Homelessness: a problem for primary care?

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SUMMARY
Homelessness is a social problem that affects all facets of contemporary society. This paper discusses the concept of homelessness in terms of its historical context and the dominance of the pervasive 'victim blaming' ideologies, which, together with the worldwide economic changes that have contributed to a fiscal crisis of the state, and the resultant policies and circumstances, have led to an increase in the number of 'new homeless' people. This paper attempts to challenge the dominant political discourse on homelessness. The widespread healthcare problems and heterogeneity of homeless people have a particular impact on health services, with many homeless people inappropriately accessing local accident and emergency (A&E) departments because of barriers inhibiting adequate access to primary care. A number of primary care schemes have been successfully implemented to enable the homeless to have better access to appropriate care. However, there is no consistency in the level of services around the United Kingdom (UK), and innovations in service are not widespread and by their nature they are ad hoc. *Despite the successes of such schemes, many homeless people still access health care inappropriately. Until homeless people are fully integrated into primary care the situation will not change. The question remains, how can appropriate access be established? A start can be made by building on some of the positive work that is already being done in primary care, but in reality general practitioners (GPs) will be 'swimming against the tide' unless a more integrated policy approach is adopted to tackle homelessness.*
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Introduction

'The availability of good medical care tends to vary inversely with the need for it in the population served.'[1]

HOMELESSNESS, for many people, conjures up images of vagrants and 'tramps' adopting feckless and idle lifestyles. This perception is often reinforced by the media[2] and by academic literature.[3] To examine the primary health care needs of homeless people requires an explanation of the historical and political context of homelessness. In the 19th century, homeless people were considered workshy and idle, and Poor Law workhouses were introduced to discourage dependency on the state.[4] Subsequent policies reflected public outrage and media interest in this group. The Housing (Homeless Persons) Act 1977[5] emerged after a period of media interest in the Rachman case, the television drama *Cathy Come Home,* and the 1966 launch of the housing charity Shelter.[6] Homelessness was perceived as a governmental failure that became a political issue, and the 1977 Act imposed a statutory duty on local authorities to house those broadly defined as homeless. Since the mid-1980s, the political establishment has been largely of the view that the homeless are beyond the realms of state assistance. The emergence of 'new right' ideological philosophies in the UK from the United States[7] in the late 1980s contributed to this ideology, vilifying 'dependency cultures'. Governments have consequently played down homelessness as a social problem, concentrating rather on negative 'individual pathologies' of homeless people, which have dominated the policy-making process. Such an ideological shift in blame towards the 'victims' of homelessness was, for example, reflected in the belief that aggressive begging contributed to the criminalisation of homelessness, and, together with single mothers, the homeless were considered a burden on welfare.[8] This has shifted the emphasis away from addressing inadequate provision of welfare for the homeless and legitimised welfare retrenchment policies at the same time as the promotion of the independent social care sector.

In parallel with these changes, a number of structural factors have reduced opportunities available to locate suitable low cost accommodation:

- the fiscal crisis of the welfare state in the 1970s inevitably led to reduced policy expenditure, resulting in an increasing number of dependent people and decreasing resources, producing large numbers of 'new homeless' people;[8]
- residualisation of social housing as privatised provision increased —characteristics of those entering, compared with those leaving social housing resulted in it being more narrowly based, both socially and economically;
- gentrification of inner-city areas and the promotion of private sector landlords meant that in certain areas the

only available properties had high rents or were of very poor quality;

- home ownership promoted through the 'right to buy' scheme caused its own problems when housing repossessions increased as a result of high interest rates;[9]
- the 1996 Housing Act[10] changed the ability of local authorities to 'fast-track' homeless people to permanent housing, and as a result, only temporary accommodation was available;
- community care legislation[11] has continued a long process of deinstitutionalisation;[12-13]
- changes in the workplace in terms of 'flexible specialisation'[14] and the decline of the UK's manufacturing base reduced job security, which contributed to the number of rising housing repossessions;
- income support for those aged between 16 and 18 years of age was withdrawn and Work Based Training for Young People encouraged;[15] and
- housing benefit for people under 25 years of age was changed in 1996.[16]

A number of policy initiatives that sought to address some of these issues were beset by their own problems:

