OCCASIONAL PAPER 4

Homelessness and the Utilisation of Acute Hospital Services in London

Mary Ann Scheuer, Mary Black, Christina Victor, Michaela Benzeval, Mike Gill and Ken Judge

King's Fund Institute

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Any errors of fact or interpretation are ours alone.

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Executive summary

It is widely believed that homeless people place considerable demands on emergency hospital services, but quantifying this in a systematic way has proved difficult. The primary purpose of this paper is to develop a better empirical understanding of the nature and extent of unplanned admissions to acute hospitals in London by homeless people.

Data was collected about the distribution of different types of homeless people in London and attributed to the 28 district health authorities.

- The estimated total number of homeless people in London who are living in temporary accommodation, hostels and on the streets is approximately 60,000.
- Ninety per cent of this homeless population is accounted for by the 'official homeless' i.e. those placed in temporary accommodation by housing authorities.
- Parkside health authority has by far the largest number of homeless people within its geographic boundaries.

Data was collected about all unplanned admissions to seven hospitals in two former inner London DHAs during November 1990, and homeless people were identified. From this data, specific admission rates were calculated for different categories of homeless people. These appear to be between two and three times greater than those for resident populations.

Although the data show that homeless people are relatively more likely than local residents to make unplanned use of hospital services, what is equally important is that there is considerable diversity of experience between the different categories of homeless people.

The housing status-specific admission rates were applied to estimates of the prevalence of homelessness across London to predict the total level of unplanned admissions by homeless people in each DHA.

- It is estimated that homeless people in London are likely to generate in excess of 7,500 unplanned admissions to acute hospitals per year.
- There is considerable variation in the number of unplanned admissions among DHAs, ranging from 38 in Bexley to 1,515 in Parkside.

The scale of the problem can be illustrated by calculating the number of extra admissions which arise from homeless people in a district for every thousand resident in-patient admissions.

- On average, homeless admissions add an extra ten admissions for every thousand in-patient admissions in a London district health authority.
- Three DHAs — Haringey, Riverside and Newham — experience over double this rate, and Parkside has an additional 35 homeless admissions per 1000 resident in-patient admissions.

The full impact of unplanned hospital admissions amongst homeless people, however, cannot be captured adequately by these bald statistics. An assessment of all the financial and organisational effects requires more detailed research about the implications of treating large groups of homeless people.

Consideration of these findings, in the context of a broader review of the problems of homelessness, suggests that a new approach to policy and practice is most badly needed in relation to housing policy, the planning of health services, and NHS resource allocation.

1 | Introduction

Homelessness is one of the most urgent, dramatic and visible social problems of the 1990s. In recent years, densely-populated urban areas have witnessed a dramatic increase in the number of homeless people. The problem is most acute in the capital. For example, the number of households placed in temporary accommodation by London boroughs increased by over fourfold from 4,600 in 1981 to 19,000 in 1987. By the end of the 1980s, London was trying to cope with more than 50,000 people in these circumstances, more than 40 per cent of whom were placed in very poor quality 'bed and breakfast' accommodation. Literally countless more were crowded into too few hostel places or huddled together in 'cardboard cities'.

A recent estimate suggests that:

> Today, Greater London has about 11 per cent of the population of Britain but nearly 30 per cent of the country's registered homeless households ... Inner London continues to have the highest incidence of registered homelessness (Greve, 1990, p. 7).

Official statistics do not include large numbers of homeless people. About twice as many people apply to local boroughs' homeless persons units for housing as are accepted. Many do not bother to apply at all. If they were included in the statistics, London's share of the nation's homeless would probably be even greater than reported. Box 1 defines homelessness and describes the various types of situations in which homeless people live.

Homelessness and health

Homelessness is not simply a housing problem; it has profound implications for health care. As the government starts its move to funding regional and district health authorities on a strict weighted capitation basis, the extra resource implications of certain population groups are becoming clearly more pressing, especially when these groups are heavily concentrated in specific areas. One striking example of this is the case of homeless people in London.

Housing conditions directly influence people's physical and mental health; however, exact quantification of this relationship is difficult because of pervasive methodological problems. Homeless people experience the most extreme form of housing problems, and because of their economic

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Definition of homelessness

The term homelessness is widely used to describe a range of circumstances. As a result, the phenomenon both lacks a precise definition and is difficult to measure. It makes most sense, therefore, to think of homelessness as part of a continuum, with sleeping rough at one end and absolute security of tenure in the form of outright ownership at the other.

Homeless populations may be described in terms of a compilation of different groups according to where individuals live or find refuge. First, there are the 'official' homeless: households which are accepted by local authorities under their statutory obligations to provide homeless people with temporary accommodation, in such places as bed and breakfast (B&B) hotels and private sector leased (PSL) accommodation, before permanent housing is found. Second, hostels provide emergency and direct-access housing for many single homeless people. Third, there is the most visible homeless population, namely those people who are sleeping rough and are 'roofless'.

Beyond these fairly clearly defined groups, there are a wide range of 'hidden homeless' – people who for various reasons are living in vulnerable, unstable or unsatisfactory situations. These include squatters, people who refer themselves to B&Bs, are sleeping in over-crowded conditions, or live in situations where they are vulnerable to physical or sexual abuse. It is very difficult to assess the numbers or distribution of these people.

The 'official' homeless are relatively easy to count but is important to understand that their temporary accommodation is far from satisfactory. The problem with homeless hostel dwellers and roofless people, however, is to identify how many such people there are and what their distribution is throughout a large urban area.

and social circumstances they make heavy demands on health and social services. There is a growing concern amongst professionals that, compared with others of the same age, homeless people are likely to have lower thresholds for admission to hospitals, may have longer lengths of stay when they get there, and put considerable pressure on community services. However, there are few empirical data which quantify the extra health needs of, and demands placed on health services by, homeless people. Stern *et al.* (1989) found that 18 per cent of their survey population of homeless persons reported an in-patient stay in the past year, as compared with 9 per cent of the general population as reported in the General Household Survey for 1986. Over 25 per cent of the people sleeping rough and in supportive housing projects in their study reported an in-patient stay in the past year (Stern *et al.*, 1989).

Homelessness in any form is a debilitating experience, with tremendous impact on a person's whole life. The situations of homeless people vary significantly, and different health problems are likely to occur in different homeless populations. For example, in Box 2, an extract from a British Medical Association (BMA) report graphically describes the kinds of

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Homelessness and health

Homelessness is the most extreme form of housing difficulty and is becoming more common ... especially in London ... Because of the housing shortage several local authorities rely extensively on bed and breakfast hotels for homeless families ... Even if hotel accommodation is in good order it is rarely appropriate to the needs of young children. It it difficult to maintain hygiene while washing, eating, and sleeping in one overcrowded room. High levels of gastroenteritis, skin disorders and chest infections have been reported. Kitchen facilities are often absent or inadequate, so people are forced to rely on food from cafes and take-aways, which is expensive and may be nutritionally unsatisfactory. The stress of hotel life undermines parents' relationships with each other and their children. Normal child development is impaired through lack of space for safe play and exploration. High rates of accidents to children have been reported, probably due to a combination of lack of space and hazards such as kettles at floor level.

Source: BMA, 1987, pp.13-14.

problems which can arise for homeless families housed by local councils in bed and breakfast temporary accommodation.

