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The use of health services by women living homeless in Madrid, Spain

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Abstract

Women living homeless make up a particularly vulnerable and significantly invisible collective, about which there is little information regarding the use of health services. The purpose of this study is to examine the use of health services by a sample of women living homeless in Madrid, Spain ($n = 138$). The information was compiled using structured interviews. Results show that women living homeless largely make use of health services (e.g., emergency care, hospitalization, and out-patient treatment) and tend to feel satisfied with them. However, a significant percentage of women living homeless did not hold a National Health Insurance Card, expressed dissatisfaction with the health services, and said that they did not receive medical care at a time when they considered it necessary. Some of the issues affected, to a greater extent, older women living homeless, foreign women, and those who had abused drugs at some point in their lives.

KEYWORDS
health services, homeless, social exclusion, women

INTRODUCTION

Homelessness represents one of the most extreme manifestations of the phenomenon of social exclusion (Panadero et al., 2015; Vázquez et al., 2017). Among people living homeless, women are particularly vulnerable in some respects (Vázquez et al., 2019), with different needs and life

paths than men in the same situation (Aldridge et al., 2018; Arangua et al., 2005; Matulič et al., 2019). Women are often underrepresented in research on homelessness, and gender issues within people living homeless is generally under-researched (Pleace, 2016; Rodríguez-Moreno et al., 2021). Winetrobe et al. (2017) have pointed out that considering the socially excluded population as a whole limits the rolling out of appropriate health and social security policies, meaning that gender analysis is a key approach to be taken in the field of public health for a better understanding of social and health inequalities (Connell, 2012; Hankivsky et al., 2018).

People living homeless tend to make considerable use of health services, emergency care, and hospital admissions, with notably elevated rates of hospital and emergency department usage compared to the general population (Hwang et al., 2013). This pattern can be seen in different countries with different healthcare systems, both with and without universal healthcare (Bharel et al., 2013; Brown et al., 2013; Hwang et al., 2013). Leonori et al. (2000) stated that of people living homeless in different European capitals, one-third to half of those interviewed received treatment with medication (specifically: Madrid 50%, Rome 50%, Lisbon 42%, Copenhagen 33%, and Brussels 33%). Beijer and Andréasson (2009) found that in Sweden, homeless people were at twice the risk of hospitalization as the general population, and that the youngest women living homeless were the most likely to be taken into hospital. Montgomery et al. (2017) found that in the United States, women living homeless were more hospitalized than men, and that they also visited the emergency department more frequently.

Accidental injuries were a major cause of morbidity and use of emergency medical services among people living homeless in the United States (Mackelprang et al., 2014), have represented around 9% of hospital admissions in this collective in recent years. Meanwhile, Beijer and Andréasson (2009) observed in Sweden that the main causes of hospitalization among younger women in homeless situations included problems linked to exposure to high levels of psychoactive substances and lack of hygiene. Vuillermoz et al. (2017) stated that among women living homeless in Paris, 25% had had at least one untreated health issue in the previous year, mainly for financial reasons (58%), due to a lack of time to seek medical attention (19%), because the medical center was too far away (7%), or because they were waiting for the issue to resolve spontaneously (6). Most had refused to go to see general practitioners and specialists.

In Spain, access to healthcare is universal, meaning that all residents in the country, regardless of their economic means or personal situation, can access full health care. All persons (national and foreign) can access a Health Insurance Card after 3 months of registration in a Spanish municipality. The Spanish National Institute of Statistics (Instituto Nacional de Estadísticas [INE], 2018) reported that in Spain, women aged over 15 years had visited their family doctor more frequently than men, with 29.2% visiting in the previous 4 weeks compared to 21.0% of men. Moreover, a slightly higher percentage of women had been admitted to hospital in the past year, at 8.8% versus 7.2% of men. Tornero et al. (2016) observed that in Seville (Spain) the average age of hospital admission among homeless people was 48; 92% of these were urgent cases, and 10% resulted in self-discharge or escaping. The average stay in hospital for homeless people was 4.8 days longer than the general population, and in-hospital mortality occurred at an average age of 23 years younger than that of the general population. Leonori et al. (2000) noted that Madrid (Spain) is one of the European capitals where the homeless population received more medication and used public health services more frequently. Lenta et al. (2023) found that only 41% of women experiencing homelessness who were interviewed in Madrid perceived their health status as good. This is considerably lower than the 70% of women in the general Spanish population (Instituto Nacional de Estadísticas

