

Case study 3

The Mainz Model: bringing health care to the homeless

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“You know, Herr Doktor, the pills you gave me really worked. I feel much better now.” Only rarely do doctors meet their patients in a tea room and hear comments like this, but for Dr Gerhard Trabert this is not rare. Unlike the usual practice of patients coming to him, he goes to them, and the tea room is one of the consultation places. His patients are the homeless and other socially excluded groups in Mainz, Germany. It is not just a German trait that a number of the homeless do not make use of health services; it is a general trait in many countries. Many public services are designed to be sought out, but many who suffer from much poorer health than the average person often do not go to the doctor. That is why Dr Trabert goes to them: in shelters for the homeless, in the basements of parking houses and on the streets. He knows where to find them, they know when he is around – and slowly he has gained their trust.

Dr Trabert started as a social worker, working in a hospital. Appalled by the medical care delivered to the homeless and by what he saw as the inertia of the health system to assist them, he read medicine. His doctoral dissertation in 1994 portrayed the health situation of the homeless.¹⁷ But research was not enough; he wanted to put his knowledge to practical use. He believed that efficient health care for the homeless could be provided only through carefully planned cooperation with the social services. The health care system could contribute medical expertise, but the social services should play an important role in reaching the homeless.

¹⁷ TRABERT, G. *Gesundheitssituation und Gesundheitsverhalten von alleinstehenden, wohnungslosen Menschen im sozialen Kontext ihrer Lebenssituation*. Bielefeld, VSH Verlag Soziale Hilfe, 1995.

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His approach to bringing health care to the homeless has been called the “Mainz Model”. It is based on a combination of paid and voluntary work and consists of four modules:

- open consultation, with both a general practitioner (GP) and a nurse, at a refuge for the homeless;
- open consultation, with both a GP and a nurse, at a daytime shelter for the homeless;
- open consultation from a van (*Arztmobil*) fitted with a consultation “room” in the rear, in places in the city where the homeless are known to be; and
- medical and palliative care for the seriously/terminally ill in homes for the homeless.

The consultations are carried out at regular hours, so that the homeless know when and where the help can be sought. The fifth and much needed module on assistance for the mentally ill homeless is now being prepared, and would most likely start later in 2002. Every week the medical team sees about 50–60 patients, making 80–100 patient contacts.

*Gerhard Trabert (left) and
Andreas Pitz*



The health service for the homeless is embedded in the social services offered to the homeless. Dr Trabert and Andreas Pitz, who heads the department for service for the homeless on behalf of *Diakonisches Werk* (a welfare organization run by the German Lutheran Church),

both agree that the key to success in this field is close cooperation between health care and social workers. “The strength of the Mainz Model,” says Pitz, “is that we cooperate with all the institutions that work with the homeless. In order to succeed, this work must be interdisciplinary.”

In 1997, the association *Armut und Gesundheit in Deutschland* (Poverty and Health in Germany) was founded, both to raise funds for the Mainz Model

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and to raise general awareness of the connection between poverty and health. Apart from raising funds and providing services to the community, the association organizes an annual conference on health and poverty and is rapidly extending links to other organizations in Germany and elsewhere. “The first reaction,” says Dr Trabert, “was that there was no poverty in Germany, so why should there be an association and a conference working in this field.” Now the attitude is different, in no small part thanks to the work of the association.

The success of this work is now turning into a problem that needs to be solved soon: the work is becoming too extensive to be dealt with only through voluntary help. The next step is to hire someone to run the service. A system to service the homeless, however, is not an end in itself. According to Dr Trabert:

Our final aim is to involve the municipal council and the state in the running of the service, making it a part of the existing health service. A health service for the homeless should not be separate but should be an integral part of current systems: [the health service] should include the homeless, not exclude them.

We now have a 10-year track record, which shows that the model works.

From words to deeds

According to official German statistics, there were around 700 000 homeless people in Germany in 1998, of which around 180 000 were single individuals on the move. The poorest of these – around 31 000 people, of which 3100 are women – live continuously on the streets. The statistics collected by Dr Trabert for his dissertation on the health of the homeless were shocking, especially considering that this group, in general, has a worse state of health than that of the average citizen.

