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Unmet Needs: Unveiling Barriers to Healthcare Access Among the Homeless

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Abstract

Access to healthcare remains a persistent concern among individuals experiencing homelessness, particularly because health needs are often shaped by poverty, unstable shelter, stigma, and limited capacity to navigate formal health systems. This study explored the barriers faced by homeless individuals in accessing healthcare services in Batangas City. A descriptive phenomenological design was employed, guided by the Health Belief Model. Data were gathered through semi-structured interviews with 12 participants who were experiencing homelessness and had encountered illness during their period of homelessness. Participants were selected through convenience and purposive sampling, and the data were analyzed using Colaizzi's phenomenological method. Findings revealed five emergent themes: survival-driven health prioritization, living under the open sky, locked out of care, invisible in plain sight, and bridging gaps in healthcare access. Participants commonly prioritized food, shelter, and family survival over medical consultation. Harsh environmental exposure, informal labor, financial limitations, lack of documents, long waiting times, system complexity, stigma, and perceived exclusion further restricted access to care. Despite these barriers, participants showed willingness to seek healthcare when assistance, guidance, and child-related concerns were present. The study concludes that healthcare inaccessibility among homeless individuals is not merely an individual problem but a layered structural and social concern. The findings support the need for simplified healthcare procedures, patient navigation support, outreach services, temporary identification mechanisms, and non-discriminatory care for homeless populations.

Keywords: *homelessness; healthcare access; health inequity; social determinants of health; descriptive phenomenology; Health Belief Model*

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1. Introduction

Healthcare access remains a central concern in public health because the ability to obtain timely, affordable, and appropriate care strongly influences individual well-being, disease prevention, treatment outcomes, and broader social welfare. Although global and national health policies emphasize universal access to healthcare, many vulnerable populations continue to experience substantial barriers to receiving services. These barriers are particularly evident among individuals experiencing homelessness, whose health needs are often intensified by poverty, unstable shelter, food insecurity, environmental exposure, stigma, and limited capacity to navigate formal health systems.

The global commitment to health and well-being is reflected in the Sustainable Development Goals, particularly the goal of ensuring healthy lives and promoting well-being for all. However, the persistence of healthcare inaccessibility shows that policy commitments do not automatically translate into equitable service utilization. The 2023 Universal Health Coverage Global Monitoring Report noted that a large portion of the world's population still lacks access to essential health services (World Health Organization, 2023). This problem is more pronounced among socially and economically marginalized groups, who are more likely to experience delayed treatment, untreated illness, preventable complications, and worsening health outcomes. In this sense, healthcare access is not only a clinical issue but also a social equity concern.

In the Philippines, the enactment of the Universal Health Care Act in 2019 signaled a major policy effort to ensure that all Filipino citizens are covered under the National Health Insurance Program and are entitled to equitable access to quality healthcare services (World Health Organization, 2019). Despite this policy direction, gaps remain in actual access, especially among individuals whose socioeconomic conditions prevent them from meeting administrative, financial, and procedural requirements. Homeless individuals are among those most affected by these gaps because they often lack stable residence, identification documents, financial resources, social support, and access to reliable information about available health services.

Homelessness is closely linked to poor health because the absence of stable and adequate shelter exposes individuals to physical, environmental, psychological, and social risks. Globally, homelessness continues to affect millions of people, and the Philippines has been identified as one of the countries with a substantial homeless population (Aguila, 2024; Homeless World Cup, 2022; Pacaol, 2021). In local contexts such as Batangas City, homeless individuals may be found in public areas such as parks, churches, streets, markets, transportation terminals, and spaces under bridges. Their living conditions increase exposure to heat, rain, pollution, unsafe surroundings, poor sanitation, communicable diseases, untreated wounds, hunger, and exhaustion. These conditions make healthcare access more urgent, yet at the same time more difficult to pursue.

For individuals experiencing homelessness, healthcare-seeking is often shaped by survival priorities. Food, temporary shelter, safety, and family needs may take precedence over medical consultation, even when illness is already present. As a result, health concerns may be endured, minimized, or treated only when they become severe. In addition to survival pressures, homeless individuals may also face structural barriers such as cost, documentation requirements, distance from facilities, long waiting times, and complex procedures. These obstacles are further intensified by social barriers, including stigma, discrimination, shame, perceived inequality, and mistrust of health institutions.

The Health Belief Model provides a relevant theoretical lens for understanding these experiences. The model explains health-related behavior through perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy (Green et al., 2020). In the context of homelessness, individuals may recognize illness and vulnerability but still avoid or delay healthcare because perceived barriers are stronger than perceived benefits. Financial constraints, administrative requirements, social exclusion, lack of information, and low confidence in navigating healthcare systems may weaken healthcare-seeking behavior. Conversely, assistance from others, concern for children, and accessible healthcare guidance may serve as cues to action that increase willingness to seek care.