More specifically, the health problems of homeless families housed temporarily by local councils can be summarised into three categories:

- problems of mental strain – living conditions are stressful and depressing;
- hygiene problems – generally poor conditions for storing, preparing and cooking food, and washing and general facilities;
- unemployment or low wages, large families, and dislocation make the homeless particularly vulnerable.

These problems may occur in an exaggerated form for pregnant women and children under 5. The Health Visitors' Association (HVA) and the BMA (1988, p. 12) state that:

> research indicates that pregnant women living in B&B accommodation were more than twice as likely to have problems in pregnancy as women who became homeless after the birth of their baby. Homeless women were also more likely to be admitted to hospital during their pregnancy.

A study by Patterson and Roderick (1990), cited in the Faculty of Public Health Medicine report (1991, p. 72), compared a group of pregnant

homeless women housed in B&Bs with a group of pregnant housed women. The babies of the homeless women had significantly more problems in spontaneous breathing after delivery, and there was a higher prematurity rate.

Single homeless people living in hostels and sleeping rough experience different circumstances and have different types of health needs than people in B&Bs and PSLs. Barry *et al.* (1991) summarised the common problems experienced by single homeless people as follows:

- broad range of illnesses related to the condition of being homeless (bronchitis, tuberculosis, arthritis, skin diseases and infections);
- alcohol and drug related problems;
- psychiatric problems, most commonly schizophrenia.

Neglect of illnesses until an advanced stage is reached also intensifies many of these problems.

The issues surrounding mental health problems and the single homeless are complex and it is not easy to untangle the direction of causation. The recent report by the Faculty of Public Health Medicine (1991) discusses these issues. Among other things they state:

> Mental illnesses (eg schizophrenia, depression) have been found by numerous studies to be more prevalent in homeless people. Homelessness is itself a stressor and it is probable that it is directly responsible for cases of mental illness; conversely, mental illness, particularly psychosis, can lead to homelessness (Faculty of Public Health Medicine, 1991, p. 125).

Although establishing causality may not be possible, it is important to realise that areas with high concentrations of single homeless people will also have high concentrations of people with problems of mental illness.

Poor access to primary care

Despite the varied health problems which they face, homeless people in London may encounter many barriers to access for primary health care services and, as a result, rely excessively on acute services. The provision of primary health care services across London is patchy, at best. Sir Donald Acheson's review (1981) highlighted many problems with primary health care services in inner London. The report cites factors such as the large number of single-handed GPs and the lack of support staff as obstacles to patients' access to primary care.

> In areas with major social problems the primary care services are less well organised to cope with the extra burdens involved in caring for patients in the community and many more people end up being treated in hospital (Acheson, 1981, p. 19).

This is still a problem today. London has 70 per cent more single-handed GPs and 40 per cent fewer support staff than the rest of the country (Benzeval *et al.*, 1991, p. 28).

The homeless are particularly vulnerable to poor primary care services. Again, there is a diverse experience among homeless persons. Stern *et al.* (1989) found a 'clear disparity' when they looked at GP registration by length of stay at the current address. The homeless individuals in the study population who had been in their current accommodation for more than 6 months were far more likely to be registered and were 2.5 times more likely to be registered in the local area than those in the study group who had lived in their accommodation less than 6 months. Stern *et al.* concluded that

> the data suggests that registration with GPs is not a particular problem for all single homeless people; but for people in the worst accommodation groups (sleeping out or in large hostels) or for people who frequently moved between accommodation, it is a severe barrier to access (1989, para 5.5.2.1).

Homeless families housed temporarily by local councils are likely to encounter similar barriers to access if they are moved outside of their local area. In London, boroughs frequently house people outside of their home borough because temporary housing units (either B&Bs or private sector leased accommodation) are concentrated in some parts of London. As the HVA and BMA (1988) reported, 'homeless families who hope that their situation is temporary might well give registering with a GP much lower priority than the more immediate problems of food, warmth and basic amenities'. They may be unfamiliar with local GP and surgery arrangements, unaware of the family health service authority (FHSA) and its functions, and there may be a substantial language problem. Even if families do try to re-register with a local GP, the GP may only register them as temporary patients.

As a result of these barriers of access to primary care services, homeless people use accident and emergency services as an entry point into the health service. As one homeless person told Stern *et al.* (1989), 'I won't go to a doctor unless I'm seriously ill; and if I'm seriously ill, it's time to go to the hospital.' It is not valid to assume that all utilisation of acute A&E services by homeless people could be dealt with more effectively by a GP.

While for some cases this may be so, it is also likely that the homeless become acutely ill far more often than the general population because of barriers to primary care services and because of their social and economic circumstances.

Objectives of the report

Given the health-related problems associated with homelessness and the new emphasis on funding the needs of resident populations, it is essential to develop a better empirical understanding of the nature and extent of the problem. The study reported in this paper investigates the utilisation of acute unplanned in-patient services by homeless people housed temporarily by local councils, living in hostels or sleeping on the street. Despite our focus on the utilisation of acute services, we are fully conscious that acute services form only one part of the health care services needed by homeless persons.

This study has four specific objectives. First, to describe the numbers and distribution of homeless people across London district health authorities. Second, to quantify the utilisation of acute in-patient hospital services by homeless people in two study areas encompassing the former London district health authorities of Bloomsbury and Paddington & North Kensington (PNK). Third, to assess the impact of the utilisation of acute service by homeless people across London. Finally, in the light of our findings, we identify specific areas where further action is required to tackle health problems associated with homelessness.

2 Distribution of homeless populations in London

As discussed in Box 1, an essential feature of homelessness is the range of circumstances it refers to. Information was gathered for this study on the distribution of different types of homeless people in London, according to where the individuals live or find refuge. The following are the most common categories:

- 'official' homeless – households which are accepted by local authorities under their statutory obligations and placed temporarily in either:

  a) bed and breakfast (B&B) hotels,

  b) private sector leased (PSL) accommodation;
- hostels – individuals staying in emergency night shelters, traditional and short-stay hostels;
- sleeping rough – individuals who are literally roofless.

The wide range of 'hidden homeless' have not been included in this study because no formal count has been assembled of their numbers across London. In addition, they are difficult to identify consistently at the point of service use.

Studies which count the number of various types of homeless people across London almost always group people according to the boundaries of London boroughs. In order to assess the number of homeless people in district health authorities (DHAs), we first assembled information on different types of homeless people by boroughs and then translated those figures to DHA boundaries on the basis of information supplied by the Office of Population Censuses and Surveys (OPCS).

It is important to bear in mind that much of this data consists of the best available estimates and it is widely acknowledged that these figures are underestimates.

Homeless populations in London boroughs

'Official' homeless

Local authorities are required to provide accommodation for homeless people who are in 'priority need' and are not 'intentionally homeless'. The Housing Act of 1985, Section 3 states that a person or family is in priority need if they:

- have a dependent child, usually under 16;

- are pregnant or with a partner who is pregnant;
- are 'vulnerable' because of old age, mental illness or handicap, physical disability or for 'other special reasons'; or
- are homeless because of an emergency such as flood or fire.

In practice, councils have a great deal of scope in determining which persons qualify under these criteria.

Although the original legislation foresaw temporary accommodation being used only to house families undergoing investigation, it is clear that in London the majority of households in temporary accommodation have been accepted as homeless and are awaiting permanent rehousing.