- urbanisation policies, such as the City Challenge initiative,[17] have been criticised because of the competitive tendering process between regions;
- the irregular geographic distribution of the Rough Sleeping Initiative's funding in the early 1990s was based, not on need, but on the ability of local authorities to successfully process complicated application procedures;[15]
- parts of the New Deal and Welfare to Work programmes[18] have put the emphasis, for those who want to be participating citizens, onto actively seeking paid work, such as Job Seekers Allowance; and
- the Criminal Justice and Public Order Act[19] 1994 gave the police force the right to remove 'trespassers' and eventually to arrest them without warrant, which marginalised and restricted settlement for many travellers.

The rest of this paper assesses the various definitions of homelessness, as well as homeless people's health needs, the barriers they may face when accessing health care, and the availability of innovative schemes to ameliorate their access to health care. Further information on the topic of homelessness and primary care can be found in *Homelessness: a primary care response*.[20]

How are the homeless defined?

Governments, both past and present, have dominated the debate surrounding homelessness. Part three of the 1985 Local Authority Housing Act[21] categorises the homeless as either being officially registered as homeless (statutory) or not registered as homeless (non-statutory).[22] Those who are officially recognised as homeless people by local authorities include the following: people with one or more dependent children; vulnerable groups, such as older people, people with learning difficulties, the disabled, and those with mental health problems;[23] and others who can prove their unintentional homelessness and a connection to the local area.

In 1999, local authorities accepted 104 770 people as homeless households with a priority need. Of these,[24] 59% were households with dependent children, nearly 30% of them were no longer able to live with parents or friends, and 17% had had a violent relationship breakdown.[24] In 1999, English local authorities placed 62 180 households in accommodation: 8120 households in bed and breakfast accommodation, 8920 in women's refuges or hostels, 22 390 in private sector accommodation, and 22 700 in other types of accommodation.[24]

Unofficially homeless people

Unofficially or non-statutory homeless people[25] include: single people in hostels; rough sleepers; individuals spending time between the two, and staying with friends and family; as well as squatters (people occupying property to which they have no legal entitlement).[23] Accurate figures are not available for the numbers of those who are unofficially homeless in the UK. The housing charity Shelter, however, estimated that 41 000 people were living in hostels or squatting, and that 78 000 couples or lone parents were sharing accommodation in the year 2000.[22,26] An estimation of the numbers of squatters is difficult to ascertain,[23] but it has been estimated at 20 000 people.[27]

The majority of the unofficially homeless are single, unattached, and living in hostels, bed and breakfast accommodation or hotels. There are disproportionately high numbers of single homeless people from minority ethnic groups among those in hostels.[28] The group attracting most government and media concern are rough sleepers,[29] although they represent a small minority of the unofficially homeless. There are rising numbers of young people in this category,[22] 30% of whom are males over 50 years of age.[30] Older homeless people are often reluctant to stay in hostels and shelters,[31,32] preferring 'skippers' (derelict buildings) and derelict buildings.[33,34] Older women who sleep rough are not as visible on the streets and may seek safety in solitude, unlike older men, who seek safety by sleeping in numbers.[31] It is also recognised that there are a number of homeless who are sleeping rough who join the homeless population temporarily until they find appropriate accommodation.

The range of those who are unofficially homeless includes the 'hidden' homeless, such as squatters and people staying at friends' houses or in inadequate dwellings that are insecure and temporary. However, issues about poor quality, inadequate, overcrowded housing go beyond the scope of homelessness.

Health needs of homeless people

The health status of all homeless people is generally poorer than that of the stable, housed population,[22,35-39] There is evidence explaining their difficulties in gaining access to health care,[23,40-44] which includes inappropriate access.[25,45-47]

Officially homeless people

Those people who are registered with the local authority experience higher rates of acute ill health and high levels of psychiatric morbidity.[45,48-51] Asylum seekers housed by local

authorities have high levels of mental illness, which compound the problems of being housed temporarily.[52,53] The adverse effect on children's and mothers' health have been well documented,[22] and they may persist after rehousing.[53] Children who are officially registered homeless are more likely to have been born with low birth weights, have developmental and behavioural problems,[54] and suffer from infectious diseases,[22] and they are prone to accidental injury.[23,35,55-57]