While policies and programs exist to promote healthcare access, the lived experiences of homeless individuals remain underrepresented in local health research. Quantitative indicators may show coverage or service availability, but they may not fully capture how marginalized individuals understand health, negotiate survival, encounter barriers, and decide whether to seek care. Recent work on narrative health analytics similarly argues that patient stories can be translated into ethically governed evidence for understanding empathy, trust, communication quality, and patient-centered care (Atento, Quinto, Espelita, & San Juan, 2025). A qualitative examination is therefore necessary to reveal the layered and lived nature of healthcare inaccessibility among homeless individuals.

This study aimed to explore the barriers faced by homeless individuals in accessing healthcare services in Batangas City. Specifically, it sought to examine how homelessness shapes participants’ perceptions of health and healthcare, identify the individual, environmental, structural, and social barriers they encounter, describe their coping strategies and willingness to seek future healthcare, and generate practical recommendations for improving healthcare access among homeless populations.

2. Review of Related Literature

2.1 Health as a Right and the Continuing Challenge of Universal Healthcare Access

Health is widely understood not merely as the absence of disease but as a condition involving physical, mental, and social well-being. This broader understanding is important because access to healthcare is closely linked with dignity, social participation, and the ability to maintain a livable quality of life. In the original thesis, health is framed as a fundamental human right, emphasizing that individuals should be able to access healthcare without discrimination or exclusion (Ghebreyesus, 2019; Sampson, 2023). This rights-based view situates healthcare not only as a personal need but also as a public obligation.

The global health agenda reinforces this position through the Sustainable Development Goals, particularly the goal of promoting good health and well-being. Universal health coverage is central to this agenda because it seeks to ensure that individuals can obtain safe, effective, quality, and affordable health services (United Nations, 2023). However, despite global commitments, healthcare access remains uneven. Meru and Humme (2023) noted that billions of individuals continue to be left behind in the movement toward universal health coverage, with progress slowing in recent years. This indicates that formal policy commitments may exist while actual service access remains limited for vulnerable groups.

Government responsibility is therefore central to addressing inequity in healthcare access. The World Health Organization (2022) emphasized the role of governments in developing health systems, implementing health programs, ensuring affordability, improving service delivery, and providing adequate resources. In the Philippine context, the Universal Health Care Act was enacted to promote equitable access to quality health services and financial protection through automatic membership in the National Health Insurance Program (World Health Organization, 2019). However, the existence of universal health policy does not necessarily eliminate access barriers among those who lack stable residence, identification, income, or information. This gap is especially relevant for homeless individuals, who may remain outside the effective reach of health systems despite formal legal entitlement.

2.2 Homelessness, Housing Instability, and Health Vulnerability

Homelessness is a major social determinant of health because the absence of stable, safe, and adequate housing directly affects physical, mental, and social well-being. The literature in the thesis defines homelessness as the lack of stable, safe, and adequate housing and the absence of means to obtain it, a condition that has been recognized as a human rights concern (United Nations Human Rights, 2020). Homeless individuals are exposed not only to the absence of shelter but also to risks involving stigma, humiliation, unsafe surroundings, poor sanitation, and reduced access to essential services.

The scale of homelessness demonstrates the significance of the issue. Global estimates cited in the thesis indicate that millions of individuals experience homelessness, with the Philippines identified as one of the countries with a substantial homeless population (Aguila, 2024; Homeless World Cup, 2022; Pacaol, 2021). Leal (2023) associated homelessness in the Philippine setting with poverty, job loss, and disaster-related displacement. These circumstances suggest that homelessness is not simply the result of individual choices but a structural condition linked to poverty, livelihood instability, and social vulnerability.

Housing conditions also influence health outcomes. Finch et al. (2023) emphasized that the condition, safety, quality, and location of housing shape individual health. Brown (2021) similarly described housing as a social determinant of health, noting that unstable housing increases exposure to inequity and illness. The National Health Care for the Homeless Council (2020) further linked homelessness with worsened chronic conditions, poor nutrition, difficulty maintaining hygiene, and increased exposure to disease. In the Philippine context, Jena (2020) described homeless individuals as being exposed to heat, rain, poor sanitation, open defecation, malnutrition, infectious disease, abuse, accidents, and environmental hazards. These conditions make healthcare access more necessary, yet they also make healthcare-seeking more difficult.

2.3 Healthcare Barriers among Homeless and Vulnerably Housed Individuals

The literature indicates that individuals experiencing homelessness often encounter intersecting barriers that delay or prevent healthcare utilization. These barriers include financial limitations, lack of documents, poor knowledge of available services, distance from facilities, complex procedures, and the prioritization of immediate survival needs. The National Health Care for the Homeless Council (2020) emphasized that homelessness increases the difficulty of managing health conditions because individuals may lack stable shelter, safe food preparation, hygiene facilities, and continuity of care.

