

## **Kerslake Commission - Pathway submission paper**

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### **Learning the lessons from the Covid19 pandemic, how can we get inclusion health adopted at scale and with sufficient intensity of provision across the National Health Service?**

The health status of people experiencing homelessness and other inclusion health groups is a barometer for the overall performance of the NHS, and, as Michael Marmot says, for the overall health of society.<sup>1</sup>

In relation to inclusion health groups the health service has a dual role:

1) to respond to people facing the most extreme health challenges and risks with urgent, patient-centred, evidence based interventions, wherever possible working to prevent people falling into homelessness and chronic exclusion, and supporting people to become more resilient active members of society, and so reduce the early mortality and suffering associated with profound social exclusion;

2) to vociferously highlight the connections between the harms the health service sees and responds to in its patients, and the wider social and economic factors that create poor health and health inequalities.

#### **Introduction**

Over the last 15 years clinicians working with homeless patients, vulnerable migrants, sex workers, people with substance use disorders and in the criminal justice system have defined and developed a new area of medical and clinical practice. This has been called 'inclusion health'<sup>2</sup>. It is based on a growing weight of evidence that shows just how harmful extreme accumulations of adversity are for people. A seminal paper published in The Lancet in 2017 showed relative risks of morbidity and mortality were 10 times higher among homeless or multiply excluded populations<sup>3</sup>. This shocking level of relative risk of death or

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<sup>1</sup> 'Inclusion Health: addressing the causes of the causes', Prof Sir Michael Marmot, The Lancet, 2017  
DOI:[https://doi.org/10.1016/S0140-6736\(17\)32848-9](https://doi.org/10.1016/S0140-6736(17)32848-9)

<sup>2</sup> 'Joint Statement on Inclusion Health', The Academy of Medical Royal Colleges and the Faculty for Homeless and Inclusion Health, Pathway, 2017,  
<https://www.pathway.org.uk/aormc-joint-statement-inclusion-health/>

3. Aldridge RW., Story A., Hwang SW., et al. 'Morbidity and mortality in homeless individuals, prisoners, sex workers, and individuals with substance use disorders in high-income countries: a systematic review and meta-analysis.' *Lancet*. 2017; (published online Nov 11.) [http://dx.doi.org/10.1016/S0140-6736\(17\)31869-X](http://dx.doi.org/10.1016/S0140-6736(17)31869-X)

disease is a consequence of multiple and sustained exposure to adverse circumstances and experiences across the life course. Social gradients in health in general are driven by structural inequalities in society. The catastrophic collapse in health status for populations pushed to the extreme margins of society has been described as a ‘cliff edge’ effect. Health risks and health harms multiply dramatically when people are pushed to the very bottom of the social gradient and exist in circumstances of extreme economic and social exclusion. Chronic homelessness is perhaps one of the most extreme manifestations of this degree of social exclusion.

Pathway and the Faculty for Homeless and Inclusion Health have used this evidence to make the case within the UK’s healthcare system for more focused attention to and investment in services for people and groups on the very margins of society. We might expect that this evidence of extreme health risk and awful health status would make an NHS founded on principles of equitable access to care based on need and not ability to pay would automatically make inclusion health groups the highest priority for the health service.

### **A forty year view: homelessness, exclusion and human health**

As in so many other infectious disease pandemics Sars-Cov2 infection and disease rates have followed the contours of society, with higher rates of disease and death correlated with poverty, overcrowding, poor housing, low skill/low status employment, ethnicity and many other factors. Covid19 has taught us again that wealth and privilege give protection from disease while poverty and deprivation increases that risk. The observation that the unequal distribution of health status follows social class and reflects our social structure is not new. Since the Black report of 1978 we have seen repeated efforts by public health epidemiologists to persuade Government to act in response to this evidence. In the first decade of the new century the Blair Government set targets to try to narrow health gaps between places. Selected authorities were known as Spearhead areas, additional funding was allocated, targets were set. While that Government was more comfortable being seen to invest in interventions that could be delivered at the individual person to person scale, it was probably its large scale social investments (Sure Start, Tax Credits, benefit reforms to support families with children) that had the most positive impact on health inequalities. In the homeless sector Government invested very significant sums in ‘supporting people’.