Unofficially homeless people

The high level of psychiatric morbidity among unofficially homeless people, particularly single hostel dwellers, has been well documented.[28,58-62] Some authors have concluded that this is a result of 'de-institutionalisation,' and for some to claim that hostels are outposts for the severely affected mentally ill.[12,63-65] However, others have found important differences between those people in psychiatric wards and those in homeless hostels. They claim that psychiatric wards contain people with considerably higher levels of need in terms of social disablement than people in hostels for the homeless.[66-67]

Although there has been recent academic interest,[68] the issue of homeless people who have high levels of psychiatric morbidity and who sleep rough has been under-researched.[22,31]

In addition, unofficially homeless people have the following problems: they are at high risk of physical violence,[23] which is often alcohol or drugs-related;[39,69] they have a greater than average risk of developing cancer;[37] they suffer from musculoskeletal problems, and are prone to severe foot conditions;[22,39] and they have high levels of infestations and exposure to communal dwellings, which have implications for their health.

Many homeless people who sleep rough are intravenous drug or alcohol misusers.[30,32,38] Alcohol misuse causes high levels of accidental injury and nerve damage.[46] For those using intravenous drugs there is the increased likelihood of infection with HIV, hepatitis B, and hepatitis C, neurological disorders, anaemia, eye disorders, and cardiac disease.[22] The link between tuberculosis and socioeconomic deprivation has been known for many years, but this is particularly prominent among the UK's HIV-positive homeless population.[38,70] Single homeless people in hostels and rough sleepers have an increased risk of tuberculosis and other respiratory infections.[22,71] In addition, they have higher mortality rates than comparable housed people.[22,36,38] Further investigation demonstrates that the mortality rate of male rough sleepers in London between the ages of 16 and 29 years is almost 40 times that of the general population.[72]

Access to primary care

One approach to addressing the health needs of the homeless population is to encourage and enable their access to primary care. Being registered with a GP gives access to a range of other healthcare services, but homeless people often have difficulties registering with a practice.[35] Because of their transience and the insecure nature of their accommodation, many of those categorised as officially homeless live further than walking distance away from their GP.[45] A

study conducted in the mid-1990s showed that only 37% of immigrants and asylum seekers who were officially registered by the local authority as homeless registered with a GP in their first year in the country.[23] Those not recognised as officially homeless by their local authority also experience difficulties accessing a GP.[25,47] For homeless people who live on the streets, registration levels may decline further during prolonged periods of rough sleeping as they become progressively marginalised from mainstream society. Many rough-sleeping people and single hostel residents access healthcare services through accident and emergency (A&E) departments.[73] They commonly delay attending,[46] then present with advanced conditions,[74] a costly and inappropriate use of services.[75] Even if adequate primary health care is available, rough sleepers may continue to use A&E departments in preference to GPs,[76] and as a consequence, continuity of care and health promotion opportunities are commonly missed.[77,78] Rough sleepers are regularly discharged from hospital back into potentially unhealthy living conditions, and a reduced number of hospital social workers contributes to this lack of follow-up.[47] Poor support mechanisms in the community mean that some homeless mentally ill individuals may remain in hospital inappropriately because no suitable accommodation is available.[76]

Barriers to primary care access

The homeless have various individual characteristics that may prevent their access to primary care services. The social isolation[34] and transience[23] of some of those people registered by local authorities as homeless makes the provision of primary care to them problematic. Many fail to register with a GP because their accommodation is only temporarily located in a specific area.[40] Some homeless people may be suspicious of traditional medical services and conventional health care, and may be unaware that they can register with a general practice.[44,46]

The system for record taking of homeless people has been inefficient, and their records have often not followed when a homeless patient has changed their practice.[46] Homeless people have also found waiting rooms and appointment systems difficult to cope with.[42] Providing continuity of care for highly mobile rough sleepers is particularly difficult, since a number of them are extremely chaotic and because of their erratic behaviour are barred from GPs' surgeries.[23] This inhibits continuity of care, access to community health services, and co-ordination between health promotion agencies.[78]