[INE], 2018) who hold the same view. Women experiencing homelessness had a higher incidence of health problems such as HIV/AIDS, headaches, accident-related injuries, chronic bronchitis, or asthma than the general Spanish population (Instituto Nacional de Estadísticas [INE], 2018; Lenta et al., 2023). Vázquez et al. (2019) observed that women living homeless in Madrid frequently stayed in shelters overnight and slept less often on the street compared to men. However, women living homeless were found to have worse health than men, with a greater number experiencing serious and chronic illnesses and consuming more medication.

Analyzing different aspects related to the use of healthcare services by women living homeless can help to identify inequalities (e.g., gender, social class, age, substance misuse, and migratory status) that can translate into inequalities of health (Bauer, 2014; Hankivsky, 2012; Vázquez et al., 2021). It is important to examine the level of satisfaction regarding health care services amidst women living homeless. Verbeek (2001) contended that user satisfaction represents a patient-centered gauge that must be implemented to evaluate the quality of health services. The responses of users are acknowledged as pointers of the quality of healthcare services and satisfaction is considered a measure of healthcare outcomes. Surveys of consumer satisfaction are a valuable tool for care providers to enhance quality (Verbeek, 2001).

Instituto Nacional de Estadísticas (INE) (2022) stated that in 2022 in Spain there were 28,552 homeless individuals living in shelters and other similar facilities (76.3% men and 23.3% women), although organizations working with this group consider the number of people living homeless in Spain reach 33,000 people. In Madrid in 2018, there were 2998 people living homeless (Ayuntamiento de Madrid, 2018), with around 16% of them being women (Vázquez et al., 2017). In Madrid there is a lack of specific information regarding the use of healthcare services by women living homeless. The purpose of this study is to examine specific aspects related to the use of health services by women living homeless in Madrid, analyze differences in their use according to variables such as age, nationality, and drug misuse, and find out the satisfaction with health care services among women living homeless. This information can help to carry out actions focused on facilitating access to health services for women living homeless and to improve the quality of these services.

METHOD

Participants

The study was carried out using data obtained from a sample of women living homeless ($n = 138$) in Madrid (Spain). The inclusion criteria for the sample required meeting two conditions: being female and belonging to one of the first three operational categories in the "European Typology on Homelessness and Housing Exclusion" (ETHOS): (1) people living rough, (2) people in emergency accommodation, and (3) people in accommodation for the homeless. All participants were adults, with an average age of 45.5 years (SD = 11.38), and had spent the previous night in a shelter or supervised accommodation for the homeless, on the street, or in other nontraditional sleeping locations such as abandoned buildings or basements. The participating women had become homeless for the first time at an average age of 35.3 years (SD = 14.96) and had spent an average of 75.7 months (SD = 90.54) in this situation.

56.9% of the women interviewed had children, but none lived with them. 22.3% of the participants in the study had not completed their primary education, 32.6% had a primary education, 27.5% had a secondary education; 17.4% had completed some kind of university

studies. 69.5% of the women interviewed held Spanish nationality. 36.8% of the interviewees stated that they had consumed drugs in excess at some point in their lives. During the previous month to the interview, 11.7% of these women had spent some nights on the street or in public spaces.

Procedures

The research adhered to the ethical standards for human research as approved by the Internal Review Board (Comité de Ética de Investigación y Experimentación Animal) of the University of Alcalá (Ref. CEIP/2021/2/027). The research adhered to the ethical standards for human research. The participants in this study were women recruited from homeless shelters, drop-in centers, public spaces, and the streets of Madrid. The research team obtained access to participants through all the facilities in the "Network of Care Centres for People Living Homeless" that serve women. The shelters and drop-in centers offered facilities that guaranteed the interviewees' wellbeing, security, and confidentiality during their interviews. If the women preferred, appointments were arranged to conduct the interviews in more suitable venues (such as a café, park, or shopping center). For women who were homeless, outreach teams arranged for a meeting place and facilitated contact with the interviewees. The priority was to select environments that afforded comfort, safety, and privacy to the interviewees. Upon initial contact, the interviewers introduced themselves, requested cooperation, and ensured that the participants met the inclusion criteria. Due to the limited number of women living homeless who spent the night in shelters, supervised accommodation, on the street, or in public spaces, all eligible women who were contacted were invited to participate in the study. No incentives were offered to participants, and they were free to withdraw their data at any point during the interview.