In 2009 Michael Marmot delivered his Fair Society Healthy Lives<sup>4</sup> report, the most comprehensive summary to date of the way socially patterned inequalities in health arise, and the most direct challenge to Government to focus on ‘the causes of the causes’, that is the structural social and economic factors that most powerfully drive differential health status in the population, and which shape the society in which we live.

Publicly the 2010 coalition Government’s main apparent response was to establish the ‘nudge’ behaviour change unit in No 10 and launch ten years of austerity-based budgeting. The Government appeared to be signalling that whatever it was going to do, it was not going address any of the causal, structural factors that create health inequalities. Instead

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<sup>4</sup> Marmot, M. Fair society, healthy lives : the Marmot Review : strategic review of health inequalities in England post-2010. (2010) ISBN 9780956487001

they alighted on some emerging social psychology that human behaviour can be shifted somewhat by clever marketing, or psychological tricks. This also had the political advantage of firmly locating health problems, health related social problems and any responsibility for them on individuals. Despite the wealth of evidence presented by Marmot et al. that people's health, and indeed the choices they can make, are constrained by their circumstances, Government chose to talk about 'shirkers and skivers', 'people not carrying their weight', and so on. The deserving and undeserving poor were back.

Government policy for public consumption was that they would nudge us to eat more healthily or exercise a bit more (although they shied away from any of the most powerful nudges in the armoury – taxation or minimum pricing for alcohol for example). If people failed to become healthier, it would plainly be their own moral or character flaw, and nothing to do with austerity and the increasingly harsh social context in which people lived their lives.

In 2020 Professor Marmot's update report<sup>5</sup> showed that the progress made in narrowing health inequalities in the first decade of the 20<sup>th</sup> century had stalled, and that life expectancy improvements for women in the lowest social class groups had actually gone into reverse. Prof Danny Dorling, David Stuckler and many health commentators observed that this stalling in the rise in average life expectancy, and rising health inequalities, was the predictable consequence of austerity and political decisions to reduce public spending, and to distribute those spending reductions (and taxation policy) in such a way that, for example, the poorest ten percent of households saw their incomes fall across the 2010-20 decade.

Across the same decade startling levels of cuts were made to homeless services, the Supporting People programme was effectively cancelled, and UK drugs policy turned towards an evidence-free focus on abstinence as the National Treatment Agency was shut down. By 2017/18 St Mungo's estimated that around £1 billion had been cut from the supporting people budget and English local authorities had reduced spending on homeless services by over 50%. Levels of rough sleeping and homelessness rose across the decade, as did deaths on the street and drugs related deaths.

In a slightly parallel universe, and despite the 'hostile environment' that Government policy created for poorer people in general (and some groups in particular), within the NHS stated commitments to action on health inequalities gradually increased at the same time that wider public policy was making things worse. It seemed Government realised it could not directly tell health professionals the immense scientific base in relation to health inequalities was wrong. However, conveniently for the Government healthcare itself is composed largely of person-to-person interventions, individualised responses. Treatments delivered by healthcare professionals can therefore fit loosely alongside a public policy stance that seeks to minimise or obscure the importance of the wider determinants of

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<sup>5</sup> Health Equity in England, The Marmot Review Ten Years On, Prof Sir Michael Marmot et al, UCL Institute of Health Equity, 2020, <https://www.instituteofhealthequity.org/resources-reports/marmot-review-10-years-on>

health. As the evidence in relation to the structural causal factors that create health inequalities continues to grow, Government has felt comfortable allowing and even encouraging the NHS to try to respond, even while wider public sector and NHS funding formulas have shifted public spending away from poorer areas and towards richer ones. The ‘inverse care law’<sup>6</sup> has been operating at a societal level despite health inequalities related policy pronouncements. When pushed, Government rhetoric describes health inequalities as some kind of naturally arising phenomenon disconnected from social, economic (or indeed racial inequalities) and which can therefore be sorted out by clever doctors and exercise programmes for those lazy, fat, poor people.