Survival needs often become more urgent than healthcare. Omerov et al. (2020) found that homeless persons frequently prioritize basic needs such as food and shelter over medical care. This is consistent with the thesis focus because homeless individuals may endure symptoms, self-manage illness, or delay consultation when healthcare access competes with daily survival. In such contexts, health behavior cannot be understood only as a matter of personal motivation; it is shaped by material scarcity and unstable living conditions.

Communicable and preventable diseases are also more likely to occur among homeless individuals. Liu et al. (2020) reported that homeless populations are at higher risk of communicable diseases compared with housed populations. Glenn (2022) similarly noted that inadequate hygiene facilities, crowded conditions, and unsafe environments increase exposure to infection, while mental health risks may be intensified by stress, isolation, and limited access to mental health care. These risks demonstrate how homelessness produces both direct health threats and indirect barriers to timely care.

Healthcare systems themselves may also create barriers. Purkey and MacKenzie (2019) found that homeless and vulnerably housed individuals may avoid healthcare because of stigma, shame, and experiences of judgment. Participants in such studies valued nonjudgmental, flexible, and equitable care, indicating that access is not only about the physical availability of services but also about whether services feel safe, respectful, and responsive to marginalized populations.

2.4 Philippine Programs, Outreach Efforts, and Remaining Access Gaps

The Philippine policy and program environment contains several initiatives intended to improve access to health, housing, and social assistance among vulnerable populations. The Universal Health Care Act seeks to ensure that Filipinos have equitable access to quality health services and financial protection through automatic membership in the National Health Insurance Program (World Health Organization, 2019). However, policy coverage does not automatically resolve access problems when individuals lack documentation, awareness, transportation, or capacity to navigate service procedures. In a related Philippine health-access context, Atento and Atento (2025) emphasized that medicine-access intermediaries such as retail pharmacy networks remain strategically important where healthcare infrastructure and service reach are uneven.

Several government and community-based programs attempt to address these limitations. The Modified Conditional Cash Transfer Program was described as a mechanism for reaching homeless street families, geographically isolated Indigenous communities, and families requiring special protection, with benefits related to education, shelter assistance, and healthcare access obligations (Department of Social Welfare and Development, n.d.). Housing-related initiatives, including emergency housing assistance and programs for Indigenous peoples, were also identified as forms of government support for populations with housing needs (Philippine Assistance, 2020). In addition, the Pambansang Pabahay para sa Pilipino Program was presented as a government effort to expand access to housing among families unable to secure decent shelter (Reganit, 2023).

Healthcare outreach initiatives are also present. ChildHope Philippines (2022) described health-related programs for street children, including mobile clinic approaches and consultation services. Montemayor (2023) reported on the LAB for ALL caravan, which aimed to bring free medical services, consultations, diagnostic tests, and medicines closer to communities. Carlos (2024) likewise discussed the use of mobile clinics for underserved and disadvantaged areas. These initiatives suggest that mechanisms for expanding access exist, but availability alone is insufficient. If homeless individuals are unaware of programs, unable to meet requirements, discouraged by stigma, or unable to leave survival activities for long waiting periods, service utilization remains limited.

2.5 Health Belief Model and Healthcare-Seeking among Homeless Individuals

The Health Belief Model provides a useful framework for interpreting healthcare-seeking behavior among homeless individuals. The model explains health behavior through perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy (Green et al., 2020). In the context of homelessness, these dimensions are useful because individuals may recognize illness and vulnerability but still delay care when financial, administrative, emotional, and logistical barriers appear stronger than the expected benefits of consultation.

Perceived susceptibility and perceived severity are relevant because homeless individuals are frequently exposed to illness, environmental hazards, poor sanitation, hunger, injury, and untreated conditions (Jena, 2020; Liu et al., 2020; National Health Care for the Homeless Council, 2020). However, repeated exposure to hardship may normalize illness and reduce urgency. Perceived benefits may also be weakened when individuals believe that seeking care will involve cost, long waiting time, humiliation, or incomplete treatment. In this case, healthcare may be viewed as desirable but practically unreachable.

Perceived barriers are particularly important in the present study. Financial incapacity, lack of documentation, low health literacy, procedural complexity, discrimination, and distance from facilities can discourage healthcare utilization even when services formally exist (Brown, 2021; Finch et al., 2023; Purkey & MacKenzie, 2019; World Health Organization, 2022). Cues to action may come from family responsibility, worsening symptoms, assistance from others, mobile services, or community outreach. In an adjacent Philippine community-health study, Temporada et al. (2025) found that awareness alone had weaker associations with preventive practice than attitude and enabling supports, reinforcing the need to examine whether knowledge can actually be converted into action under constrained living conditions. Self-efficacy is also important because individuals with limited literacy, unstable residence, or prior negative healthcare experiences may lack confidence in navigating health systems. The model therefore supports the study's focus on how homelessness shapes health perceptions, perceived barriers, and actual healthcare-seeking behavior.