To minimize any communication or language obstacles, we conducted a structured interview to collect data. The questionnaire utilized was a gender-specific adaptation of a prior survey on Madrid's homeless population (Vázquez et al., 2017, 2019), adjusted to fit the unique needs of female respondents. The interview focused specifically on issues affecting women, such as stressful life events (such as sexual assault, sexual exploitation, and unwanted pregnancies), women's health concerns (such as Pap smears, mammograms, contraceptive use, and terminations of pregnancy), working conditions, gender-based violence, and motherhood. After explaining to participants the aims of the study and how their data would be handled, they were requested to give their informed consent while assuring them of their anonymity throughout. The interview sessions lasted between 45 and 80 min. Protocols for the management of participant distress were developed and discussed with participants before their interview.

The SPSS statistical analysis and data management system was used to develop and process the database. Comparisons were made using the Chi-squared statistic (χ^2) for nominal variables (such as drug misuse and nationality) and the Student t test for independent samples for continuous variables (such as age). To maintain confidentiality, only aggregate data was utilized.

RESULTS

Table 1 shows how in the year before the interview, the majority of women living homeless in Madrid had access to some kind of medical attention. Over half of them said that they had received emergency medical attention, mainly due to illness or health problems and, less

commonly, after an accident or assault. Over a third had been hospitalized at least one night in the year before the interview, mainly due to illness or health problems or to undergo surgery of some kind; to a lesser extent having suffered an accident or assault.

The women who had been hospitalized for at least one night in the year before the interview were older, on average, than those who had not: 48.3 years old (SD = 9.40) versus 43.7 years old (t (133) = −2.93; $p = 0.023$). Furthermore, the women taking part in the study who reported excessive drug use at some time in their life had used emergency hospital services more in the year before the interview (73.5% vs. 50.0%; $\chi^2 = 7.029$, $p = 0.006$; $\varphi = 0.230$).

It can be seen from Table 2, that over three-quarters of those interviewed were under some kind of medical treatment, and almost 90% had taken prescription medication in the previous 2 weeks. Twenty-two percent of the women questioned declared that on occasion they had not

TABLE 1 Use of health services in the year before the interview by women living homeless in Madrid.

		Reason for use % ($n = 138$)			
	Use in past year % ($n = 138$)	**Diagnosis or health issue**	**Accident**	**Assault**	**Surgical intervention**
Out-patient treatment	91.0% (122)	60.2% (62)	1.9% (2)	1.0% (1)	—
Emergency medical services	57.8% (78)	82.1% (64)	19.2% (15)	6.4% (5)	—
Admission to hospital for at least 1 night	37% (50)	71.2% (37)	13.5% (7)	5.8% (3)	26.9% (14)

TABLE 2 Medical treatment, perception of health services and difficulties in accessing healthcare among women living homeless in Madrid.

	% ($n = 138$)
Under medical treatment during the month before the interview	78.5% (106)
Taking medication in the two weeks before the interview	86.7% (117)
Medication consumed under medical prescription[a]	91.3% (105)
Needed medical care on some occasions and did not receive it	21.8% (29)
Holds a Spanish Health Card	76.9% (103)
Satisfaction with health services	
Very satisfied	33.6% (44)
Quite satisfied	27.5% (36)
A little satisfied	9.2% (12)
Neither satisfied nor dissatisfied	13.0% (17)
A little dissatisfied	6.9% (9)
Quite dissatisfied	2.3% (3)
Very dissatisfied	7.6% (10)

[a]Of the interviewees who consumed any medicine.

received the medical care they considered necessary. 70.3% of the interviewees said that they were satisfied with health services, while 16.8% expressed dissatisfaction.