The London Research Centre's Bed and Breakfast Information Exchange (BABIE) regularly publishes information on the numbers of homeless households housed by London boroughs in bed and breakfast hotels and private sector leased accommodation.

i) Bed and breakfast hotels

The data are based on households placed in bed and breakfast hotels by London borough homeless persons units in March 1990 under their statutory obligations (BABIE, 1990). The data is organised by the borough in which the hotels were located, not by the funding boroughs. The figures were collected in household units and converted to number of individuals using the current best estimate that there are an average of 2.8 individuals in a household placed in hotels by local authorities (Thomas and Niner, 1989, Table 4.8, p. 50).

ii) Private sector leased accommodation

The data are based on households housed in private sector leased accommodation by London borough homeless persons units in March 1990 under their statutory obligations (BABIE, 1990). The data is organized by receiving borough, not by placing borough. Again, the figures were collected in household units and converted to individuals as above.

Hostels

It was very difficult to determine which types of hostels house the homeless and therefore should be included in this survey. The *London Hostels Directory* (Newman *et al.*, 1989) classifies hostels into 16 categories depending on the group targeted. These range from emergency nightshelters to hostels for students or ex-offenders. This study has focused on three categories of hostels which provide housing for homeless individuals:

emergency nightshelters, short-stay hostels and traditional hostels.

Emergency nightshelters are defined by the directory as hostels which provide immediate access accommodation for people who are homeless and do not have enough money to find alternatives. Short-stay hostels provide accommodation for between a few weeks and 3 months for people who are homeless. Traditional hostels are large hostels, many of which have developed from the old 'common lodging houses' and have traditionally been used by people who have been homeless for some time (Newman *et al.*, 1989). The total number of bedspaces in these three categories of hostels were counted for each borough in order to estimate the number of people living in hostels.

Given the high occupancy rate in hostels – Canter *et al.* (1990) found a 96.3 per cent occupancy rate in their survey of London hostels – it was assumed that the distribution of bedspaces is a fair indication of the distribution of individuals staying in hostels. Therefore, the total bedspaces in hostels was counted, not the actual number of individuals.

Sleeping rough

The data about people sleeping rough are based on a comprehensive street count carried out by the University of Surrey and Salvation Army researchers on 25 April, 1989 (Canter *et al.*, 1990). It is important to note that the survey did not include sixteen of the thirty-three London boroughs because the researchers could not establish local contacts to assemble search teams. This does not mean that there are not any people sleeping rough in these boroughs.

The University of Surrey report states that

> these figures must be taken as the minimum possible number of people found on the streets on one night as it does not include those sleeping in squats or derelict buildings, nor those in inaccessible places such as parks or car parks... The general feeling on the night of the survey was that there were fewer people on the street than usual. However the results of these surveys indicate that there is no 'usual' number but rather one that is prone to seasonal, weather and possibly other conditions (Canter *et al.*, 1990, p. 14 and p. 19).

Homeless populations in London district health authorities

Since there was no feasible and comprehensive way of doing otherwise, it was assumed that the distribution of homeless populations within boroughs was the same as the distribution of the resident population. The Office of Population Censuses and Surveys (OPCS) provided a formula for each borough which identified the proportion of its population belonging to

related DHAs in mid-1988. Using the homelessness data by borough and where necessary the population distribution formulas provided by OPCS, the numbers of each type of homeless persons were estimated for all of the London DHAs.

Twenty-seven of the thirty-three boroughs are coterminous with or included completely within individual DHA boundaries. The remaining six boroughs – Camden, Kensington and Chelsea, Lambeth, Southwark, Wandsworth and Westminster – are split between two or more DHAs. For example, in mid-1988, 59.4 per cent of Camden Borough's population lived within the boundaries of Hampstead Health Authority and the other 40.6

3

Applying the OPCS formula

In some cases the homeless populations are clearly concentrated in certain parts of boroughs and this is not reflected in the formula. Since the original information about homeless populations was expressed by local authority (LA) and not individual post codes, we were not able to assess which district health authorities the concentrated homeless populations lived in. Because of this, some estimates may appear substantially higher or lower than those with local knowledge may believe are the case. The table below illustrates this problem with the examples of Camden and Westminster.

	Percentage of LA population residing in:		
Area	DHA	B&Bs	hostels
Camden LA			
Bloomsbury DHA*	40.6	65.7	94.3
Hampstead DHA	59.4	34.3	5.7
Westminster LA			
Bloomsbury DHA*	30.9	6.8	49.9
Parkside DHA*	44.1	70.1	0.0
Riverside DHA	25.0	23.1	50.1

*Using 1988 boundaries (eg before NE Westminster was transferred to Parkside and before Bloomsbury and Islington were merged)

Sources: [1]OPCS, personal communication, February 1991
[2]BABIE, address lists of B&B hotels used by local authorities, September 1991
[3]Newman *et al.* (1989)

The most graphic illustration of this problem is perhaps the allocation of Westminster residents to Parkside. According to the OPCS formula, 44.1 per cent of Westminster's resident population is in Parkside. In contrast, the known distribution of B&B residents and hostel spaces in Westminster shows that 70.1 per cent of B&B residents but none of the hostel spaces are in Parkside.

per cent of the Camden population was part of Bloomsbury Health Authority.

The reliability of this method of producing estimates varies significantly, as Box 3 illustrates.

Results

The total number of homeless people living in bed and breakfast hotels, private sector leased accommodation, hostels and sleeping rough in London is estimated to be at least 60,000 people, or approximately 1 per cent of the 1988 population. Using a wider definition, which would include squatters, the total would be much closer to 100,000 people.

Figure 1 shows the distribution of people housed in B&B hotels and private sector leased (PSL) accommodation. In March 1990 there were 22,187 persons housed in B&B hotels and 33,225 in PSLs in London. Parkside Health Authority had the greatest number of people living in B&B (6,250) and PSL (4,806) properties followed by Riverside (2,315 B&B and 2,192 PSL) and Ealing (1,442 B&B and 2,954 PSL).

Figure 2 shows the distribution of hostel bedspaces in emergency nightshelters, short-stay hostels and traditional hostels. There were a total