2.6 Synthesis and Literature Gaps

The reviewed literature shows that homelessness is closely linked with health vulnerability, not only because homeless individuals lack shelter but also because they are exposed to poverty, environmental hazards, poor sanitation, stigma, and social exclusion (Brown, 2021; Finch et al., 2023; Jena, 2020; National Health Care for the Homeless Council, 2020). The literature also establishes that healthcare access is a human right and a major policy objective under universal health coverage, yet actual access remains uneven among marginalized populations (Meru & Humme, 2023; United Nations, 2023; World Health Organization, 2019, 2022). Comparable ASEAN evidence suggests that macroeconomic strength and formal development progress do not automatically translate into equitable health and nutrition outcomes, especially when structural support systems are weak (Quinto & Atento, 2025). Existing Philippine programs on health access, social assistance, mobile clinics, and housing suggest that support mechanisms are present, but these may not fully reach individuals who lack stable residence, documents, awareness, or trust in formal systems.

The remaining gap lies in the limited local qualitative understanding of how homeless individuals themselves experience and interpret barriers to healthcare access. Much of the available literature explains homelessness and health in general terms, while fewer local studies capture the voices, emotions, priorities, coping strategies, and perceived system barriers of homeless individuals in specific community settings. This study addresses that gap by using a descriptive phenomenological approach to examine the lived experiences of homeless individuals in Batangas City, focusing on the barriers that shape healthcare-seeking behavior and the practical improvements needed to make healthcare more inclusive and accessible.

3. Methodology

3.1 Research Design

This study employed a descriptive phenomenological research design to explore the lived experiences of homeless individuals in accessing healthcare services. The design was appropriate because the study sought to describe how participants understood health, experienced barriers to healthcare access, coped with illness, and interpreted their encounters with formal health systems (Neubauer et al., 2019).

3.2 Research Setting

The study was conducted in Batangas City, Batangas, particularly in areas where individuals experiencing homelessness were commonly observed. These included public parks, churches, underpasses, public markets, transportation areas, sidewalks, and other temporary shelter locations. These sites were selected because they represented spaces where homeless individuals commonly stayed, worked, rested, or sought temporary protection from environmental exposure.

3.3 Participants and Sampling Technique

The participants were 12 individuals experiencing homelessness at the time of data collection. They were selected through a combination of convenience sampling and purposive sampling. Convenience sampling was used to identify individuals who were present and willing to participate during the data-gathering period. Purposive sampling was then applied to ensure that the selected participants met the study criteria and could provide relevant information about healthcare access barriers.

The inclusion criteria were as follows: participants had to be 18 years old or above, currently experiencing homelessness or had experienced homelessness in the past, and had experienced sickness or illness during their period of homelessness. Data collection continued until data saturation was reached, which occurred after 12 participants. To protect confidentiality, participants were assigned pseudonyms inspired by house materials.

The participants' ages ranged from 18 to 50 years old. Several were engaged in informal work such as vending, scavenging, or daily labor, while some were parents responsible for supporting their children. These characteristics were relevant because their livelihood conditions, caregiving responsibilities, and housing instability shaped their health priorities and healthcare-seeking decisions.

3.4 Research Instrument

The study used a semi-structured interview guide composed mainly of open-ended questions. The guide was designed to elicit participants' experiences, perceptions, and challenges in accessing healthcare services. The questions covered participants' understanding of health and healthcare, the effects of homelessness on health, daily survival priorities, experiences in seeking healthcare, barriers encountered, emotional responses to these barriers, coping strategies, willingness to seek future healthcare, awareness of available health and housing programs, and recommendations for improving access.

The interview guide was prepared in both English and Tagalog to ensure clarity and accessibility for the participants. The self-developed instrument underwent expert validation before data collection to determine the appropriateness, clarity, and alignment of the questions with the objectives of the study.

3.5 Data Collection Procedure

Prior to data gathering, the study underwent ethical review and approval by the LPU Research Ethics Review Committee. Data collection was conducted during weekends in February and March 2026, based on prior observation that individuals experiencing homelessness were more commonly present during those periods.

Eligible participants were identified from selected public locations in Batangas City. Informed consent was obtained before each interview. The participants were informed of the purpose of the study, their voluntary participation, their right to refuse or withdraw, and the measures taken to protect their privacy and confidentiality.

Semi-structured interviews were conducted through phone calls because the researcher was located in Singapore during the data-gathering period. Family members assisted in locating and coordinating with eligible participants. Each interview lasted approximately 20 to 25 minutes and was audio-recorded with participant consent. The recordings were later transcribed verbatim for qualitative analysis.

3.6 Data Analysis

The interview data were analyzed using Colaizzi's phenomenological method (Gumarang et al., 2021). The analysis began with repeated reading of the transcribed interviews to obtain a general understanding of the participants' experiences. Significant statements related to healthcare access barriers were then identified and extracted. Meanings were formulated from these statements and grouped into clusters of related ideas. These clusters were organized into themes and subthemes that represented the participants' shared experiences.

