Many described putting off or skipping care entirely because they feared being judged, dismissed, or treated as less than human, thus often suffering serious health consequences as a result. These patterns point to deeper failures in how healthcare institutions operate, eroding trust and widening existing inequities. Reducing fear-based avoidance means more than just making care available; it requires creating compassionate, non-judgmental, trauma-informed environments that truly acknowledge what people experiencing homelessness have been through. Participants also identified structural barriers built into healthcare systems themselves. Bureaucratic red tape and poor access to information made it harder to seek care, even for those who wanted to engage with services.

Theme 4: Barriers Due to Bureaucracy and Lack of Information

Bureaucratic complexity and lack of clear information repeatedly blocked participants' access to healthcare. People experiencing homelessness described running into administrative roadblocks such as requirements for documents they didn't have, confusing registration steps, and uncertainty about which services they could actually use. Study after study revealed the same pattern: participants wanted healthcare but couldn't get it, not because they weren't trying but because the system itself stood in their way. These repeated rejections bred frustration, hopelessness, and a growing distrust of healthcare institutions. One participant described the challenges of meeting documentation requirements while unhoused:

"Getting proof of address when you're on the streets you don't have an address so it does get quite difficult and like I managed to get erm my uncle to let me stay with him for a while, get some bills sent there er like my bank statements stuff like that so I could actually get a GP … I know several people who have been coughing up blood and all that kinda stuff but they can't get in to see a GP coz they can't register (male, (M), aged 24 years, shelter A (SA))" (Gunner et al., 2019).

This account illustrates how standard administrative requirements, such as proof of address, conflict with the realities of being unhoused, effectively excluding individuals from primary healthcare access despite serious medical need.

Another participant described losing access to essential documentation after fleeing domestic violence, thus emphasizing how changing life circumstances can make bureaucratic processes unmanageable:

"Because you know … when you've got all this going on … you haven't got access to your paperwork … you haven't got the same mental capacity when you are in that emotional turmoil … to do these things. It all sounds very simple. I was a manager you know … so I was really able to fill paperwork out and be organised. But then yeah … but after … [in these circumstances] it's too much … (female, aged 41 years, with domestic violence history relocated to hostel from the street)" (Strange et al., 2018).

This quote shows how bureaucratic systems are designed for people with stable housing, reliable phone access, and proper documentation—circumstances that vanish during crisis. The participant's frustration reveals how administrative barriers become unbearable when someone is also dealing with trauma and emotional distress.

Other participants expressed confusion and frustration with healthcare access even when coverage existed. One participant asked, *"So why do I even have medical coverage if nobody takes it?"* (Henderson et al., 2022). This statement reflects the disconnect between having insurance and being able to successfully navigate provider networks and eligibility requirements. Participants also described how learning disabilities, mental health conditions, and substance use further complicated healthcare navigation. One individual explained: *"People have dyslexia … learning difficulties, people that maybe are on drugs or addictions will not be able to maybe erm get through so easy in signing up to a GP because of their mental state, personality disorder, erm also not understanding the waiting times and procedures, they get frustrated (M, aged 30 years, SA)"* (Gunner et al., 2019). This quote illustrates how bureaucratic systems often fail to accommodate cognitive, emotional, and mental health challenges, increasing frustration and limiting access for those already facing significant barriers.

These challenges were echoed by service providers, who observed that navigating multiple systems and appointments was often unrealistic for individuals in crisis. One provider noted: *". . . if they're in a sensitive state, you know, a mental health state, then they don't necessarily have it in them to chasing multiple locations and multiple services (MHNC staff, 15)"* (Bennett-Daly et al., 2021). This account reinforces how mental health challenges can further restrict an individual's capacity to manage complex healthcare systems.

Finally, participants emphasized that lack of information about available services was itself a barrier to care. One individual stated: *"There's a lot of things that Medical covers that a lot of people don't know about that they kind of just have to somehow, someway find out about"* (Saharan et al., 2021). This quote highlights how limited access to clear, accessible information can prevent individuals from seeking care they may otherwise be eligible to receive.