As we have seen building engagement across the health service with the problems of health inequalities, and the NHS itself also being rooted in scientific evidence-based practice, NHS institutions, professional bodies and clinicians have been drawn to talk and campaign ever more loudly about the wider determinants of health, as they see the unfair results of social inequalities coming at them – most starkly of course during the pandemic. The ‘Anchor Institutions’ programme for example asks all NHS trusts to think about their wider social role, as local employers, in tackling poverty, in addressing climate change and so on.<sup>7</sup>

Despite the austerity flowing from the Treasury the 2012 Health and Social Care Act included legal duties to reduce health inequalities between patients in access to care, and with respect to the outcomes from care. NHS England’s 2019 Long Term Plan included a set of commitments in relation to health inequalities, to the wider role of the NHS as an ‘anchor institution’ and specific commitments for inclusion health groups (significantly a consequence of the growing body of research evidence and clinical practice generated by the inclusion health sector). Following commitments in the 2018 rough sleepers strategy, Government has asked NIHC to produce formal guidance in relation to rough sleeping. Most recently the newly appointed national clinical director for Health Inequalities has identified inclusion health groups as a key focus for the NHS.

### **Homelessness and health – structural and personal factors combine**

Multi-layered structural social and economic factors (the social determinants of health) set the context for peoples’ lives and how relative good or poor health is distributed. Negative factors act as stressors on individuals, positive factors or experiences increase resilience. The chronic stresses of poverty, of poor quality, insecure or a complete lack of housing, of experiencing racism or unfair discrimination, cause direct physical harm to our bodies and minds, and such stresses accumulate to exacerbate pre-existing problems and reduce an individual’s reserves with which to cope with or recover from a particular life crisis.

Problems that might be manageable for someone with money, a good job, and a stable home can be too much for people who already have little<sup>8</sup>. In this way the UK’s social

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<sup>6</sup> ‘The inverse care law,’ Julian Tudor Hart, The Lancet, 1971.

<sup>7</sup> ‘Wider Social Impact: NHS as an Anchor Institution’, NHS England, 2019  
<https://www.england.nhs.uk/ltp/menu/wider-social-impact/wider-social-impact-nhs-as-an-anchor-institution/>

<sup>8</sup> Glen Bramley & Suzanne Fitzpatrick (2018) ‘Homelessness in the UK: who is most at risk?’, Housing Studies, 33:1, 96-116, DOI: 10.1080/02673037.2017.1344957

structure, particularly our diminished social safety net, has the effect of filtering or sorting people, so that people who are already vulnerable and disadvantaged are more likely to become more vulnerable and ultimately more likely to fall into homelessness. People who end up homeless are therefore likely to have more other problems than people who do not, including, as a huge weight of research now shows, nearly every kind of health problem.<sup>9</sup> However the negative trajectories towards homelessness (and towards the poor health that so often accompanies it) are not different to the negative trajectories described in wider work relating poverty and social exclusion to poor health for individuals and health inequalities in society.

Once people become homeless, and the longer they spend in a homeless or deeply excluded position in society, physical and psychological harms increase rapidly, health deteriorates, risk of death rises and the enmeshed, negative and interlocking nature of people's problems is likely to become more intense. It is suggested that long term exposure to poverty, to low social status, to structural inequalities speed up the 'weathering' effect of life. One recent study found rates of multiple long term conditions in 50 year olds living in a homeless hostel equivalent to those found in the over 80s in the general population, and with rates of multimorbidity that are rare even in care homes.<sup>10</sup> However homelessness, and the harms it causes, are not just problems that afflict single people, the same layering, cumulative negative health impacts are felt by homeless families, and children in homeless families are particularly vulnerable.

At the individual level, poor and deteriorating health is both a consequence of homelessness and a risk factor for homelessness and other forms of deep exclusion. Homelessness, and the wider constellation of extreme negative social markers for high health risk, should be recognised as a serious problem for the UK's health system. The provision of a home, a job, some purpose in life and the potential for meaningful relationships may not be seen as core business for the NHS but any examination of the chains of events that lead people both into and away from homelessness and social exclusion shows that health services could be configured to do more to prevent a decent towards the street. Preventing homelessness should be considered a health service priority.

