



Homelessness is a healthcare issue

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DECLARATIONS Chronic homelessness is a red flag symptom, marking a significantly increased risk of ill-health and premature death. For too long the NHS has dismissed homelessness as simply an issue of housing and social care, but there is a growing body of evidence that long-term homelessness is fundamentally an issue of health.

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A recent study of homeless patients (including hostel-dwellers) admitted to hospital in Glasgow with drug-related problems found that they are seven times more likely to die over the next five years than housed patients with the same drug-related reason for admission.¹ Research from Canada shows that a 25-year-old man living in a shelter or rooming house has only a 1 in 3 chance of surviving to 75 years, compared to 2 in 3 for all 25-year-old Canadian men.² The average age of death for homeless patients in the UK is between 40 and 44 years old.³

One consequence of the failure to treat and prevent the health outcomes of homelessness is increasing expenditure in secondary care. For example, comparison of practice-based commissioning data from a GP practice for homeless patients in Leicester with the activity of neighbouring inner-city practices shows that homeless patients attend A&E six times as often as the housed population, are admitted four times as often, and stay twice as long. The result is unscheduled secondary care costs that are eight times those of housed patients.⁴ There are estimated to be 40,500 homeless people in England (defined as rough sleepers plus those in hostel accommodation) generating secondary care costs of £85 million annually.³ Investigations by the Office of the Chief Analyst have shown that high secondary care costs associated with prolonged stays are not, as might be supposed, the result of bed-blocking. Comparison of duration of stay with Hospital

Episode Statistics data shows that the lengths of admissions are generally appropriate for the admitting condition. In other words, homeless patients stay twice as long in hospital because they are twice as sick.

Chronic homelessness is characterized by trimorbidity; physical ill-health with mental ill-health and substance misuse. Primary care is the only specialty with the training and skills to address all of these issues in one consultation and most of the innovation around healthcare for homeless people has arisen in primary care.

There are a number of high quality homeless health services around the country that have developed innovative and collaborative methods of working with homeless people. But rarely has a Joint Strategic Needs Assessment identified an excluded group and commissioned a new service to meet their needs. Usually these services have been chiselled out by local champions, against active and passive resistance from commissioning bodies, but perhaps this is going to change.

A recent Cabinet Office project on 'Inclusion Health' draws attention to the particular needs of excluded groups such as homeless people, sex workers, gypsies and travellers, prisoners and those with learning difficulties.⁵ The combination of complex needs with chaotic lifestyles results in low expectations of healthcare, which are frequently realized. Both patients and those who specialize in addressing their needs often feel isolated and discriminated against by a system that seems to blame the individual who does not fit narrowly-defined criteria for access to services.

The Marmot review⁶ highlights the fundamental unfairness and injustice inherent in the increasing inequalities of our society, and the economic and social consequences that impact on the rich as well as the poor. He proposes a system of

'proportionate universalism' – helping all sections of society 'but with a scale and intensity that is proportionate to the level of disadvantage'. For the homeless population this raises the possibility of improving outcomes by targeted investment, with the very real prospect of reducing unscheduled expenditure in secondary care.

Homeless patients and those who work with them are accustomed to the creativity and ingenuity that arises on the edge of chaos. One radical approach is to encourage multi-agency community teams onto hospital wards. At UCH, people with an experience of homelessness join a GP and nurse team on regular ward rounds to visit homeless patients throughout the hospital, advocate for their treatment in hospital, plan for their discharge and support them in the community. Early indications are that this approach improves care and discharge planning, while offering overall savings by reducing the small numbers of patients with very prolonged durations of stay.⁷

Marmot encourages us in the words of Pablo Neruda to 'rise up with me against the organisation of misery'. Working with homeless people to

improve the health of their peers gives health professionals the opportunity to re-ignite the passion and vocation that took them into the caring professions, and offers the prospect of improving healthcare systems for the benefit of us all.

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