It appeared that 80–90% of the homeless were in acute need of medical treatment, 60–70% had more than one disease and around 40% had three or more diseases. The homeless are mainly afflicted with diseases of the lung, intestine, heart and skin. Not surprisingly, there is a connection between the time spent on the streets and their state of health: the longer people have been homeless, the worse their health. Also, injuries related to violence are increasing, as violence against homeless people appears to be increasing.

In spite of their poor health, the homeless were seldom seen visiting health care institutions. Dr Trabert’s research showed that they have little faith in the system, have had bad experiences, are afraid of being thrown out and

often feel too embarrassed to visit regular health units – either hospitals or GP surgeries. Furthermore, they feel that the system is too bureaucratic, requiring many documents. Adding to these experiences, the homeless often have a reduced awareness of their bodily needs, and they simply feel that they do not need medical help, in spite of sometimes being quite ill.

Werner Schwarz, the treasurer of Poverty and Health in Germany, leads a day centre for the homeless in Bingen, close to Mainz, where a medical team visits regularly. He says, “There are doctors out there willing to attend to the homeless, but the homeless don’t want to go there, because they don’t like waiting in the waiting room. The homeless don’t go to the doctor until they are very ill and even then it can be difficult to convince them to seek treatment.” Schwarz knows that even under such circumstances his clients are prone not to show up, so he tries to accompany them if he can.

Health workers are invariably embarrassed themselves when receiving the often dirty and smelly homeless people, and show little understanding of their situation. Medicines to prevent diseases, or to prevent an illness from getting worse, often do not reach the homeless. Apparently, most homeless people come in contact with the health care system when brought in by the police, either because of accidents or because they have been found to be helpless.

While working on his research, Dr Trabert wondered how better health care for this group could be established. In recounting his experience, he says:

There were plenty of people ready to tell me that what I wanted to do could only be achieved by changing the whole health care system. But I couldn’t wait for that. I wanted to explore the possibilities at hand: how health care for the homeless could be constructed with what we had there and then. It is very important to search for new possibilities within the existing framework, in order to show that something can be changed. If that proves successful it can be used as an argument and pave the way for structural changes.

During 1993, his plans were laid out, and work among the homeless started in September 1994.

Placing new ideas inside the system

The German welfare system is traditionally a combination of governmental and church institutions, both the Lutheran Church and the Catholic

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Church. In addition, the trade unions have their own welfare structure. Although the Mainz Model is a private initiative, it is embedded in existing welfare structures, within both the official system and the Lutheran Church system, thereby linking existing structures in a new way. In addition, there are voluntary work and fund raising.

At first, the service was offered at shelters for homeless people, both day centres and homes where they could stay overnight. But that still excluded

those who never or hardly ever made use of these shelters and stayed exclusively on the streets. In order to reach them, it was obvious that a mobile surgery would be ideal. A van was bought with donations, was fitted with the necessary equipment and began operating in 1998. This proved



Patients who live in containers, waiting to see the doctor in the Arztmobil

to be the easy part of setting up the mobile service. The difficult part was that none of the institutions involved was willing to own it or run it.

In order to provide the van with a legal owner, Dr Trabert and others founded Poverty and Health in Germany. The association now not only runs the van, but is also an active fund-raiser for the work as well as one of the several organizers of the annual Berlin Conference on Poverty and Health. The Conference and the association itself are playing an increasingly important part in pooling and distributing knowledge on poverty and health, not only in Germany but also in adjacent countries. The aim is to create a European network in the field. “There is so much financial cooperation in Europe, so it’s now time for some social cooperation as well,” says Trabert.

The association is also an important focal point for the work in Mainz, since it has members who not only contribute to the work of the Mainz

Model but also carry out work in other fields in a similar spirit, creating opportunities for those who are usually disadvantaged. For example, one of the members runs a hotel in Mainz, the *Inndependence*, where mentally and physically handicapped people are given the opportunity to work in a commercial setting.

One health system: not first- and second-class systems

Dr Trabert has a message he often repeats.

We don't want to create a special system for the homeless outside the regular health care services. We are not constructing special health care for the homeless, but demonstrating the need for it. The aim is not to have a well run separate system, but that the official system recognizes the need for taking the homeless and their special needs seriously, offering them the kind of service that is of use to them.