General practitioners are sometimes reluctant to register rough sleeping and hostel-dwelling homeless people because of the protean nature of their health, social problems, and the absence of adequate remuneration for the time required for their care.[41] The financial incentives of GP independent contractor status have had a perverse effect on access to care, particularly for the homeless.[79] Practices in some deprived areas, where homeless people are more likely to reside, have difficulties recruiting and retaining GPs, who are at increased risk of suffering 'burn-out'.[80] General practitioners have been criticised for stigmatising the homeless as dirty, drunk, and abusive people who make other patients and staff uncomfortable.[42,43,81] The negative atti-

tudes of some primary care staff, and the lack of specific training for GPs,[81] also inhibit access to health care, which may cause some homeless to lose faith with the healthcare system.[47]

Improving primary care access

To overcome these problems, projects have commenced to facilitate this group's access to primary care and in 1994 the Royal College of General Practitioners identified three models for delivering primary care to the homeless that have particular relevance today:[22]

1. Full integration into mainstream health services.

Examples include using health visitors to:

- encourage the development of safe child play areas, offer breastfeeding advice, carry out HIV awareness work,[35] and teach other principles of healthy living to homeless families;
- become patient advocates with a GP or practice nurse and promote links with health, education, welfare, and social services regarding clients;[82] and
- refer minority ethnic clients to an advocacy project for officially homeless people and a fully computerised notification system for the arrival of temporary homeless families into the area, facilitating identification.[48]

2. Integration via specialist schemes

Examples of specialist schemes established in hostels for single homeless include:

- GP services in night shelters[28] or hostels;[29,83]
- the provision of nurses to carry out health checks and referral into primary care in Salvation Army hostels;[62]
- the provision of clinical nurses for the homeless mentally ill;[84] and
- systems for the diagnosis and treatment of tuberculosis for homeless people[70] — although the cost effectiveness of screening for tuberculosis has been considered too expensive.[85]

3. Exclusive services

Examples of separate services developed and adapted for rough-sleeping homeless people include:

- nurses with experience in the developing world providing daily surgeries for the homeless with minor primary care needs;[43]
- outreach work by nurses for rough sleepers incorporating health promotion activity, such as the promotion of safe sex, and the use of portable records to prevent the duplication of effort — this has been successful;[86]
- separate specialist services providing general practice-based holistic models of primary health care, involving work with substance misusers and integration with psychiatric services and outreach services;[43] and
- clinics engaging in outreach work on the streets and providing a drop-in service to provide 'hard-to-reach' groups with HIV education and prevention materials

and opportunities for referral to more specialist care.[87]

Discussion

Provision of primary care for homeless people has hitherto been makeshift and the way services are offered do not always match the needs of homeless people. It is recognised that improved access to primary care for homeless people will not be a panacea for their problems. A coordinated approach that examines the underlying causes of homelessness has been neglected, and homeless and primary care agencies are forced to adopt a reactionary approach to their health care as a consequence. The very fact that more specialised clinics are needed to offer primary care to homeless people is perhaps indicative of some of the detrimental public policy changes.

The current UK government has expressed its commitment to helping the most vulnerable in society, particularly the rough-sleeping homeless.[88] The Rough Sleeping Initiative reported the government's declaration to cut the number of rough sleepers by two-thirds by 2002 and to give them better access to a range of health and social services to facilitate their integration into mainstream society.[88] Interim targets have been set to monitor this reduction,[89] and estimations by the unit were of a dramatic reduction in the number of rough sleepers, from 1850 in 1998 to 532 in December 2001.[90] These figures are calculated by undertaking 'night counts', which have been criticised for not being sufficiently thorough.[91]

The government has warned against members of the public providing money to homeless people on the streets. They have found an unlikely ally in the founder of the charity publication *The Big Issue*, John Bird, who pronounced that this actually does not help them because it allows them to stay on the streets; this actually prevents them looking for jobs, and the cycle of dependence continues.[92] Commentators have warned that the governmental stance on begging, and the reduction of cold winter shelters for the street homeless, may marginalise some of them further.[91] By providing accommodation without investment in social support and improvement of their social networks, it is possible that many will return to the streets.[2]