An exhaustive description of the phenomenon was developed based on the emergent themes. Irrelevant or repetitive descriptions were filtered out to ensure that the findings remained focused on the study objectives. The findings were then validated by returning to the informants to confirm whether the analysis accurately reflected their lived experiences.

3.7 Ethical Considerations

The study observed the principles of beneficence, respect for persons, justice, confidentiality, and voluntary participation. Since the study did not involve clinical intervention, participants were not exposed to direct physical risk. However, because the participants belonged to a vulnerable population, the researcher took care to minimize discomfort and ensure that participation remained voluntary.

Participants were informed about the purpose of the study, the nature of their participation, their right to ask questions, their right to refuse participation, and their right to withdraw at any time. Their privacy was protected through the use of pseudonyms, and all information obtained from the interviews was treated with confidentiality. The study was conducted only after ethics approval had been secured from the appropriate institutional review body.

4. Results and Discussion

4.1 Overview of Emergent Themes

The study generated five emergent themes describing the barriers experienced by homeless individuals in accessing healthcare services. These themes reflect a layered pattern of exclusion: participants first struggled with survival needs, then with environmental exposure, structural barriers, stigma, and limited knowledge of available support systems. The five themes and corresponding subthemes are summarized in Table 1.

Table 1. Emergent Themes and Subthemes on Healthcare Access Barriers among Homeless Individuals

Emergent Theme	**Subthemes**
Survival-Driven Health Prioritization	Living in survival priority; delayed or avoided medical consultation; child-centered survival decision; neglect of illness
Living Under the Open Sky	Frequent illness and environmental health risks; physical strain from informal work
Locked Out of Care	Financial and administrative barriers; service accessibility issues; low health literacy and system complexity

Invisible in Plain Sight	Stigma and discrimination; emotional distress; perceived inequality and exclusion
Bridging Gaps in Healthcare Access	Informal support and conditional healthcare seeking; awareness gaps; system improvement suggestions

The themes indicate that healthcare access among the participants was not limited by a single obstacle. Instead, access was shaped by the interaction of material deprivation, unstable living conditions, administrative exclusion, emotional burden, stigma, and lack of procedural guidance. Within the Health Belief Model, these findings suggest that perceived barriers were often stronger than perceived benefits, while cues to action and self-efficacy were weakened by homelessness, poverty, and social exclusion.

4.2 Survival-Driven Health Prioritization

The first theme, survival-driven health prioritization, describes how participants placed immediate survival needs above healthcare. For many participants, health was not understood primarily in terms of preventive care, regular consultation, or institutional support. Rather, health was associated with the ability to survive each day despite hunger, unstable shelter, and lack of income.

Several participants defined their priorities in terms of food, shelter, and daily endurance. Bamboo stated that health meant being able to survive daily hardship, while Clay explained that food and a place to sleep were prioritized first. Concrete emphasized the parental dimension of survival, stating that feeding the children came first, even when this meant going without food personally. These responses show that homelessness reorganizes health priorities around immediate bodily and family survival rather than formal healthcare-seeking.

This survival orientation also affected consultation behavior. Participants frequently viewed hospital visits or medical check-ups as expenses they could not afford. Wood described hospital consultation as a cost beyond their means, while Bamboo considered medical consultation less urgent than food and shelter. Clay also expressed that enduring illness was easier than undergoing a long and complicated process. Such responses suggest that healthcare was not necessarily rejected because it was perceived as unimportant, but because it competed with more urgent survival needs.

A child-centered dimension was also evident. Participants who were parents often placed their children's needs above their own health. Stone prioritized food for the children even without eating personally, while Fiber worried about who would care for the children if she sought medical consultation. This demonstrates that caregiving responsibility can intensify self-neglect among homeless parents.

Illness was also normalized. Steel reported sleeping off sickness, while Wood expressed resignation toward illness and death. These statements suggest that repeated exposure to hardship may reduce the perceived urgency of healthcare. In Health Belief Model terms, even when susceptibility and severity are present, perceived barriers such as cost, time, uncertainty, and family responsibility may suppress action. This finding is consistent with Omerov et al. (2020), who noted that homeless individuals often prioritize basic needs over medical care, and with Brown (2021), who emphasized that unstable housing conditions shape health behavior and self-care.

4.3 Living Under the Open Sky

The second theme, living under the open sky, captures the direct health consequences of environmental exposure. Participants associated homelessness with frequent illness, poor sanitation, physical exhaustion, untreated wounds, hunger, and vulnerability to weather changes. Their health risks were not occasional but embedded in their everyday living conditions.

Participants described recurring fever, cough, colds, wounds, and stomach pain. Glass reported frequent fever, colds, and cough, while Stone described wounds that did not heal properly and were managed only by washing them with water. Fiber connected hunger with stomach pain and weakness. These accounts show how unstable shelter, poor hygiene access, hunger, and exposure to environmental hazards directly shape morbidity among homeless individuals.