At the same time the NHS should see the onset of homelessness as an extreme 'red flag' marker of health risk and health harm. Services should avoid attaching 'homeless' as a fixed or permanent label on a person experiencing homelessness but they should find out about people's housing status and act where it raises concerns. People experiencing homelessness

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<sup>9</sup> For a recent example see Lewer D, Aldridge RW, Menezes D, *et al* 'Health-related quality of life and prevalence of six chronic diseases in homeless and housed people: a cross-sectional study in London and Birmingham, England' *BMJ Open* 2019;9:e025192. doi: 10.1136/bmjopen-2018-025192

<sup>10</sup> 'Premature frailty, geriatric conditions and multimorbidity among people experiencing homelessness: a cross-sectional observational study in a London hostel', Rogans-Watson, R., Shulman, C., *et al*; Housing Care and Support. 2020. DOI [10.1108/HCS-05-2020-0007](https://doi.org/10.1108/HCS-05-2020-0007)

will very often have had other life experiences known to be severe health risks – care leaver, prisoner, alcoholic, poor person – but people who have survived these experiences quite rightly routinely object to being defined by their histories.

We strongly support Crisis’ vision for any episode of homelessness to become rare and brief so that the harms that follow from it are minimised. Crisis’ broad call is for a national policy response that, to use medical terminology, ‘treats’ the problem at the individual level when it happens, while at the same time aligning all services and public policy to ‘prevent’ homelessness in the first place.

For health service commissioners and planners we believe that the wider lens of ‘inclusion health populations’, helps to encourage services to be concerned not just with the immediate problems confronting a patient, but also the causes and the causes of the causes of their poor health. This frame asks clinicians to take a broad view of what is going on for someone. For homeless and inclusion health services we endorse the strong call from many mental health services to shift the mindset away from the question ‘what’s wrong with you?’, towards the exploration with a patient of ‘what’s happened to you?’

At the same time direct homelessness – the absence of a home – is obviously eminently treatable, with the rapid provision of safe, affordable housing for example. The NHS needs to recognise that it is core business to engage with housing and other support agencies to prevent homelessness and respond rapidly whenever it comes to light. Homelessness is a very direct cause of ill-health so health services should see responding to homelessness as core business, in terms of treatment and prevention. For people who have gone on to accumulate multiple health conditions, psychological harms and other problems, the NHS should provide ongoing, needs-based, integrated care and support<sup>11</sup>.

### **The NHS in 2021 – opportunities for inclusion health – how to build back fairer.**

As we emerge from the first phase of the Covid19 pandemic what the lessons for the NHS from ‘Everyone In’ and the wider response? What should the NHS do now to improve services for inclusion health populations and address the shocking health inequalities faced by these groups?

The NHS Long Term Plan, and the forthcoming Health and Social Care Act, are driving another re-organisation of NHS bureaucratic structures. Two core changes are the shift away from the heavily marketised approach to NHS service commissioning that has been dominant for the last 20 years, to be replaced by ‘population health’; and this to be delivered by a new organisational infrastructure – Integrated Care Systems (ICS). As part of their mandate to look after their population’s health, the ICS structures will be charged with acting on health inequalities.

Responsible for health services for areas with populations of 1.5 million, NHS England considers ICS’s to have about the right scale of operations to take a strategic overview, to

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<sup>11</sup> Using Housing First in Integrated Homelessness Strategies: a review of the evidence, Nicholas Pleace, 2018, Centre for Housing Policy, University of York.

generate economies of scale for many services and to mobilise resources to better respond to local need. This thinking is informed by the development of ‘population health’ and ‘population based commissioning’ as new management concepts within healthcare. “Population Health is an approach that aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population.”<sup>12</sup>

### Three lessons of Covid

1. One of the fundamental lessons from ‘Everyone In’ was that rough sleeping and the more extreme end of homelessness is not an intractable problem. In the face of the pandemic, and with Government funding, it was possible to get most people off the street very rapidly. Giving people decent, non-stigmatising accommodation with no strings attached, while providing care and support was immediately transformational for many. ‘Everyone In’ also rapidly surfaced the very significant burden of pre-existing unmet health need in the homeless population. The long-term lack of appropriate, accessible (and joined up) mental health and substance mis-use services was particularly obvious.
2. For inclusion health groups the pandemic response also demonstrated the huge value of specialist inclusion health services. These were the services that mobilised around the hotels, knew many of the residents, and understood how to work with patients with long histories of exclusion. In some parts of the country well motivated mainstream primary care services also stepped up. The pandemic response also showed that when bureaucracies got out of the way, practical collaboration and joint working between agencies, at the level of the front line staff can rapidly become the norm.
3. The pandemic also showed that ‘inclusion health’ services were in many places either non-existent or very seriously under-resourced. Many of the services that mobilised found themselves working completely beyond their routine service boundaries, way beyond their capacity, and many individual staff found themselves working far beyond what should be expected of anyone.