The structure chosen was a combination of paid and voluntary workers. The medical team consists of Dr Trabert (who is also Professor of Social Medicine in Nuremberg) and Ulrich Graeber, a retired and highly respected doctor.

Trabert and Pitz point out that, for a new initiative, the choice of co-workers is important. It is not only important to choose well qualified people but also to choose workers who bring respect and attention to the new initiative.

As a rule, and based on agreements with statutory health insurance funds, Dr Trabert can charge the funds for his work as a panel physician. In principle, health insurance directly or indirectly covers every citizen resident

in Germany in one way or another. Thus, the insurance funds normally pay for use of the health system. The costs for people in need and others who are not in the insurance system are met by the state (for example, by the social services); this also applies to asylum

Nurse Anke and Dr Trabert visit a patient who lives in a camping van



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seekers. Illegal immigrants and other people not known to the social services are not covered in this way, but the Mainz Model team never denies medical care to anyone.

There are three nurses on the medical team. Sister Maria-Theresia and Sister Anegret, working for a Christian organization, are allowed time to work with the team; the other nurse, Anke, works with the team on a voluntary basis. Pitz and his colleagues provide social services within the shelters for the homeless.

The first barrier that Dr Trabert ran into when planning this drastically different kind of service was a law stemming from former times when quacks were a problem and, consequently, doctors were forbidden to practise medicine unless at a fixed setting. Dr Trabert's intention to seek out patients was hindered by this law, and it took some time before this could be overcome. Now, however, the Mainz Model is outside the ordinary health care system, though it benefits from Dr Trabert being able to charge the health care system for his services, like any other practising doctor.

An essential part of providing a first-class health service is documentation. Dr Trabert and his co-workers take a great deal of care to document their visits to each of the patients – in no less painstaking a way than visits within the health care system. This also wards off the criticism that the service being offered is in any sense inferior to that of the established health care system.

An important part of this documentation is the *Krankenpass*, a patient passport. The patients making use of the Mainz Model complained that it could be difficult for them to convince other doctors they might see that they had already been seen by a doctor. Others found it difficult to simply keep track of the treatments they had received from Dr Trabert's team. To meet these needs, a small folder of sturdy material was designed, listing vaccinations and other necessary health information.

Meeting the patients

“It is good that one can also be allowed to die here”, said a homeless man, often staying at a shelter for the homeless, when he heard that palliative care was now being offered to terminally ill patients. The gratitude of those using the service is obvious: “Oh yes, I make a point of being around when I know

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that Herr Doktor is coming,” says a rugged-looking and weather-beaten man with long grey hair and a flowing beard at the container cluster, close to a social centre in Mainz. “Before, I never went to a doctor, even if I needed it. It is too much of a hassle, also because I’m on the move. But this is fine.”

The containers are set up in the autumn by the City Council and remain in place over winter, so that the homeless can sleep in them. They only come fitted with berths, but the inhabitants quickly furnish them with other necessary things. Some are quite cosy, with TV sets, bedspreads and rugs. While the containers are there, Dr Trabert visits them regularly.

When asked about his use of the health service being brought to him, a long, lanky man with thin hair down to his collar replies, “We know him. I feel I can trust him, and the doctor is nice. He knows us. The trust makes all the difference.”

A patient with Dr Trabert in a tea room used by the homeless



In the tea room for the homeless, Dr Trabert is obviously a well known face. As he shows up and goes around to announce his visit, some of those present start moving towards the van outside. Some just ask him simple questions, like the tall, bearded youngish man who needs to

know how to get rid of the lice in his sleeping bag, as well as those on his dog. Some of the others tell him that what he prescribed for them last time helped.

As soon as Dr Trabert is in the van, a queue forms outside. One after another the men climb into the van, explain what is wrong, get asked the relevant questions by the doctor and have the nurse measure their blood pressure and make other tests. It is easy to forget that the consultation is taking place in an unusual surgery. Everything but the surroundings is part of the ordinary process of going to a doctor.

“I come here when I need the doctor,” says a heavy set man, who says he has been sleeping rough for six months. This time his stomach is bothering him. He has been sent for a gastroscopy before, but did not show up. Now

he considers giving it another try, since his suffering has increased. He is an alcoholic and knows that drinking is the cause of his problems. The prescriptions given to the homeless include vitamins and regular medicine such as beta blockers, but never any medicine that could be abused, such as sedatives, painkillers or sleeping pills.