The theme also includes physical strain from informal work. Participants continued to work despite illness or injury because livelihood was necessary for daily survival. Cement described the need to find ways to earn, Gravel continued working even while sick, and Steel recalled being wounded while repairing makeshift shelter materials but still continuing the task. These statements show how informal work becomes both a survival strategy and a source of physical risk.

The findings reinforce the view that housing is a social determinant of health. Brown (2021), Finch et al. (2023), and the National Health Care for the Homeless Council (2020) emphasized that inadequate housing conditions increase exposure to preventable illness, chronic disease deterioration, and environmental hazards. In the present study, this relationship was visible in the participants' accounts of recurring illness and limited recovery. From the Health Belief Model perspective, repeated environmental exposure may also weaken perceived benefits of healthcare because participants return to the same unsafe conditions after treatment.

4.4 Locked Out of Care

The third theme, locked out of care, refers to structural and procedural barriers that prevented participants from accessing healthcare even when services were available. These barriers included cost, lack of documents, distance, long waiting times, and difficulty understanding healthcare processes.

Financial and administrative barriers were especially prominent. Bamboo stated that hospital costs were unaffordable, while Sand emphasized the combined burden of consultation and medicine expenses. Wood described the difficulty of producing documents, especially when some requirements also required payment. Cement expressed the view that services could not be accessed without payment. These responses indicate that participants perceived healthcare as formally available but practically unreachable.

Service accessibility was another barrier. Participants described distance, long queues, waiting time, and physical exposure during travel as discouraging factors. Brick noted the difficulty of walking to distant hospitals. Glass described waiting in long lines for almost an entire day, while Fiber emphasized that time spent waiting could have been used to look for food or work. Clay stated that there was no time to attend free medical services. These accounts show that healthcare utilization has opportunity costs. For participants living in daily precarity, a day spent waiting for healthcare may mean a day without food, income, or safety.

Low health literacy and system complexity also affected access. Concrete explained that inability to read and write made forms and posted instructions difficult. Stone did not know where to begin, while Cement did not understand how to obtain the required documents. Fiber also noted that homelessness itself made it difficult to produce complete documents for free medical benefits.

These findings show that healthcare access is not only a matter of facility availability. It also depends on whether individuals can afford, understand, physically reach, and administratively qualify for services. Within the Health Belief Model, these barriers reduce self-efficacy and increase perceived difficulty. Even when participants recognize the seriousness of illness, complicated systems discourage engagement.

4.5 Invisible in Plain Sight

The fourth theme, invisible in plain sight, describes the social and emotional dimensions of healthcare exclusion. Participants reported stigma, discrimination, shame, helplessness, and perceived inequality. These experiences shaped not only their access to services but also their willingness to return to healthcare settings.

Participants felt that appearance and social status affected how they were treated. Bamboo perceived that services were intended for those who looked socially acceptable. Wood felt judged and avoided by city hall and hospital personnel. Sand believed that people with better clothing or social connections were prioritized over people like them.

These accounts suggest that healthcare spaces may be experienced as socially hierarchical, even when services are formally intended for all.

Emotional distress was also evident. Participants expressed sadness, disappointment, fear, shame, helplessness, anger, and worry. Wood felt left behind. Steel felt unworthy and unlucky. Stone felt overwhelmed by the number of requirements. Clay feared being humiliated when asking questions. Gravel felt like a useless mother when the children became sick. These emotional responses are significant because they influence future healthcare-seeking behavior. Shame and fear may discourage individuals from asking for help, while repeated experiences of exclusion may weaken trust in healthcare institutions.

Perceived inequality further reinforced disengagement. Some participants believed that lack of money, documentation, residence, or social connections made them less eligible for care. This finding is consistent with Purkey and MacKenzie (2019), who found that homeless and vulnerably housed individuals may avoid healthcare because of stigma, shame, and perceived judgment. It also aligns with the World Health Organization’s emphasis on non-discriminatory and equitable healthcare delivery. In the present study, exclusion operated not only through formal requirements but also through participants’ emotional interpretation of how they were seen and treated.

4.6 Bridging Gaps in Healthcare Access

The fifth theme, bridging gaps in healthcare access, presents participants’ coping strategies, remaining willingness to seek care, awareness gaps, and suggestions for system improvement. Although the first four themes emphasize exclusion, this theme shows that participants were not entirely unwilling to use healthcare services. Their willingness depended on guidance, support, urgency, and whether the system could become easier to navigate.

Informal support was important. Bamboo sought help from others when unable to understand forms. Stone said that if someone helped secure healthcare benefits, he would accept the assistance. Sand expressed willingness to pursue services for the children. These statements show that participants’ healthcare-seeking behavior could be activated by external support, particularly when children’s needs were involved. In Health Belief Model terms, assistance from others may function as a cue to action, while guidance may increase self-efficacy.

However, awareness gaps remained. Brick did not know of any health or housing programs. Steel had heard of free medicines and check-ups but did not know when or how to access them. Sand believed that programs might exist but were often missed because information did not reach them. These accounts reveal that programs may fail to reach intended beneficiaries when dissemination is weak or when communication assumes stable residence, literacy, or regular community participation.