### **Recommendations: how can we secure some of the gains?**

Pathway and the Faculty for Homeless and Inclusion Health have long argued that becoming homeless should always be treated as an urgent health crisis. This happened during the pandemic but should become the norm. The pandemic showed that a rapid multi-agency response is possible. Immediate access to decent temporary accommodation is a vital part of the mix and from a healthcare perspective specialist inclusion health services should be commissioned at adequate scale right across the country. The Faculty of Homeless and Inclusion Health (hosted by Pathway), alongside leading academic institutions (particularly UCL’s Collaborative Centre for Inclusion Health) have assembled a strong evidence-base of what works in inclusion health<sup>13</sup>. Much of this evidence is collected in the Faculty’s Standards<sup>14</sup>. So there is now a good body of knowledge of what health services should do.<sup>15</sup>

<sup>12</sup> <https://www.england.nhs.uk/integratedcare/what-is-integrated-care/phm/>

<sup>13</sup> ‘What works in inclusion health: overview of effective interventions for marginalised and excluded populations’. [Serena Luchenski, FFPH; Nick Maguire, DClin Psych; Robert W Aldridge, PhD ; Prof Andrew](#)

This evidence, and the learning that rapid, at-scale change is possible, should now be built into the emerging new infrastructure of the NHS and population based commissioning and lead to increased allocation of resources for the care and treatment of inclusion health groups. To achieve this end we recommend that:

- NHSEI should appoint a designated senior inclusion health lead – possibly a National Clinical Director
- At the national level NHSEI should commit to redressing the inverse care law that operates in relation to services for the most excluded populations, this will mean intentionally targeting extra resources at areas and populations with the highest health needs
- ICSs are mandated to have a board level director with responsibility for inclusion health populations, including annual monitoring of the population’s health and reporting on levels of needs, and responsible for commissioning an integrated set of services in response to that need
- As part of wider work on health equity ICS’s should set targets to reduce mortality in inclusion health groups and narrow the mortality gap with the general population (ICSs may want to commit to a target of reducing the size of these populations in their area through supporting people out of homelessness and multiple exclusion)
- ICSs are mandated to formally engage with other relevant agencies working within their geography, particularly with local housing authorities and play a leading role in eliminating homelessness and rough sleeping

In terms of service content ICSs should seek to commission:

- Integrated sets of services for inclusion health populations, with sufficient resources to meet local need, and with strong connections to all other NHS services and to relevant local authority and third sector services<sup>16</sup>;
- Services with the professional capacity to respond the interlocking and often multiple health needs of individuals in these populations, rooted in the values of the NHS in general and the Faculty for Homeless and Inclusion Health in particular: “valuing each individual, building a respectful and trusting relationship and working with their priorities from a position of hope.”

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Hayward, MD ; Alistair Story, PhD ; Patrick Perri, MD Nigel Hewett, MD. et al. The Lancet, November 11, 2017  
DOI:[https://doi.org/10.1016/S0140-6736\(17\)31959-1](https://doi.org/10.1016/S0140-6736(17)31959-1)

<sup>14</sup> ‘Homeless and Inclusion Health standards for commissioners and service providers’, The Faculty for Homeless and Inclusion Health, Pathway, 2018 (recent additions includes guidelines for street outreach services, and a quick guide for paramedics.)

<sup>15</sup> Formal NIHC guidance on homeless and inclusion health is expected in the next 12-18 months

<sup>16</sup> Delivering truly integrated care for all patients is a fundamental objective of the new NHS Integrated Care Systems. <https://www.england.nhs.uk/integratedcare/>