New policy developments, such as the personal medical services (PMS) pilots, address issues of access to health care in 25 primary care centres for homeless people around the country.[93] Although many of these sites have established separate services for homeless people, lessons can be learned from the innovative approaches taken in these sites that can be integrated into mainstream services. In certain local first-wave sites under the national evaluation of PMS, innovative approaches to health care have been adopted, with practitioners moving into new roles, towards a holistic approach to primary health care.[94] There is evidence of breaking down intersectoral barriers, promoting innovative relationships between practitioners and non-statutory voluntary organisations, with increased emphasis on the World Health Organisation's principles of primary health care[95] and community development approaches.[96] Such advances enable a socially-orientated approach to people's health and social care that is not entirely focused within the remit of health, which is more appropriate for homeless people. Let

us not forget the lessons of the first-wave PMS sites, and adopt community-focused health care for vulnerable populations, which would include homeless people within that remit. The adoption of an approach throughout primary care would enable their integration into mainstream services.

It is the heterogeneity and specialist requirements of homeless people that make catering for their health needs problematic, particularly by overstretched GP services. As a consequence, separate services, or the work of innovative practitioners, have been initiated to facilitate homeless people's access into health care. Despite the efforts of specialist services and innovative primary care practitioners, their impact can only be limited to the local areas that they serve.

There is the valid argument that separate services for the homeless would marginalise them further, and as a result the only way forward is to 'mainstream' their health needs. There is the potential for the 'ghettoisation' of health care for homeless people to occur even in successful specialist centres,[97] whereby such services exacerbate homeless people's marginalisation by ensuring that they are distinctly separate to those who receive mainstream services. This can perhaps be illustrated further by some of the results from our work on the national evaluation of PMS. Over 60 homeless people attending PMS clinics were interviewed to ascertain their levels of satisfaction with the services they received,[98] and it was found that homeless people attending them were grateful for these services. However, unlike the mainstream attendees who were also interviewed in the same study, homeless people were not acting as 'consumers' of health care.[99] Rather, they were targeted by the PMS scheme and brought under the control of the PMS organisation. Practitioners adopted a 'paternalistic' relationship with their homeless clients. It would be naïve to conclude that, because homeless people were accessing health care, they really had a full range of choice. Their true integration into the system will occur when they are able to make the same choices as mainstream users.

The solution, therefore, lies in full integration of homeless people into mainstream primary care services. For this to occur, practitioners and staff would require significantly more knowledge, training and development, and the support of Primary Care Trusts. The current preoccupation of local health care economies with the National Health Service rapid organisational change agenda, such as clinical governance, have meant that inequalities in health have slipped down the agenda. A change in emphasis is required to provide such support.

Although there are innovative practitioners, who have been mentioned in the literature, and PMS homeless clinics have been implemented, there remain plenty of gaps in the system. The geographical distribution of such clinics around the country has been quite erratic. For example, contemporary research from Crisis (the UK charity for solitary homeless people) highlights that homeless families were 40 times less likely to be registered with a GP than members of the general public, and were still more likely to use A&E services. In addition, according to a MORI survey of GPs across Britain, four out of five GPs believed that it is more difficult for a homeless person to register with a GP than an average person. This may be owing to surgery time constraints, atti-

tudes within the surgery, and to the characteristics of homeless people. Ninety per cent of those interviewed believed that extra resources are needed to care for the homeless. General practitioners should therefore be provided with incentives to register homeless people. Adequate training and resources should be provided in order to achieve this in the UK.[100]

Despite the current positive developments, the present situation remains unsatisfactory. Over a quarter of a century after Tudor Hart's landmark paper,[1] large numbers of the most vulnerable people in society have poor health and difficulties in accessing appropriate health care because of their insecure accommodation. In parallel with developing appropriate primary and social care services for the homeless, new social policies are needed to address the underlying causes of the problem. These policies need to move beyond localised or targeted initiatives, however worthwhile these are in their own right, to change society's structure and attitude. Such policies should focus on making appropriate affordable accommodation available for all and eradicating the distinction between the 'deserving' and the 'undeserving' poor. Little appears to have changed since the publication of 'The Inverse Care Law'. It is time to target resources in areas such as primary care, to support the mainstreaming of homeless people throughout services in the UK. This would be the first step of many on the long road to integration into the health system and society.

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