Bureaucratic complexity and lack of accessible information consistently emerged as major barriers to healthcare for people experiencing homelessness. Participants described how administrative requirements, missing documentation, limited health literacy, and confusing systems prevented them from getting timely, appropriate care. Trauma, mental health struggles, and unstable living situations made these barriers even harder to overcome, leading to frustration and withdrawal from healthcare systems. These findings show how bureaucratic processes built for people with stable housing can unintentionally shut out those experiencing homelessness, deepening inequities and restricting access to essential care. Even among participants who managed to navigate these administrative hurdles, many encountered dehumanizing treatment during their healthcare visits. These experiences took a serious psychological toll, reinforcing distrust of the system and influencing whether they would seek care in the future.

Theme 5: Dehumanization and the Emotional Toll of Healthcare Encounters

Throughout the studies, participants recounted healthcare visits that left them feeling dehumanized and emotionally wounded. These experiences bred deep, long-lasting distrust and made them hesitant to return. People experiencing homelessness described being treated as if they were undeserving of care, morally deficient, or somehow less human. This treatment didn't just hurt in the moment; it made seeking care feel emotionally risky and confirmed suspicions that healthcare systems were dangerous, indifferent, or openly hostile. For many, being repeatedly dehumanized meant that going to the doctor became something that caused harm rather than provided help.

One participant contrasted experiences in emergency departments with mobile clinics, by emphasizing how differential treatment shaped trust and engagement:

"At the emergency, they take their time. They go see another patient before you, and this and then. With the mobile clinic, you go right up to them. They reach you. They ask you: 'What's wrong?' And you tell them what's wrong. And then, they deal with it right there and then. It's like with the doctors, they take their time,

do whatever they have to do before anything else. And then, by the time they get to you, there's no point in . . . what's the point of staying? (P8)" (Paradis-Gagné et al., 2023).

This account illustrates how being deprioritized and treated as unworthy of attention led participants to disengage from care altogether.

Another participant described being denied treatment despite experiencing a medical emergency:

"I had passed out and they said my lungs were fluctuating like this. And when I got to the hospital and checked in and worked on and at the end of the visit I was told I didn't warrant being checked in because I was homeless. And I was told the doctor wrote out a prescription but they did not give it to me because they were afraid I was going to sell it on the streets" (Moore-Nadler et al., 2020).

This narrative reflects how assumptions about homelessness and substance use resulted in denial of care and reinforced perceptions of being viewed as untrustworthy and undeserving.

Participants also described overtly demeaning and exclusionary language used by healthcare staff. One individual shared that hospital staff told her *"'your kind' [ie the unhoused] would be better off in cities like Santa Cruz. Like there are better cities for you to be homeless in and your kind should go there"* (Saharan et al., 2021). Such language reflects explicit dehumanization and contributes to lasting emotional harm and alienation from healthcare systems.

Another participant recounted a particularly hostile encounter:

"So they admitted me and the intern that came in the following morning he just flat out told me that in no certain terms that he wasn't going to keep me in the hospital or do anything about it because I was homeless and all homeless are the same, just a bunch of junkies and drunks looking out for a fix. And for me to come back when I had insurance and a residence and they would find out why I was bleeding and having abdominal pain. And until then get the hell out. Those were his words. And like okay" (Moore-Nadler et al., 2020).

This account demonstrates how stigmatizing assumptions translated into explicit denial of care, intensifying emotional distress and mistrust.

Participants also described being discharged into unsafe conditions without regard for their living circumstances:

"Later about fiveish we went to a little ward bit and they said I could stay the night cos I had pneumonia and cracked ribs cos of the coughing. About sevenish a doctor came and said I could go home. I told him I was told I could stay the night but he said I was discharged. I told him I was staying in a tent and he said not to get wet. I had to walk back to the tent from the hospital. They gave me some pills and that was that. I'm used to it but I haven't felt that rough before. (M, 67)" (Warren et al., 2021).

This narrative highlights how disregard for patients' living conditions contributed to feelings of worthlessness and neglect.