The women who had used drugs in excess at some point in their lives were receiving medical treatment to a greater extent during the month before the interview (91.8% vs. 70.2%, $\chi^2 2 = 8.467$, $p = 0.002$, $\varphi = 0.252$), and more of them considered that they had needed medical attention at some point but did not receive it (36.7% vs. 14.3%; $\chi^2 2 = 8.374$, $p = 0.004$, $\varphi = 0.253$). On a scale of 1 to 7 (1 being "very dissatisfied" and 7 being "very satisfied"), the women who had abused drugs to excess at some time in their lives tended to be less satisfied with health services in general, with an average score of 4.81 (SD = 2.028), significantly lower than the average score of 5.55 (SD = 1.679) among those who had not abused drugs (t (82.031) = −2.120; $p = 0.037$).

The women of Spanish nationality interviewed mostly held a Spanish health card (i.e., a personal administrative document to identify a user of the Spanish National Health System and proving their right to public health care) than those who did not hold Spanish nationality (84.2% vs. 59.0%; $\chi^2 = 9.902$; $p = 0.007$; $\varphi = 0.227$). Of the 31 women interviewed who did not hold a health card, 10 stated that they did not due to not holding residence documents, six said that they had lost it, four had had it stolen, five were in the process of obtaining it, and three gave other reasons: reluctance to go through the administrative process, not knowing about it, or not requiring it. Half the women who did not hold a health card at the time of the interview had held one in the past, meaning that the National Health Service had their diagnosed medical history on file.

DISCUSSION AND CONCLUSIONS

The women living homeless interviewed in Madrid presented a high usage of health services, with 78% under medical treatment and almost 90% taking some kind of prescription medication. This high rate of use of healthcare resources among homeless women in Madrid is consistent with the high prevalence observed in this group of women with disabilities (36.6%) (Guillén et al., 2021) and of women with a medically diagnosed serious or chronic illness (53.7%) (Lenta et al., 2023). Glumbíková et al. (2020) pointed out that people living homeless who rate their health as more serious used health care services more frequently. The lifestyle resulting from adapting to homelessness immerses people into a swift process of physical and psychological deterioration (Ruiz-Coronel et al., 2019), leading to a greater need for health resources. In Spain there is universal health coverage for all citizens, which could partly explain the high rate of use of these services by women living homeless. However, it is of note that this high level of use matches that found among homeless people in different countries, with or without universal health insurance (Bharel et al., 2013; Brown et al., 2013; Hwang et al., 2013; Leonori et al., 2000). Unfortunately, Glumbíková et al. (2020) stated that individuals experiencing homelessness who refrain from using healthcare services are more likely to remain in temporary housing for extended periods of time.

The large majority of the women interviewed had a Spanish health card and in many cases those who did not have one had done so in the past (losing access to their card through means including loss and theft), were in the process of obtaining one, or did not consider it necessary. However, not being in possession of a health card is an indicator of a lack of access to primary care and preventative medicine. As multiple morbidity is common among people living homeless, accessible and available primary health care is a prerequisite for effective health interventions. This requires addressing barriers to provision and multiagency collaboration so that homeless people can access the full range of health and social care services (Wright &

Tompkins, 2006). Unfortunately, a major proportion of the women interviewees without Spanish nationality had difficulty in obtaining full access to healthcare, due to not holding a health card. Although the women not holding a health card could still access emergency health care, the difficulty in accessing full medical services could have a negative impact on their personal health, limiting the possibilities for preventative medicine, early clinical diagnoses, and preventing ongoing monitoring through primary health care services. The difficulties in accessing primary care can also lead to public health issues (e.g., less control over contagious and infectious diseases) and potential added expense for the health system (e.g., high rate of use in emergency cases, treatment of more serious health issues).

Medical treatment was found to be relatively common among the women interviewed, with an equally high rate of admissions to hospital. During the year before the interview, over half of the women interviewed used emergency health services, compared to 33% of women in the general population (Instituto Nacional de Estadísticas [INE], 2018), and over a third had spent at least one night in hospital, compared to 9% of Spanish women (Instituto Nacional de Estadísticas [INE], 2018). In line with the findings of Beijer and Andréasson (2009) in Sweden—where people living homeless were at double the risk of being hospitalized than the general population—in Madrid the women living homeless made more frequent use of specialist services than women in the general population.