Figure 1 Number of B&B and PSL homeless by DHA

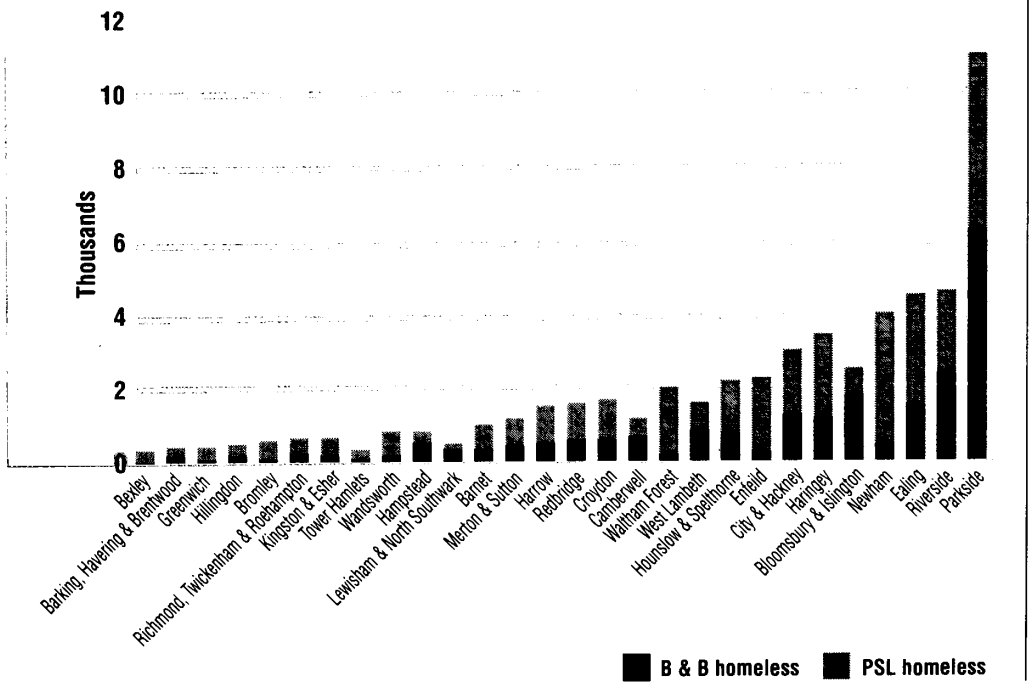


Figure 2 Number of hostel bedspaces by DHA

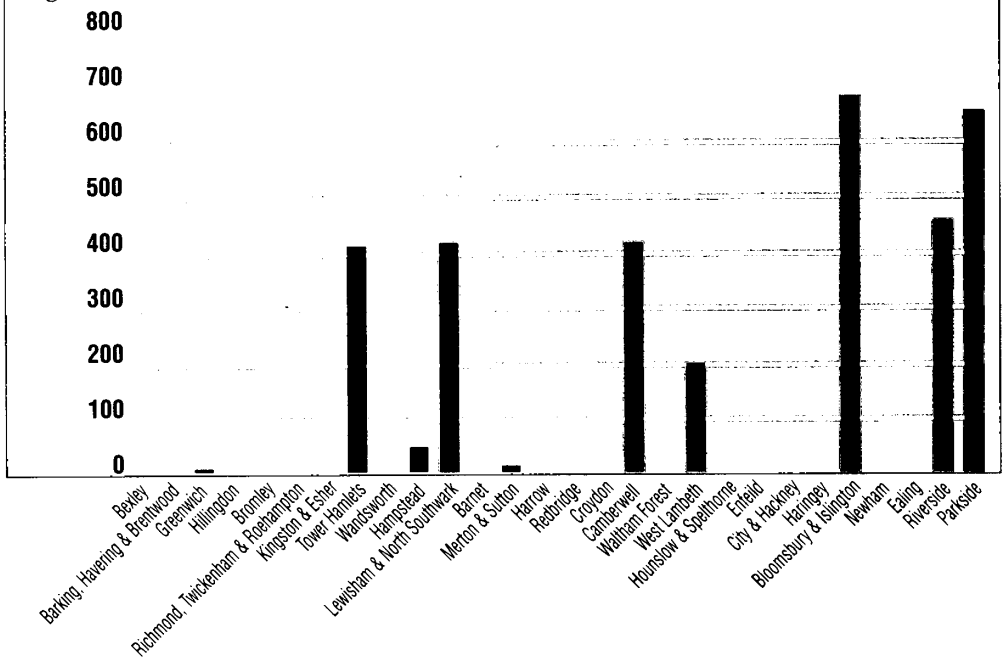
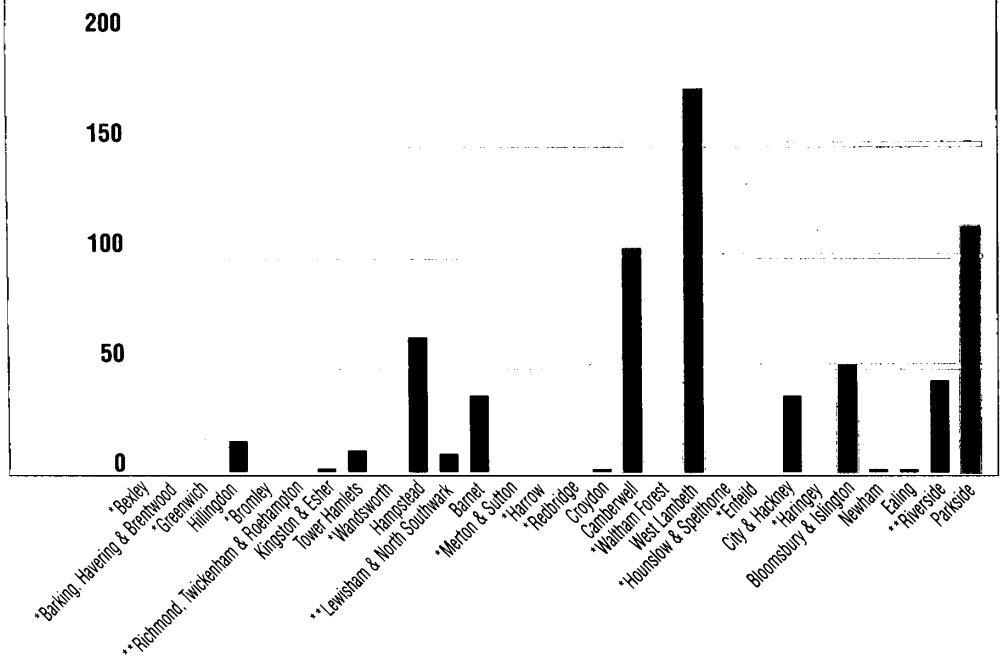


Figure 3 Number of people sleeping rough by DHA



*no street count in these DHAs **partial street count in DHA (eg: in one borough, but not all)

of 3,295 hostel bedspaces in London, and Bloomsbury and Islington Health Authority had the greatest number with 671 spaces.

Figure 3 shows the distribution of people sleeping rough. Canter *et al.* (1990) counted a total of 651 people sleeping rough in individual London boroughs on the night of 25 April, 1989. We estimate that the greatest number of people were found in the West Lambeth area, with 173 individuals. It is important to note, again, that this should be taken as the minimum number sleeping rough. First of all, street counts were only taken in seventeen of the thirty-three boroughs. Secondly, the results from the street count were notably smaller than other street counts which used the same methods but on different nights. For example, Canter *et al.* (1990) found 108 people sleeping rough in Camden in April 1989 but the Simon Community counted 320 people sleeping rough in Camden in August 1990 using the same methods.

The results found by Canter *et al.* (1990) are used in this report because at the time it was the only study with reasonably comprehensive coverage of the whole of London. However, as we went to press the results of the 1991 Census started to become available and some of these relate to the homeless, as Box 4 illustrates. The key point to note about these data is that they reinforce the conclusion that the genuinely roofless population is a highly variable, fluid and hidden one.

4

1991 Census preliminary results

The 1991 Census attempted to count the number of people sleeping rough on the night of April 21–22. OPCS worked in co-operation with the Salvation Army, who also helped organise the University of Surrey street count in April 1989 (Canter *et al.*, 1990). Similar methodologies were used for both studies.

Preliminary results show that Census enumerators found 1,275 people sleeping rough in Greater London. This is almost twice the amount reported by Canter *et al.* Most of this difference is derived from substantial increases in the number of people found in Camden, Westminster and the City of London. On the other hand, significantly fewer people were found in Lambeth. There were no people found sleeping rough in fourten of the thirty-three London boroughs.

Sources: [1] OPCS, 1991.
[2] Canter *et al.*, 1990, pp. 9–21.