Several participants described being detached from clinical decision-making and labeled without dialogue. One participant explained:

"He actually called me a pill head. What are you talking about? How can you make that diagnosis on me and we haven't even had a conversation about it? You just looked at the drug screen and come up with your own conclusion. You didn't come here and say 'Well, what's going on witcha? You came up positive on this drug screen. What's the problem?' None of that conversation took place. I come in, he decided I was a pill head, gave me some Tylenol and told me to go home. (VA Patient)" (Varley et al., 2020).

This experience illustrates how dehumanization occurs when individuals are reduced to assumptions rather than engaged as patients. Participants also described being discharged while medically unstable: *"I took some heroin and passed out… They gave me an injection… and before I know it, I'm out the door… I was feeling bad and was unsteady"* (Warren et al., 2021). Another participant stated: *"When I went back they said Mr. you don't have insurance, we already told you what it was, and we aren't going to see you"* (Moore-Nadler et al., 2020).

Throughout these narratives, dehumanization stood out as a key force driving healthcare avoidance and emotional harm among people experiencing homelessness. Participants described being treated

as unworthy, disposable, or morally suspect. This type of treatment caused deep emotional pain and shattered trust. These weren't isolated incidents but part of broader patterns of exclusion that made people even more reluctant to seek care. The emotional damage from repeatedly being dehumanized creates a critical barrier to healthcare engagement and highlights the urgent need for trauma-informed, dignity-centered approaches in healthcare systems. This dehumanization was especially severe when participants sought help for mental health concerns. Mental health needs were often sidelined or ignored completely, showing how dehumanization and systemic exclusion shaped clinical decisions and service delivery.

Theme 6: Marginalized Mental Health Needs within Fragmented Healthcare Systems

Mental health support for people experiencing homelessness is routinely overlooked, dismissed, or poorly handled within healthcare systems. Participants repeatedly described hitting walls when they tried to get mental health care. A common thread ran through the studies: providers treated mental health concerns as secondary issues, focusing instead on housing status, substance use, or perceived instability. This meant that when people were in crisis and desperately needed mental health support, they couldn't get it. These accounts point to a troubling reality: the system fails people experiencing homelessness at their most vulnerable moments.

One participant described a first attempt to seek mental health care during a crisis, stating,

"My first time for asking for help medically was horrible, when I had my mental health breakdown two years ago. I had never had a problem with my mental health before, never ever. I'd got a bit depressed before but this time I ended up getting sectioned because I was on the streets and I kept asking for help and getting, no, no, no, no, no, no, no. (M, 49)" (Warren et al., 2021).

This account shows the deep frustration and vulnerability that comes from asking for help over and over, only to be turned away. The participant's experience reflects a larger system failure: instead of treating housing instability as a reason to provide urgent mental health care, the system uses it as an excuse to deny care altogether.

Another participant reinforced this sense of exclusion from mental health services, stating,

"... I self-harm a lot right I've had a lot of suicide attempts but what [the mental health services] ... if you've self-harmed within the last 6 months they won't touch you as well as if you're on the alcohol or drugs as well they won't touch you because they think you're too high of a risk ... you shouldn't be using [recreational drugs] to self-medicate but when you don't have access to the services what else are you meant to do? (M, aged 24 years, SA)" (Gunner et al., 2019).

This quote illustrates the paradox faced by individuals whose mental health needs are deemed too complex or risky for services designed to provide care. Rather than receiving support, participants described being excluded from treatment, reinforcing harmful coping mechanisms and deepening cycles of distress.

Participants also emphasized how mental health concerns were frequently minimized or dismissed, even when symptoms manifested physically. One individual shared, *"The depression is bad and manifests itself into physical pain, phantom pains which I know are associated with my depression. I get really low sometimes and to have people just dismiss it, to show no understanding of that is just terrible, it's the worst thing ever. (M, 49)"* (Warren et al., 2021). This experience underscores the interconnected nature of mental and physical health, while revealing how dismissal by providers exacerbates suffering and reinforces feelings of invisibility and isolation.

For some participants, the debilitating effects of mental illness directly interfered with their ability to access care. One individual explained, *"Oh, my mental health, I suffer from severe depression . . . . I end up being in bed for weeks at a time. So, sometimes I miss my appointments because I'm not in the right place to go there and as medical practitioners they should be aware of that (MHNC client, 7)"* (Bennett-Daly et al., 2021). This account highlights the mismatch between rigid healthcare structures and the realities of severe mental illness. Participants emphasized the need for greater flexibility and understanding from providers when mental health symptoms themselves become barriers to engagement.