Participants also offered clear system improvement suggestions. These included free healthcare for homeless individuals, wider information dissemination, fewer or no documentary requirements, guidance desks, verbal interviews instead of written forms, faster processing, equal treatment regardless of appearance, and temporary identification documents. These recommendations directly respond to the barriers identified in the study and show that participants were able to articulate practical reforms based on lived experience.

4.7 Discussion

The findings indicate that healthcare access among homeless individuals is shaped by the interaction of survival pressure, environmental exposure, structural barriers, stigma, and limited system navigation capacity. The participants did not simply fail to seek healthcare due to personal neglect. Rather, their healthcare decisions were constrained by the realities of homelessness, including hunger, lack of shelter, lack of documents, caregiving responsibilities, distance, cost, waiting time, poor literacy, and fear of humiliation.

The Health Belief Model helps explain the findings. Participants demonstrated awareness of illness and vulnerability, particularly through accounts of fever, cough, wounds, hunger-related pain, and worsening conditions. However, perceived barriers were consistently stronger than perceived benefits. Cost, documentation, long queues, lack of information, and stigma made healthcare appear difficult, uncertain, or emotionally risky. Self-efficacy was also weakened by poor literacy, system complexity, and prior negative experiences. Meanwhile, cues to action emerged when children were affected, when assistance was available, or when participants received guidance from others.

The study also supports the argument that homelessness is a health systems issue, not merely a housing or poverty issue. Housing instability created the conditions for illness, but administrative and social systems intensified exclusion. Even under a policy environment that formally recognizes universal healthcare access, the findings suggest that homeless individuals may remain outside the effective reach of healthcare because they lack the documents, information, time, money, and confidence required to enter and navigate the system. This interpretation is consistent with integrated health and business analytics thinking, which frames healthcare improvement as dependent on the alignment of clinical, operational, and organizational decision systems rather than on service availability alone (Atento, Quinto, Espelita, & Castaneda, 2025).

The results further show that healthcare access must be understood beyond facility availability. A hospital, clinic, or outreach program may exist, but access remains limited when individuals cannot reach the facility, wait for service, comply with documentation requirements, read forms, pay for medicines, or endure discriminatory treatment. This is why participants' recommendations centered on practical access mechanisms: simplified requirements, temporary identification, patient navigation, verbal intake procedures, faster processing, mobile or outreach services, and equal treatment.

Overall, the study contributes qualitative evidence on how homeless individuals in Batangas City experience healthcare barriers. Its main contribution lies in showing that barriers are cumulative. Survival needs delay care, environmental exposure worsens health, structural systems restrict entry, stigma discourages return, and awareness gaps limit utilization of available services. These findings justify the development of more inclusive healthcare pathways for homeless populations, particularly through outreach, navigation support, simplified administrative procedures, and compassionate non-discriminatory care.

5. Conclusions, Recommendations, and Implications

5.1 Conclusions

This study explored the barriers experienced by homeless individuals in accessing healthcare services. The findings show that healthcare inaccessibility among the participants was shaped by interconnected individual, environmental, structural, social, and informational barriers. These barriers did not operate separately. Instead, they accumulated in ways that made healthcare difficult to obtain even when services were formally available.

First, the participants' healthcare-seeking behavior was strongly shaped by survival-driven priorities. Food, temporary shelter, safety, informal work, and family needs were commonly treated as more urgent than medical consultation. This led to delayed or avoided healthcare-seeking, self-management of symptoms, and the normalization of illness. Among participants with children, health decisions were often shaped by child-centered survival concerns, with parents prioritizing their children's needs over their own well-being.

Second, homelessness exposed participants to harsh environmental conditions that increased their vulnerability to illness. Living in public or unstable spaces subjected them to weather changes, poor sanitation, hunger, physical strain, untreated wounds, and recurring symptoms such as cough, fever, colds, and body weakness. These conditions worsened health risks while also limiting recovery and reducing the practicality of seeking sustained care.

Third, participants encountered structural barriers that restricted access to healthcare. Financial limitations, lack of identification documents, administrative requirements, long distances, long waiting times, and complicated procedures made healthcare difficult to navigate. These barriers reduced participants' confidence in accessing formal health systems and reinforced the perception that available services were not truly reachable for individuals experiencing homelessness.

Fourth, social and emotional barriers further discouraged healthcare utilization. Participants reported stigma, discrimination, shame, helplessness, perceived inequality, and exclusion. These experiences weakened trust in healthcare institutions and contributed to reluctance in asking for help or returning to services. Healthcare access, therefore, was not only a matter of cost or location but also of dignity, recognition, and respectful treatment.