3| Hospital utilisation study

Our aim was to quantify the utilisation of acute in-patient hospital services, including psychiatric in-patient services, by homeless people in two former inner London health authorities – Bloomsbury, now part of Bloomsbury and Islington Health Authority, and Paddington and North Kensington (PNK) Health Authority, now part of Parkside Health Authority. Subsequently the former Bloomsbury and PNK Health Authorities are referred to as the study areas.

Method

All unbooked admissions during November 1990 to the relevant hospitals in the study areas were identified from their patient administration systems. These hospitals were St. Mary's, University College Hospital, Obstetric Hospital, Royal National Throat, Nose and Ear Hospital, Middlesex Hospital, St. Pancras Hospital and St. Luke's Woodside (one of Bloomsbury's acute psychiatric facilities). St. Charles Hospital was excluded because a previous study in PNK showed that no admissions from homeless people occurred there (Victor et al., 1989). For each admission the following information was collected or derived: date of birth, sex, length of stay, specialty of admission (by Korner coding of consultant), postcode, and district of origin. All patients who were resident in the study districts on the basis of their postcode or said to be of no fixed abode (NFA) were classified as follows:

i) Bed and breakfast and private sector leasing;

ii) No fixed abode;

iii) Hostel/Shelter;

iv) Others.

In the case of i) this involved assigning a status by matching each individual's admission address with a list of bed and breakfast hotels obtained from the Bed and Breakfast Information Exchange and a list of private sector leased accommodation used by Camden, Westminster and Kensington and Chelsea local authorities. In the case of iii) this involved matching admission addresses with a list of local hostels obtained from the London Hostels Directory. In the case of iv), this involved identifying permanent district residents, those with 'care of' addresses and those staying in tourist hotels.

Admissions from individuals living in PSL accommodation have been grouped together with those of B&B residents for two reasons. Firstly, the PSL lists were incomplete since we were not able to obtain lists of PSL accommodations in the study area which are used by other boroughs. Secondly, both the B&B and the PSL populations are accepted by local authorities under the same statutory criteria and are generally thought to have similar characteristics.

Since squatters usually do not identify themselves as such and there is no comprehensive list of squatting addresses, we were unable to separate utilisation by squatters from that by residents (if an address was given) or by those of no fixed abode.

In this study, it was assumed that

i) for all groups in the study population, the relative proportion of all unplanned admissions to hospitals outside the two districts was the same regardless of housing status;

ii) almost all admissions to hospital for homeless people are on an unplanned emergency basis, as previous work by Victor *et al.* (1989) demonstrated;

iii) in deriving length of hospital stay information, there is no distinction between discharge, death and transfer;

iv) in calculating annual utilisation rates for the housing categories, admissions for the month of November are a representative sample for the whole year.

Results

The total number of unbooked admissions (excluding those permanent residents of other districts) to the study area hospitals during November 1990 was 1256. Of these, 1145 were permanent district residents, tourists or had 'care of' addresses and 111 were homeless. The distribution of homeless people by housing status and selected specialties is shown in Table 1. Overall, 9 per cent of admissions were by homeless people.

The study clearly demonstrated the heterogenous nature of the homeless populations' utilisation of unplanned acute services in the Bloomsbury and the Paddington and North Kensington areas. Tables 2 and 3 and Figures 4 and 5 illustrate how different aspects of these admissions vary by homeless population and by study area. These tables illustrate the impact of the larger population living in bed and breakfast hotels and private sector leasing accommodations in Paddington and North Kensington and the larger numbers of those of sleeping rough or living in hostels in Bloomsbury. The B&B and the PSL populations account for over 10 per cent

Table 1 Unplanned admissions by housing status and specialty in total study area, November 1990

	Specialty				
Housing Status	Obstetrics	Psychiatry	Other	Total	%
B&B and PSL	26	5	31	62	5
NFA	–	10	28	38	3
Hostel	–	2	9	11	1
Other*	317	52	776	1145	91
Total	**343**	**69**	**844**	**1256**	**100**

Table 2 Unplanned admissions by housing status and specialty in PNK November 1990

	Specialty				
Housing Status	Obstetrics	Psychiatry	Other	Total	%
B&B and PSL	22	5	24	51	8.3
NFA	–	3	1	4	0.7
Hostel	–	–	–	–	–
Other*	174	21	362	557	91.0
Total	**196**	**29**	**387**	**612**	**100.0**

Table 3 Unplanned admissions by housing status and specialty in Bloomsbury, November 1990

	Specialty				
Housing Status	Obstetrics	Psychiatry	Other	Total	%
B&B and PSL	4	–	7	11	1.7
NFA	–	7	27	34	5.3
Hostel	–	2	9	11	1.7
Other*	143	31	414	588	91.3
Total	**147**	**40**	**457**	**644**	**100.0**

*permanent residents, 'care of' adresses, and tourists

Figure 4 Homeless unplanned admissions by age, PNK

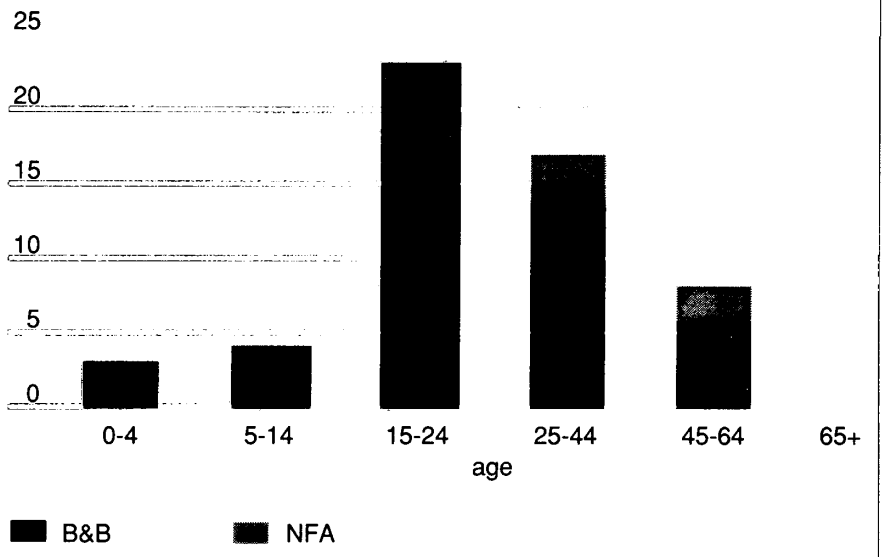
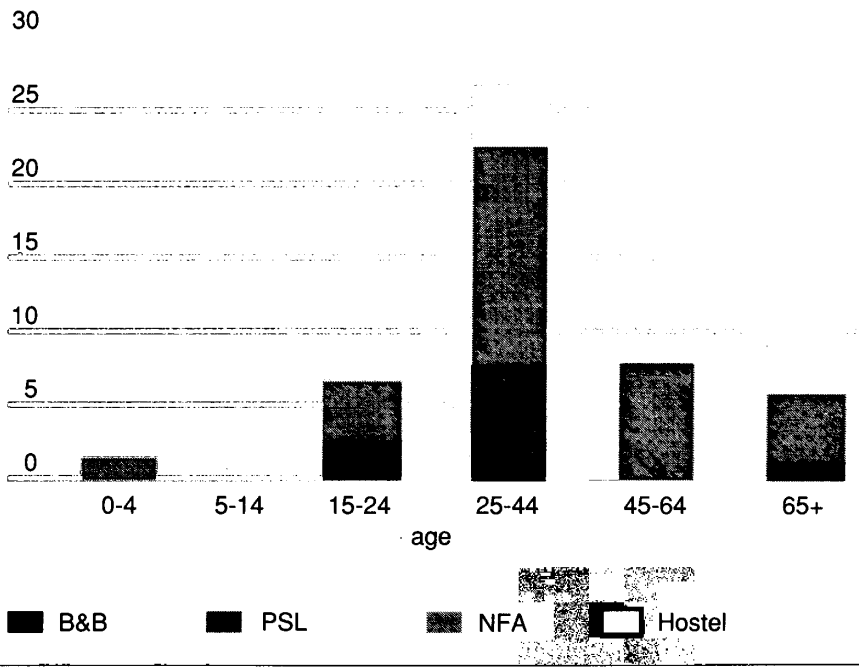


Figure 5 Homeless unplanned admissions by age, Bloomsbury



of unplanned obstetrics admissions in PNK. NFA admissions make up over 17 per cent of unplanned psychiatry admissions in Bloomsbury.