Finally, participants and service providers alike described how fragmented healthcare systems fail to

address co-occurring conditions holistically. As one provider explained,

"We are actually talking about people, who have triple problems, with drug and alcohol, mental health and a health problem, so you try to work within three areas, everybody segmented and everybody sees a different person, and then you talk about another thing and someone has a brain injury on top of their mental health, on top of everything else, they won't even recognise you ... and everything else [SP13]" (Moore et al., 2011).

This account illustrates how siloed services and lack of coordination create additional burdens for individuals already navigating complex and intersecting challenges.

These narratives consistently expose how mental health systems fail people experiencing homelessness. Participants ran into impossible eligibility rules, services that didn't communicate with each other, endless waits for responses, and rigid policies that couldn't adapt to the chaos of mental illness and housing instability. Mental health systems that should have offered care and support instead pushed people further to the margins. We need integrated, trauma-informed, flexible approaches that recognize mental health care as a basic right for people experiencing homelessness, not something they have to earn. When we look at all these themes together, a clear picture emerges: stigma, financial barriers, fear, bureaucracy, dehumanization, and mental health neglect aren't separate problems as they work in tandem. What becomes visible is a healthcare system fundamentally designed for stable, housed people trying to serve a population whose lives look nothing like that.

Discussion

This qualitative interpretive meta-synthesis examined how people experiencing homelessness encounter and navigate healthcare systems, revealing interconnected barriers that go far beyond individual choice or motivation. The six themes show that healthcare exclusion results from overlapping structural, interpersonal, psychological, and clinical forces. Stigma, financial constraints, bureaucratic complexity, fear-based avoidance, dehumanizing encounters, and neglected mental health needs don't operate separately—they compound over time, making healthcare systems feel inaccessible, unsafe, and untrustworthy to people experiencing homelessness (Miller et al., 2024; Thorndike et al., 2022). These findings reveal that delayed or avoided care is a rational response to repeated systemic harm, not disengagement or noncompliance.

Several themes reveal structural barriers within healthcare systems that systematically exclude people experiencing homelessness. Financial inaccessibility emerged as a central obstacle. Participants described how treatment costs, prescription expenses, insurance gaps, and transportation burdens forced impossible choices between health and financial survival. Even when people recognized severe symptoms, the threat of debt or bankruptcy often outweighed seeking care (Wise & Phillips, 2013). These findings confirm that healthcare systems based on ability to pay inherently disadvantage people living in poverty and housing instability (Campbell et al., 2015; Carmichael et al., 2023; Henderson et al., 2021; Meehan et al., 2023; Wille et al., 2017). Bureaucratic barriers also restricted access, even for those motivated to seek care. Requirements like proof of address, documentation, and navigating complex administrative processes clashed with the realities of homelessness (Carmichael et al., 2023). Limited health literacy, learning disabilities, mental health challenges, and crisis-related stress made these hurdles even harder. Critically, barriers persisted even for people with insurance, showing that coverage alone doesn't guarantee access (Gunner et al., 2019; Lewis et al., 2003; Meehan et al., 2023). These themes expose a healthcare system built for stability, predictability, and administrative competence—conditions that exclude people experiencing homelessness.

Beyond structural barriers, participants described interpersonal and institutional harm within healthcare settings. Systemic stigma was evident as providers made moral judgments, relied on stereotypes, and treated people experiencing homelessness as less deserving of care. Participants were assumed to be drug-seeking, irresponsible, or undeserving of attention, which often without proper assessment (Bruguera et al., 2023; Forchuk et al., 2024; Gunner et al., 2019; King et al., 2020; Meehan et al., 2023; Purkey & Greenle, 2019). These stigmatizing attitudes shaped clinical decisions, communication, and care quality, contributing to

health inequalities and service avoidance (Miller et al 2024). Repeated disrespect, dismissal, and humiliation left participants feeling objectified, degraded, and stripped of dignity (Forchuk et al., 2024; Miller et al 2024). Dehumanization wasn't just interpersonal, it was institutional harm that eroded trust and reinforced the view that healthcare systems were hostile. Many participants left care early, avoided future visits, or emotionally withdrew (Gunner et al., 2019; Purkey & Greenle, 2019). These findings align with research showing dehumanizing treatment powerfully deters healthcare engagement among marginalized populations (Sturman & Matheson, 2020; Thorndike et al., 2022).