Sleeping rough is a hard way to live, and it often lacks human contact. It is obvious that the men like the care that the nurse gives them, such as massage and other almost “motherly” attention, all given as part of the service. Dr Trabert emphasizes that the team works on health issues, and not on resocializing the homeless. “We accept that people live on the streets, though we are keen to assist them if they want to settle down in a permanent place,” says Trabert. The acceptance of their way of life is undoubtedly part of the success experienced by the medical team and is an important factor in winning the trust of the patients. But this tolerant attitude demands a lot of patience – for example, perseverance in setting up appointments within the health system, which some patients often fail to attend.

Publicity: do good and talk about the good deeds

“The attitude towards good deeds is often that you should do good but not tell anyone about it,” says Pitz. “But in our work I claim we should do good and tell as many as possible about it.” From the beginning, publicity has been an important part of the Mainz Model, both because it raised the awareness of a problem that was not generally recognized and because the work has been dependent on donations.

The publicity is channelled through Poverty and Health in Germany. “It is important to make people aware that being homeless is not just due to alcoholism or unwillingness to work,” says Dr Trabert. “People can lose their way in life for all kinds of reasons, so don’t be too judgmental about the homeless.” Dr Trabert frequently visits schools in and around Mainz to talk about the health service for the poor, in order to create an understanding of the work. This is an important factor in creating sympathy, understanding and tolerance for the homeless among children and young people, especially now that hostility against the homeless seems to be increasing.

The publicity for the Mainz Model, in Mainz and neighbouring towns, has been instrumental in securing donations. When there are birthdays to celebrate, some of those willing to assist Poverty and Health in Germany

make it known to friends and family that, instead of birthday presents and flowers, money should be donated to the association. This is just an example of how well established the association and its work have become in Mainz. But money has also come from unexpected sources: the British pop singer Phil Collins donated €100 000 to the German welfare organization Caritas Verband, run by the Catholic Church in Germany. Out of this money Poverty and Health in Germany received €10 000 for the mobile surgery.

Most donations come from private individuals. According to Schwarz:

It's difficult to get companies to donate money or even goods to the homeless. Companies like their donations to be visible and it's not easy for us to provide that kind of visibility. The van has to stand out, so we can't very well plaster it with ads. And then there may be companies, like makers of luxury cars, who feel that their image doesn't fit well with the homeless. But individuals are often more than willing to donate.

Publicity, however, is not only instrumental in attracting donations and increasing understanding of the problem; it also paves the way for a change among policy-makers. Dr Trabert says, "Publicity is necessary not only to raise money but also to put pressure on politicians for action in favour of the homeless. The homeless tend to be ignored by politicians because they usually don't vote."

The price of success

The Mainz Model has proved to be a success in the sense that it reaches a target group who formerly would probably not seek assistance. There is now a growing demand from neighbouring towns and cities to extend the service to them, and also a demand from others for information so that they can profit from the experience of the group behind the Mainz Model.

Both Trabert and Pitz agree that the priority now is to get a full-time, paid worker. "We are rapidly reaching breaking point, where the service can't just be managed by volunteers and people doing a full-time job elsewhere," says Dr Trabert. "We are close to not coping with the operation any more," adds Pitz.

What is needed is someone who would be paid to oversee and organize the service, provide the necessary tools, service the van and synchronize the

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publicity work. “It’s not easy to find someone who can be outgoing in informing and fund raising, as well as take care of the daily running of the service, but that’s the type we would be looking for,” says Pitz. “And this person has to be hired for a paid, full-time job. The service has become too extensive to be run from day to day just by us, who are actually doing full-time work elsewhere.”

“What we lack, for example, is the time to sit down now and go through our experience and discuss new working methods. We operate too much on short-term thinking, because there is too little time to think long term,” says Dr Trabert. The time tends to be used just for seeing the patients and keeping an eye on everything needed to operate on a day-to-day basis. The effort is now on securing the means to hire a coordinator: all in all a pleasant problem, since it is in a way a proof of the success of the Mainz Model.