Calculation of utilisation rates

In order to assess the implications of the hospital utilisation study for the rest of London, rates were calculated for each group of homeless people and applied to the estimated number of homeless in each DHA. Annual admissions for each housing category were estimated by multiplying November admissions (from Table 1) by twelve, assuming that November admissions were a representative sample for the year. This may have led to higher morbidity rates because of damp and cold weather; however, the results found were similar to previous research by Victor *et al.* (1989). The estimates of annual admissions were then divided by the estimated number of homeless people in the study areas, as shown in Table 4. The calculation of utilisation rates for each population group is shown in Table 5.

The NFA admissions are much more difficult to deal with. The population sleeping rough in London was estimated from a street count performed on one night in April 1989. However, it is not valid to assume that the NFA admissions for an area are drawn solely from those sleeping rough in it. Not only are other groups such as squatters likely to be admitted as NFAs, but also the street population is very mobile and studies indicate that the size of the population sleeping rough can vary tremendously in an area, depending on the night surveyed. Therefore, it is difficult to feel confident in estimating a utilisation rate for NFA admissions. For example, a local street count in Bloomsbury in August 1990 found 320 individuals sleeping rough. If used as a denominator, this would give rise to an annual admission rate of 1,425 per 1,000. This seems too high, but it serves to highlight the very real difficulty in estimating hospital admission rates at the local level for this most mobile group of homeless people. The results suggest, however, that NFAs can be intensive users of services and cannot be ignored for policy purposes.

In summary, one month's unplanned admissions for two former inner London DHAs were used to generate housing status-specific admission rates. These are likely to be underestimates because:

i) there is no distinction between transfers and discharges;

ii) those who gave a 'care of' address were not classified as NFA, even though some may have been;

iii) the definition of hostels used for this study is possibly too strict;

iv) all relevant B&B and PSL admissions may not have been identified.

Table 4 Population estimates by housing status in the study areas

Housing Status	PNK	%	Bloomsbury	%	Total	%
B&B and PSL	3,700	2.9	2,011	1.5	5,711	2.2
NFA	–	–	–	–	–	–
Hostel	107	0.08	1,040	0.8	1,147	0.4
Other*	124,000	97.0	127,000	97.7	251,000	97.3
Total	**127,807**		**130,051**		**257,858**	

Table 5 Calculation of estimated annual unplanned admission rates by housing status

Category	Admissions November	Admissions Yearly	Population estimates	Admission rate per 1,000
B&B and PSL	62	744	5711	130
Hostel	11	132	1147	115
NFA	38	456	–	–
Other*	1142	13,704	251,000	55

*permanent residents, 'care of' adresses, and tourists

4 Implications for London

The previous section has shown that homeless people are relatively more likely than local resident populations to make unplanned use of hospital services. It seems equally clear that there is a considerable diversity of experience between groups of homeless people in different parts of London. Notwithstanding the small-scale nature of this empirical study, the results reported have potentially far reaching implications.

The level of unplanned acute hospital admissions across London can be estimated by applying the homeless person-specific admission rates, as shown in Table 5, to estimates of the numbers of homeless people in different parts of the capital. As explained earlier, homeless people of no fixed abode present exceptional difficulties for anyone trying to calculate an admission rate because of the extraordinary imprecision of any estimate of an appropriate denominator. Figure 6 presents the estimates of the likely unplanned acute hospital admissions associated with those categories of homeless people who live in private sector leasing, bed and breakfast, and