Structural and interpersonal barriers produced profound psychological and clinical consequences. Fear-based healthcare avoidance emerged as a learned, adaptive response to repeated negative encounters. Participants avoided hospitals and clinics unless conditions became life-threatening, treating healthcare as a last resort rather than preventive support (Purkey & Greenle, 2019; Sturman & Matheson, 2020). This avoidance stemmed from personal experiences and shared community narratives, where stories of mistreatment circulated and reinforced collective mistrust (Gunner et al., 2019). Mental health needs were especially marginalized. Participants' mental health concerns were dismissed, delayed, or deemed too complex due to co-occurring substance use, housing instability, or physical health conditions (Bennett-Daly et al., 2021). Rigid structures, fragmented systems, and exclusionary eligibility criteria left many without support during acute psychological crises (Everdingen et al., 2021). These findings expose a critical contradiction: those at highest risk are often deemed ineligible or "too complex" for care (Priebe et al., 2012). Service fragmentation compounded harm as people with intersecting mental health, substance use, and physical health needs navigated multiple disconnected systems without coordination or continuity (Distasio et al., 2014; Lamanna et al., 2017; Siersbaek et al., 2023; Zucchero et al., 2016).

Implications for Healthcare Practice

The findings carry important implications for healthcare practice. First, they underscore the urgent need for trauma-informed, nonjudgmental approaches that recognize the cumulative harm experienced by unhoused individuals (Bennett et al., 2021; Dobischok et al., 2024; Edgar et al., 2025; Hopper et al., 2010; Lording et al., 2021). Healthcare providers must move beyond deficit-based assumptions and engage patients as whole persons with complex histories and needs. Flexible models of care—such as walk-in clinics, mobile health units, and extended appointment times—may reduce barriers related to fear, avoidance, and administrative burden. Importantly, provider training should emphasize empathy, structural competence, and awareness of how stigma and dehumanization influence health outcomes.

Implications for Policy and Systems Design

These findings show that individual level interventions can't address systemic exclusion. Structural reforms must reduce financial barriers, simplify documentation requirements, and expand low-barrier healthcare services. Policies decoupling healthcare access from housing status, employment, and rigid eligibility criteria could mitigate documented exclusion. Integrating mental health, substance use, and primary care services could reduce fragmentation and improve continuity for people with co-occurring needs (Lamanna et al., 2017; Priebe et al., 2012; Siersbaek et al., 2023).

Implications for Research

These findings highlight the importance of qualitative and participatory research in understanding healthcare access for people experiencing homelessness. Future research should prioritize lived experience perspectives and examine integrated, low-barrier care models. Longitudinal studies could illuminate how repeated stigma, avoidance, and exclusion shape health trajectories. Research centering the voices of people experiencing homelessness can inform more equitable healthcare system design.

Strengths and Limitations

This synthesis draws strength from diverse qualitative studies across multiple healthcare contexts, thus enabling rich examination of shared experiences. Centering participant narratives provides nuanced insight into healthcare exclusion. However, limitations include variability across healthcare systems and geographic contexts, and reliance on secondary data. The literature may overrepresent individuals with particularly negative experiences,

potentially amplifying accounts of harm. Despite this, consistency across studies suggests robust, transferable insights.

Conclusion and Recommendation

These findings reveal a healthcare system fundamentally misaligned with the realities of homelessness. Stigma, financial barriers, bureaucratic complexity, fear, dehumanization, and neglected mental health needs converge to create a system that people experiencing homelessness find inaccessible and unsafe. Addressing these inequities requires more than expanding services. It demands systemic redesign grounded in dignity, equity, and trust. Without change, healthcare systems risk perpetuating the harms they should prevent.

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