Finally, the study found that participants were not entirely unwilling to access healthcare. Rather, their willingness depended on the availability of support, simplified procedures, reliable information, and humane treatment. Informal assistance, concern for children, patient guidance, and clearer access pathways functioned as possible cues to action. Overall, the study concludes that healthcare barriers among homeless individuals are systemic and layered. Addressing them requires more than the availability of health facilities; it requires inclusive, accessible, and non-discriminatory systems designed around the realities of homeless populations.

5.2 Recommendations

Based on the findings, healthcare institutions and local health systems should adopt more inclusive access mechanisms for homeless individuals. Public hospitals, barangay health centers, and local health offices may establish simplified procedures for persons without permanent residence, formal identification, or complete documents. Temporary identification mechanisms or alternative verification processes may be considered to prevent documentation gaps from becoming barriers to basic healthcare.

Healthcare providers should strengthen patient navigation support. Assistance desks, social service personnel, barangay health workers, or trained community health volunteers may be assigned to guide homeless individuals through consultation, referral, documentation, and follow-up procedures. The need for such navigational capacity also aligns with health workforce planning arguments that emphasize competency alignment, readiness mapping, and coordinated workforce development for resilient health systems (Atento, Quinto, & Espelita, 2025). For participants with low literacy or difficulty completing forms, verbal intake interviews may be used as an alternative to written forms, consistent with participants' own recommendations for more accessible procedures.

Local government units and health agencies should expand outreach-based healthcare delivery. Mobile clinics, community health caravans, and scheduled health visits in areas where homeless individuals commonly stay may reduce barriers related to distance, transportation, waiting time, and opportunity cost. These services should include basic consultation, wound care, screening, health education, medicine assistance, referral pathways, and social welfare coordination.

Health information dissemination should also be improved. The findings show that some participants were unaware of existing health and housing programs or did not know how and when to access them. Information campaigns should therefore be brought directly to areas frequented by homeless individuals, using clear language, verbal explanation, visual materials, and coordination with barangay officials, social workers, faith-based groups, and community organizations.

Healthcare institutions should provide continuous training on compassionate and non-discriminatory care. Since stigma and perceived exclusion discouraged healthcare utilization, providers and frontline personnel should be oriented on the needs of homeless populations, respectful communication, trauma-informed care, and equitable treatment regardless of appearance, social status, residence, or documentation. Equal treatment was one of the participants' explicit system improvement suggestions.

A multisectoral response is also recommended. Healthcare access among homeless individuals cannot be separated from housing, social welfare, livelihood, sanitation, and food security. Local health offices, public hospitals, city social welfare offices, barangay units, PhilHealth assistance desks, non-government organizations, and community groups should coordinate referral and support mechanisms for homeless individuals requiring medical and social assistance.

Finally, future research may extend the study by including a wider group of homeless participants across different cities or municipalities. Comparative studies may examine differences by age, gender, family status, duration of homelessness, and location. Further qualitative studies may also explore the experiences of healthcare workers, social workers, and local officials in delivering services to homeless populations.

5.3 Implications of the Study

The study has practical, policy, institutional, and theoretical implications.

Practically, the findings indicate the need for healthcare access pathways that are designed for people with unstable living conditions. Standard procedures that assume literacy, documentation, transportation, residence, and waiting capacity may unintentionally exclude homeless individuals. Similar operational concerns appear in Philippine healthcare accreditation research, where documentation burden, process efficiency, staffing, and resource constraints shaped implementation capacity (Garcia & Atento, 2026). Practical reforms such as simplified requirements, temporary identification, verbal assessment, assistance desks, and outreach services can make healthcare more usable for marginalized populations.

For local health policy, the study suggests that universal healthcare should be evaluated not only by formal coverage but also by actual accessibility among those most likely to be excluded. Homeless individuals may technically be entitled to care, but entitlement becomes limited when they cannot comply with administrative requirements, afford medicines, reach facilities, or understand procedures. Local implementation of universal health coverage should therefore include explicit mechanisms for undocumented, transient, and homeless populations.

Institutionally, the findings point to the importance of compassionate service culture in healthcare settings. Stigma, shame, and perceived inequality are not secondary concerns; they influence whether vulnerable individuals seek or avoid care. Public hospitals, health centers, and social service offices should therefore treat dignity and non-discrimination as part of access, not merely as ethical ideals.

Theoretically, the findings support the relevance of the Health Belief Model in explaining healthcare-seeking behavior among homeless individuals. The study shows that perceived susceptibility and severity may be present, but healthcare action is weakened when perceived barriers are overwhelming. It also shows that cues to action, such as assistance from others, concern for children, and patient guidance, may increase willingness to access care.

The proposed Advocacy-Information-Communication material, “Kalusugan ay Karapatan, Walang Sinuman ang Maiiwan,” may serve as a practical output of the study. Its purpose is to guide homeless individuals on where and how to seek healthcare assistance through barangay health centers, public hospitals, local social welfare offices, and PhilHealth assistance desks. The material directly responds to the barriers identified in the study, particularly lack of awareness, financial constraints, lack of documents, and difficulty navigating health systems.

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