Figure 6 Total predicted annual admissions by DHA, not including NFA admissions

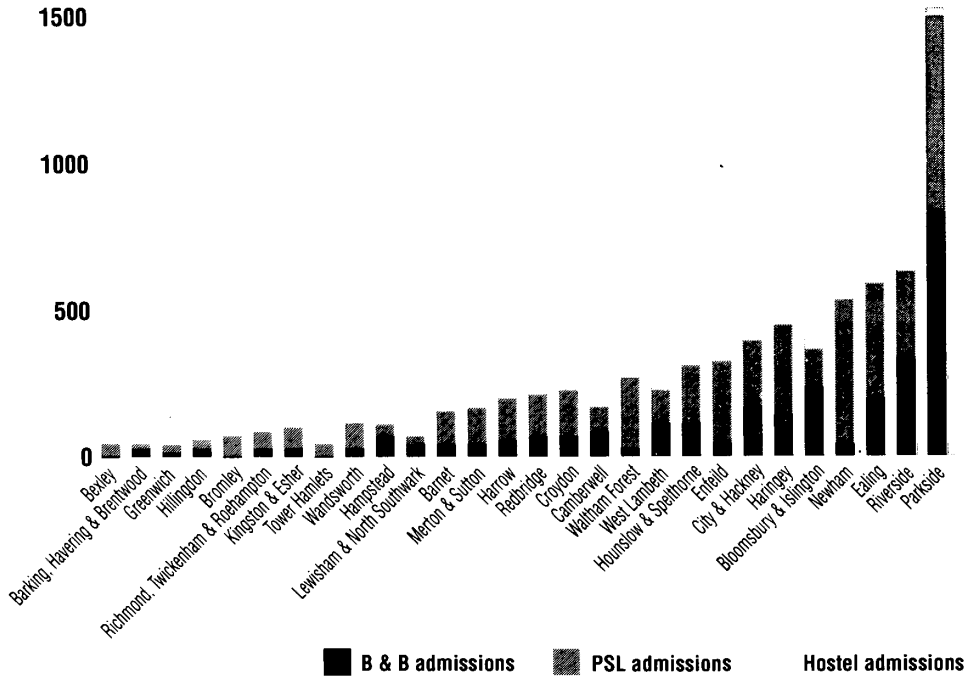


Table 6 Annual costs (£000) of acute admissions of homeless people, 1990/91

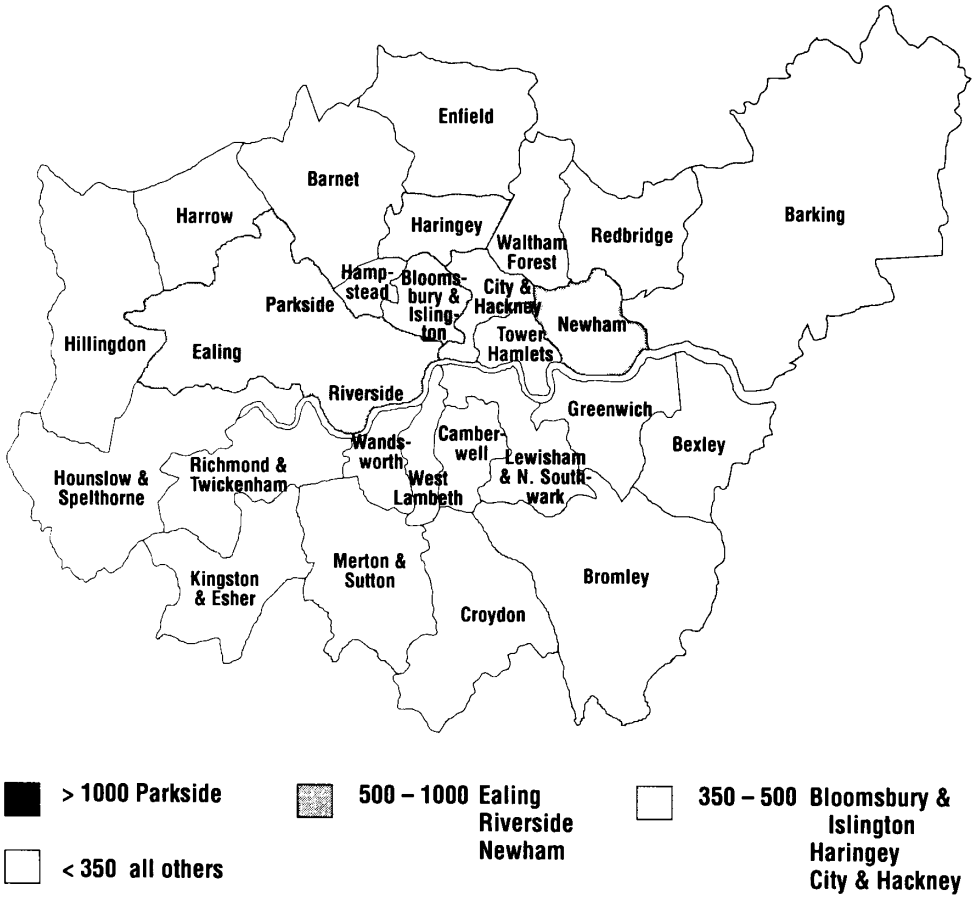
	DHA		
Housing Status	Parkside	Bloomsbury	Total
B&B and PSL	599	173	772
Hostel	–	636	636
No fixed abode	82	1,409	1,491
Total	**681**	**2,218**	**2,899**

hostel accommodation. The total number of such admissions is estimated to be over 7,500, with 57 per cent from PSLs, 38 per cent from B&Bs and 5 per cent from hostel dwellers.

Although these estimates suggest that hostel dwellers account for a relatively small proportion of unplanned admissions from the homeless population, people living in hostels tend to be more intensive and expensive users of hospital services than those living in B&Bs and PSLs. For example, the mean length of stay for hostel dwellers was eighteen days, compared with less than four days for admissions from B&B and PSL residents. If local specialty average per diem costs are assigned to the observed length of stay, the annual cost figures shown in Table 6 are generated. It should be noted that this study was based on a relatively narrow definition of hostels and this might have influenced the intensive utilisation patterns found in this group. Despite the small numbers of individuals identified as of no fixed abode, they consume as many resources as the other two homeless categories combined. However, there has deliberately been no attempt to compare the length of stay distributions among homeless people with those of other in-patients, because it is impossible to judge what would count as a properly comparable 'control' group, weighted by age, sex, socioeconomic status and severity of illness. Nevertheless, the variation in cost by housing category emphasises the need for districts to collect their own numerator data, particularly in the case of those of no fixed abode.

From these results it is possible to draw some broader implications for London. Figure 7 shows a map of the distribution of predicted admissions from homeless persons in London DHAs. Because of its concentration of short-term B&B and PSL accommodation, Parkside has the highest number of predicted unplanned acute hospital admissions – almost 20 per cent of the total admissions. The high number of admissions in Newham, Ealing

Figure 7 Map of total predicted annual homeless admissions in London DHAs



and Haringey reflects the trend for local authorities to place homeless in B&Bs and PSLs outside the centre of London to less expensive areas. Bloomsbury has the highest number of similar admissions from homeless hostel dwellers – approximately 20 per cent of the total hostel admissions. While it is evident that these admissions are concentrated in the northern districts, it is important to realise that these are only admissions from the 'official' homeless and hostel dwellers. Homeless groups who are more difficult to count and to identify at the point of admission, such as those sleeping rough or in squats, tend to be concentrated in southern inner London districts.

To illustrate the scale of the problem for individual DHAs, the number of predicted homeless admissions per 1000 resident in-patient admissions has been calculated using data from the 1989/90 health service indicators package (Department of Health, 1991). In-patient resident admissions

were calculated by subtracting the number of finished consultant episodes which were day case admissions from the number of all consultant episodes of district residents treated anywhere in England. For London as a whole, homeless people add an extra ten admissions for every thousand resident in-patient admissions. However, the estimates suggest that three DHAs – Haringey, Newham and Riverside – experience over double this rate and Parkside has an additional 35 homeless admissions per 1000 resident admissions. Given that data were only collected about a small portion of all homeless people, the additional utilisation of health services by these people represents a significant problem for the capital in general and a major problem for several individual authorities in particular.

The unplanned nature of homeless admissions and the difficulties associated with discharging certain groups of homeless people result in a significant expenditure and a reduction in capacity to admit other patients on a planned basis. The size of the financial and organisational effects must be informed by more qualitative research which examines more detailed implications of treating large groups of homeless people.

5 The way forward

> I don't need a doctor unless I'm ill. Then I want to be able to consult one. But what I want right now is somewhere warm and dry to sleep, with something hot to eat and a decent pair of shoes (Sadgrove, 1990, p. 32).

These comments from a young man sleeping under a flyover remind us of what must be done to tackle the expressed needs of homeless people. The chief priority must be to address the 'dwindling supply of affordable housing' (Greve, 1990). In addition to the growing numbers of people sleeping rough during the 1980s it is estimated that in England three million people were registered as homeless and currently about 1000 households apply to local authorities for help each day on these grounds.

As several studies have demonstrated, many homeless people have special health care needs. It was not the intention of this study to set out in detail how these needs can best be met. However, reviewing our findings in light of other research studies, it is worth noting three areas where the implications for policy are most profound. A new approach to policy and practice is most badly needed in relation to:

- housing policy;
- planning health services;
- NHS resource allocation.

Housing policy

One indication of the absurdity of present policy is that it has been estimated that 'the £11,000 a year it costs to keep a family in a B&B in London would finance the debt repayment on two new council homes with some £1,000 to spare' (Dean, 1990, p. 715). The main problem is the lack of adequate low-cost rented housing. Instead of ameliorating this lack of supply, public policy during the 1980s has exacerbated the situation. Continuing problems, which must be addressed if homelessness is to be seriously reduced, include the following:

- the huge sales of council houses to sitting tenants which has been one of the flagship policies of the Conservative government;
- a massive reduction in the level of new public sector building and a very

low level of overall investment in housing – Britain now invests less than any other major state in Western Europe;

- poor management of the existing public sector housing stock which denies access to some of the shrinking supply actually available;
- a grossly unfair system of fiscal subsidies which favours wealthy owners by comparison with poorer renters.