The interviewees who had been hospitalized in the year previous to the study were of a higher average age. In Madrid, it was the older homeless women who had required more health care, mainly relating to illnesses or to undergo surgery. This information contrasts with the points made by Beijer and Andréasson (2009) who found that in Stockholm hospitalization of women living homeless was among those younger in age and was largely associated with issues arising from substance abuse. In this regard, it was seen in Madrid that women living homeless who had had problems with drug-taking at some point in their lives were mostly receiving some kind of medical treatment at the time of the interview and tended to use emergency hospital services to a greater extent, often having suffered accidents or assaults. The lifestyle associated with substance abuse when living homeless can have a significant impact on health problems, given how vulnerable these women are to suffering accidents, injuries, and assaults, as well as issues around food, hygiene, and exposure to infectious and contagious disease relating to sexual violence. Concerning this matter, Beijer and Andréasson (2009) pointed out that in Sweden, young homeless women presented high rates of hospitalization, mostly connected with greater exposure to the consumption of psychoactive substances and the lack of hygiene exercised while consuming them. Likewise, Di Iorio and Pawlowicz (2021) in Argentina argued that the double stigma of being women as well as drug users leads many of them to hide information regarding drug use out of fear of sanctioning by the health service, which has an even greater negative effect on their health.

Seventeen percent of the women living homeless in Madrid expressed that they were dissatisfied with health services and 22% said that they had on occasions not received the medical care they considered necessary. This percentage is similar to that observed by Vuillermoz et al. (2017) among women living homeless in Paris, where 25% indicated that they had had at least one unmet healthcare need in the last year, having largely refused to see general practitioners and specialists. Of the interviewed women living homeless in Madrid, those who had abused drugs proportionally believed that they had needed medical attention at some point and not received it, and they declared less satisfaction with the health service overall.

The study's limitations include the restrictive criteria for sample inclusion (assignment to ETHOS operational categories 1, 2, and 3) and the absence of random or stratified participant selection. Thus, the sample's representativeness cannot be guaranteed. Additionally, the study is

confined to Madrid, Spain, hindering generalization of results to other contexts. Furthermore, it should be noted that this study design is cross-sectional, therefore one must exercise caution when attempting to establish causal relationships. Although this study has its limitations, it can enhance the awareness of conditions regarding health service usage among women living homeless in Spain. This can provide valuable information for designing and implementing public policies, facilities, and healthcare resources to improve the health of homeless women.

Women living homeless in Madrid experience significant health deterioration and an increased reliance on emergency services, highlighting the need for targeted prevention and treatment programs. Madrid possesses sufficient healthcare services to effectively cater to all medical requirements of individuals experiencing homelessness. However, it is crucial to eliminate the obstacles that prevent individuals experiencing homelessness from accessing healthcare (e.g., lack of a Spanish health card, not knowing where primary care services are located or how they work, limitations due to drug use or mental health problems, language barriers (Lenta et al., 2023; Vázquez et al., 2021; Wright & Tompkins, 2006). In this sense, special attention should be paid to women of foreign nationality—with greater difficulties in fully accessing primary care services— and to women who have abused drugs, who report low levels of satisfaction with health services, and a high percentage of whom reported having had unmet healthcare needs. It would be pertinent to introduce homelessness outreach teams and gender-sensitive support that emphasizes primary healthcare provision. Healthcare providers must be cognizant of the living conditions experienced by individuals living homeless and tailor their management of health issues accordingly (Hwang et al., 2013; Lenta et al., 2023). The provision of tailored psychological aid for such women together with enhancing their accessibility to consumption of psychoactive substances treatment and medical monitoring for improved healthcare outcomes is crucial.

Further research should explore the less studied situations that impact women who find themselves homeless. This should involve an in-depth analysis of their support and healthcare requirements. An improvement in the access to healthcare for socially vulnerable people would help to prevent the slide into homelessness, making it easier to get out of the situation and leading to an overall improvement in the quality of life of people living homeless.

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