Planning health services

This emphasis on remedying defects in housing policy, however, does not mean the health services can absolve themselves of responsibility for the plight of homeless people. The role of district health authorities in assessing the health needs of their population must apply to homeless people as well as other resident groups. Planning services to meet these needs means finding ways of encouraging a more appropriate pattern of service provision and use. Departments of public health need to make greater efforts to map the distribution of homeless people in their area, to identify their needs and to set out the service and resource consequences.

One interesting piece of research currently underway in this area is the extension of the North West Thames regional health survey to B&B dwellers. This will provide utilisation, health status and lifestyle data together with individuals' social and economic circumstances, at population level rather than hospital admission level. It will be possible to compare the characteristics and health variables of people living in B&Bs with those of the general population in North West London on a reasonably large scale for the first time. This will enable more appropriate measures of need – other than service utilisation – for these vulnerable groups to be established.

It must always be remembered that not only are homeless people likely to have higher levels of morbidity than the general population but they frequently postpone or do not make contact with the health services because, given their circumstances, their health does not always seem a high priority. In addition there may be considerable barriers to access to the appropriate forms of care. Compounding their problems, homeless people often do not have sufficient contact with preventative health care services.

As the SHHARP report argues:

> to break this pattern of using services, measures need to be taken to encourage not just increased registration with GPs but effective use of a whole range of primary health care services (Stern *et al.*, 1989, para 5.5.3.5).

At a national level the Department of Health needs to revise the new GP

contract to provide specific incentives for GPs to encourage mobile populations to register with them and provide them with preventative as well as curative care. If people expect to live in a place for less than three months, as many homeless families and single people do, they may only register with a local GP as a temporary patient. The current contract does not include temporary patients in its calculation of vaccination and other targets. Thus, GPs who provide vaccination and other targeted services for homeless people are often not remunerated as they should be.

At a local level, improvements may involve the use of specialist teams, drop-in centres and outreach services as well as the appointment of one member of the local primary care team to coordinate service provision. Regional health authorities may wish to consider setting targets for both DHAs and FHSAs to develop a more coordinated approach to primary care for homeless people.

The most immediate issue to be addressed is the need for more coordinated planning by DHAs, FHSAs and local boroughs.

> Unless this happens, the health service provision for homeless families will remain a haphazard mixture of crisis intervention intermingled with the praiseworthy efforts of committed individual professionals, charitable organisations, or pilot and research projects (HVA & BMA, 1988, p 17).

Accurate information is vital for planning purposes. Given the diverse health problems of different subgroups of the homeless population, authorities need to establish the characteristics of all the homeless groups resident in their area in order to target appropriate care. For B&B and PSL residents this means more rapid and coordinated notification by local boroughs to receiving health authorities. At present, DHAs are often only aware of homeless families which the coterminous local authorities have placed with the borough. Local authorities need to notify appropriate DHAs when homeless families are placed outside, as well as within, the borough. In addition, a means of identifying the needs of hostel dwellers, squatters and people of no fixed abode also needs to be found.

NHS resource allocation

One important way in which the special health care needs of homeless people can be better accommodated is by making further adjustments to the allocation of purchasing power in the new NHS. To appreciate the implications of our results for resource allocation, it is important to understand three key features of the new financing system:

- the national HCHS revenue allocation formula to regions;
- the Department's instructions to regions for developing district allocation policies;
- the guidelines for determining DHA responsibilities where residency may not be clear.

The Department of Health has established a method for allocating revenue resources for Hospital and Community Health Services (HCHS) to regional health authorities based on a weighted capitation formula. This formula weights regional population estimates by age and by the square root of the all-cause standard mortality ratio (SMR) for people under 75 years. The SMR weighting is used as a proxy for variations in populations' morbidity levels. No weighting for social deprivation factors has been included in the national formula. There are also additional weightings to reflect the higher costs of services in the Thames regions in general, and in London in particular.

The Department has asked regions to develop their own policies for allocating HCHS revenue resources to districts based on a weighted capitation policy, and has indicated that the national formula might not be sensitive enough to local circumstances for it alone to determine allocations to district health authorities. In its national guidance to regional health authorities in February 1990, the Department invited regions to consider other factors which their formulae might need to take into account.

> Regions should have discretion to take account, in consultation with districts, of factors other than age and morbidity in determining weighted capitation based funding at district level. There should be a presumption however towards clarity, simplicity and stability ... A number of regions may wish to consider taking account of other factors: eg old long-stay mental illness and handicap patients; poor primary care services; high levels of homelessness. Others may consider that the Regional allocation formula is sufficiently fair and robust to be adopted unchanged at district level (Department of Health, 1990).

The Department also recognises that regions may want to consider including a weighting for social deprivation factors and A&E departments in areas with high commuter or tourist populations.

Under the new arrangements, districts will be responsible for purchasing health care services for their resident population. While for most people district of residence will be very clear, this is likely to be a difficult issue for

mobile populations like the homeless. The Department has stated that

> the principle is that the patient's perception of where he is resident (either currently or, failing that, most recently) is the criterion. If patients consider themselves to be resident at an address which is, for example, a hostel, there is no reason why that should not be accepted. Equally, a DHA should continue to accept responsibility for a patient if he considers himself not to have been resident anywhere else since leaving its District. Finally, if the patient cannot give any address, the safety net would apply, and the District where the Unit providing treatment is located will accept responsibility (Department of Health, 1989).

While districts are meant to take responsibility for patients who perceive themselves to be local residents (whether temporary or permanent), there is a possibility that some districts will try to 'disown' various types of homeless people by pressing them to give their last permanent address. In particular, for people who have been homeless for many years or who are roofless or mentally ill, assigning a district of residence may be very difficult. Regions may need to monitor how hospitals handle assigning district of residence for homeless people.

Although the Department has stated that some regions might want to incorporate other factors besides age and morbidity into district weighted capitation formulae, most are still in the process of developing a practical way to do this. To our knowledge, North East Thames is the only region to begin to take some account of the extra demands placed on districts by high concentrations of homeless, under-enumerated and unenumerated populations. We very much welcome these attempts to develop approaches to resource allocation which are more sensitive to comprehensive assessment of need. Nevertheless, it seems likely that further adjustments to sub-regional allocations will be necessary to accommodate the broad thrust of these and other research findings.

One specific problem in need of urgent attention is improving the estimates of local resident populations with regard to mobile and homeless people. In developing annual population estimates, OPCS adjusts Census figures by taking into account FHSA registration lists (permanent registrations) and migration figures from international ports and air terminals. If the homeless do not register with GPs in their local area or are only able to register as temporary patients, they will not be included in local OPCS population estimates. Even small inaccuracies in the numbers of relatively high need groups will reduce the validity of allocation methods. Although the 1991 Census results may provide a better base for assessing relative

health needs, population estimates will still need to be adjusted annually to take account of mobile and homeless people.

In the light of our findings and of other literature on homelessness, we conclude that district allocation formulae need to be adjusted to take better account of three factors:

- the heterogeneity of homeless populations;
- the uneven distribution of different types of unenumerated homeless and migrant people;
- the extra health needs of different types of homeless people.

Finally, one point worth reiterating is that if regions do allocate resources to account for the extra needs of the homeless, it is important that districts do not use this money in an unthinking way simply to buy additional acute care; instead, it may be more appropriate to use the additional resources to strengthen community services for the homeless.

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